Physicians End Running The Payers

Health Law Institute

PBI

March, 2019

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Overview

- Physician dissatisfaction with payors
- Direct contracting with employers
- Provider-Employer contract issues
- Provider-Provider governance and contract issues for a network
- Direct Primary Care and Concierge Care
- Opting out of Medicare

Physician dissatisfaction with payers

- Exceeded only by EMR as a source of frustration
- Wasting time on unnecessary administrative work
- Opacity of what qualifies for prior authorizations

Prior authorizations

- Physicians spend 6 hours a week on them
- Staff spends an additional 13 hours a week
- Time spent getting them
- Payers are practicing medicine
- Unclear what requires prior authorization
- Opacity of reasons for denial
- More services are becoming subject to prior authorizations
- Drug prior authorizations are particularly problematic

On a scale of 0-10: 3.8

- Clarity of information on insurance cards
- Lack of responsiveness to changes in patient data provided by the practice
- Pre-authorizations
- Inability to identity whom to contact with inquiries
- Failure to notify regarding contract changes
- Difficulty in reporting required data
- Difficulty in navigating websites
- Complexity of navigating phone systems

On a scale of 0-10: 3.3

- Payer responses to inquiries on claims denied
- Response times to inquiries
- Time on hold
- Willingness to negotiate rates
- ACP: Position paper “Reducing Administrative Burden”
- Lack of collaboration with stakeholders

Direct contracting with payers old style

- MN Buyers Health Care Action Group
  - 3M, Pillsbury Honeywell and GM
  - 400,000 covered lives
- Tiered systems including physicians and hospitals
- Single claims administrator
- Adherence to quality standards, center osf excellence, measurement of performance,
- Standardized payment and risk adjustment
- Desire to force HMOs into more patient-centric behavior

What's different today?

- Increased consolidation: fewer actors
- Payors no longer lead change
  - Physicians, systems, CMS
- Shared risk-taking between plans and providers
- More tools to pursue coordinated care with guidelines, standards of practice and evidence-based medicine.
- Quality is tied to enhanced payment
- More electronic infrastructure
- More patient-centered
  - Large employers are unimpressed with plans' ability to meet their needs: Catalyst for Payment Reform

Who's doing it?

- GM, Walmart, Intel, Whole Foods, Lowe's and JetBlue
- Some through ACOs
- Some with bundled payment
- Carve out Centers of Excellence
  - Bariatric surgery, infertility, cardiac surgery, orthopedic surgery, oncology, maternity and transplants

Physicians doing it

- AAFP advice: primary care plus:
  - Wellness and prevention, worker's comp, occupational health, comprehensive primary care for episodic and chronic illnesses, work site clinics
- Payment models
  - Per employee per month
  - Flat rate covering physicians, mid-levels and copays
  - Additional payment above capitation
  - Bundled payment with others
- Specialists taking full continuum of care

Lessons from experience

- Employers have to realize paying more on primary saves on specialty care and urgent care
- Doesn’t have to be all or nothing (employee choice)
- Standard EMR is important as is standardized documentation
- Physicians need to continually analyze data
- Eliminates need for referrals; no need for claims
- PBMs are still a problem
- Problem of scope and scale for one practice

Provider-Employer contract issues

- Data
  - What information is made known and how quickly?
  - What do any providers get to know about any other providers?
  - How can data be challenged for corrected
- Elimination of medical management
  - Prior authorization, utilization review
  - All the PBMs, BHBMs, imaging managers
  - Restrictions on roles of non-physicians not necessary
  - Post-payment audits, especially of E/M
- Provider selection can enhance the elimination or mitigation of medical management

Dispute resolution

- Not subject to appeal
  - The budget for a bundle or the fee for add on fees
  - Rules for triggering, breaking or ending an episode payment
  - Rules for severity adjustment
- Appealable issues
  - Whether an episode is triggered or broken
  - Whether a provider qualifies for upside payment or met thresholds
  - The amount of payment if it varies with scores
  - Whether the data supporting payment is accurate

Provider-provider issues

- Variety of entities can play
- Governance issues
  - Issues of governing the money
  - Supermajorities
    - Typical issues
    - Special issues: changing to compensation metrics, allocation formula, adding new classes of providers, adding new providers, terminating a provider
- Agreements regarding risk sharing and gainsharing, attribution rules, post-termination rules

Direct primary care

- Office visits, laboratory work, vaccinations, generic drugs and sometimes low level imaging.
  - Emphasis on electronic communication
- Patients carry health insurance for hospitalizations
- Physicians opt out of Medicare: primary care is covered by Medicare
- Periodic fee for services (monthly)
- No claims submitted to third parties.

DPC contract issues: Medicare and insurance

- Relationship of DPC to Medicare and why opt out is required
  - Some say agreement terminates if patient becomes a Medicare patient
  - Some provide private contract to be completed if patient becomes a Medicare patient
- No claims will be submitted and patient may not submit either
- Patient financially liable for all care

State regulation: 27 states do

- Exempts the monthly fee as the business of insurance for ‘retainer’ practices
- Addressing scope of permissible practices
- Nature of payment (e.g., monthly fee)
- Some prohibit charging an insurer in addition
- Some prohibit dispensing drugs

What could prevent regulation as insurance

- The issue is the physician is taking risk in the volume of care to the patient which is the business of insurance
  - Limiting patients in the panel
  - Disclaim insurance
  - State that all patients need insurance.
  - Let patients terminate at any time
  - Require at least one annual visit.
  - Limit visits or lab tests contractually

Scope of services

- Some just say primary care
- Others list what's included
- Some exclude patients seeking chronic controlled substances or patients with high cost diseases like hep C, MS and Rh issues
- Some charge extra above a defined number of office visits
- Some offer additional services like lab, imaging and drugs at cost

Communication and privacy

- Almost all state their reliance on electronic communication
  - One limits covered e-interactions to 99/yr
- All emphasize that electronic communications (email, fax, video chat, cellphone, texting, etc) are not secure and that patients waive rights by participating
  - Even though HIPAA says otherwise
- Some reference HIPAA rights, some even asserting they have a will conduct secruity risk assessment

Financial terms

- Monthly fee
  - Term is month to month
  - Term is minimum two months
  - One term is six months
- Additional enrollment fee
- All allow termination at will but most charge a re-enrollment fee
  - One requires a one year wait after termination
- Some say health savings accounts may not be used per the IRS

Other terms

- Obligation to treat staff civilly
- Requirement for patient to disclose all information relevant to treatment
- One has a practice hold harmless provision against circumstanced beyond its control, another for patient breach
- One reserves the right not to renew to maintain panel size or any other reason

Concierge care: Non-covered fee for services

- Higher payment than DPC
- Many do not opt out of Medicare and bill other insurances
  - The two physician scenario for HMOs
- Patients have to make payment explicitly for non-covered services
  - Personalized amenities of care
  - Extensive diagnostic testing
- But Medicare now pays for 26 separate screening and preventive services
  - OIG March 31, 2004 said “coordination of care”, “a comprehensive assessment and plan for optimum health”, and ”extra time with patients” are all covered.

Opting out: private contracts

- No claims may be submitted by physican or patients.
  - Services are not covered
  - Will pay for services ordered (not an exclusion)
- Private contract with ALL Medicare beneficiaries
- Affidavit sent to MACs

Network competition for CC

- MDVIP sued former employees who went to SignatureMD
- Signature MD sued MDVIP for anti-competitive practices
  - Requirement that all patients participate
  - Panel size limited to 600
  - Evergreen clauses
  - Post-termination 2 yr restrictive covenant
  - Non-disclosure agreements'
  - $1M liquidated damages

Other litigation

- LVHN sued MDVIP over a physician employees disclosure of PHI to MDVIP in considering joining
  - He was fired
  - HIPAA authorizes sharing but he wasn't authorized to do so
  - settled
- MI physicians sued MDVIP over fax transmissions soliciting other physicians to join
  - Filed as a class action 2/2018
- Malpractice liability for false advertising
  - $8.5M jury verdict
  - Overturned on appeal because of prior relationship between physician and patient

Opting Out of Medicare

- First available in 1997
- Small numbers
  - 2010: 130 nationally
  - Peak in 2016 of 7400
  - 2017—3732 (maybe because no renewal every 2 years anymore)
- Effects
  - No claims may be submitted by anyone
  - Services rendered are non-covered
  - Medicare will pay for services order: not an exlcusion
  - Essential to DPC because all the basic services are covered: for CC depends on services

Private contract

- Large print
- Patient accepts full financial responsibility
- Limiting charges do not apply
- Patient can get services elsewhere and not compelled to enter agreement
- Term two years, but automatically renews unless physician terminates opt out
- Must state beneficiary understands Medigap policies may not pay either since services are not covered
- Must be signed by beneficiary who must be given a copy
- Original must be retained by physician

Affidavit

- Filed with MAC for any jurisdiction to which physician submits
- Must contain physicain demographic data
- Except in emergencies, physician will only provide services through private contract
- No Medicare services (MA too) will be covered
- If participating must state participation ends with the filing of the affidavit
- In an emergency no patient will be asked to sign a private contract
- Must be filed within 10 days of first private contract signed.

Failure to maintain opt out

- If physician neglects to enter into private contract with all Medicare patients
- If physician submits claims directly or indirectly (e.g., through an assignment)
- If physician fails to follow rules on emergency care
- If physician fails to maintain a copy of the original private contract!
- Effects
  - Must submit claims, limiting charge applies, prohibition on reassignment of any claims
- MAC may permit physician to cure by repaying any monies within 45 days of notice

Conclusion

- Most payors have not demonstrated any sensitivity to physician dissatisfactions
- Medicare is beginning to understand that time is the most precious resource physicians have and need
  - Teaching physician documentation
  - Payment for virtual visits
- Physicians will continue to look for ways to avoid the problems they confront with the current system
- Those who report the changes are very pleased.
- The system needs to change to pay physicians for what they do without the overarching inspection/regulation approach