



Private Practice Toolkit

Payor Contracting 101

Practicing physicians encounter a wide variety of options when negotiating the terms and conditions of payment for services. This Payor Contracting Toolkit, provided by the American Medical Association, is designed to help physicians evaluate contracts with payors, understand the differences among payors, and develop a basic working knowledge of the range of insurance products and payment models associated with the contracting process. The materials in this toolkit are for education and informational purposes only and should not be considered legal advice. Physician practices should consult their own health care counsel or other advisors to evaluate specific agreements or contracting opportunities with payors.

What is a “Payor”?

Answering the fundamental question of who or what is the “payor” may be complex. At base, a “payor” is the entity that pays for services rendered by a healthcare provider. The payor may be a commercial insurance company, government program, employer, or patient. Physicians may also contract with third-party administrators or intermediary contracting entities, including other health care providers who have assumed financial risk from a payor. The identity of the payor may determine the degree to which terms are fixed or negotiable, the applicable laws, negotiating strategy and goals and objectives of the relationship. Common examples of “payors” include:

- **ERISA Self-Funded Employee Benefit Plan/Union Trust** – An employer-sponsored health benefit plan where financial responsibility for overall cost of care lies with the employer instead of with an insurer. ERISA plans are usually exempt from state insurance laws (e.g., prompt pay laws).
- **Third Party Administrator** – An entity that contracts with ERISA plans to administer the health plans, including claims adjudication and payment, utilization management, physician contracting, and other administrative functions necessary for plan operations.
- **Fee-for-Service Government Programs** – Medicare, Medicaid, Workers’ Compensation, Veterans’ Administration, etc. The terms of such plans are typically set by the government entity and there may be little room for a physician or practice to negotiate anything different.
- **Health Maintenance Organization (HMO)** – HMOs contract with a network of health care providers that have agreed to the HMO’s reduced payment structure or fee schedule. Subject to few exceptions, care provided under an HMO is covered only if a member sees physicians within the HMO’s network.
- **Preferred Provider Organization (PPO)** – A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of “preferred” providers. These preferred providers agree to the PPO’s payment structure, or fee schedule, for services. PPOs also offer coverage for services provided by non-preferred (non-contracted) physicians.
- **Exclusive Provider Organization (EPO)** – EPOs are similar to PPOs, however, EPOs typically require members to receive services *only* from participating physicians.
- **Point of Service (POS)** – A POS plan is a hybrid PPO/HMO which provides the flexibility of a PPO while retaining cost controls. For example, POS plans may offer coverage for services provided by non-preferred (non-contracted) physicians, but only upon a referral from a PCP.
- **Leased Network/Contracting Networks** – Physician networks are typically organized and managed by entities other than insurers. The network contracts with physicians to form a network that insurers pay to access, including self-funded plans and their TPAs.
- **Accountable Care Organization (ACO) Clinically Integrated Network (CINs)** – The voluntary networks of providers are typically organized and managed by health care providers (e.g., health systems) instead of insurers with the goal of delivering high-quality, coordinated care. The ACO or CIN may contract with insurers on behalf of the physicians and may require the physician to adhere to ACO or CIN clinical guidelines for care.
- **Health Care Sharing Ministries** – A nonprofit ministry that solicits contributions for sharing of health care costs among members. Health Care Sharing Ministries are not “insurers” but are recognized under the Affordable Care Act as satisfying the requirement for individual coverage.

How Are Physicians Paid?

Payors use a variety of reimbursement methodologies and reimbursement structures. Several reimbursement methodologies might be combined in a single arrangement with a payor, often as a means of transitioning to “**value-based**” payment. Reimbursement methodologies may include the following: the following:

- **Fee-for-service reimbursement** – fixed reimbursement amounts per item or service furnished, commonly negotiated in a physician participation agreement with the plan. At base, the “plan” pays the cost of medical care, while the “payor” is an entity responsible for the processing of patient eligibility, services, claims, enrollment, or payment.
- **Direct to Employer** – direct and unique arrangements between physicians and ERISA self-funded plans for discrete categories of care. (Note that AMA has **guidance** on direct-to-employer contracting).
- **Care coordination** – payment for care coordination activities, often with a focus on population health management.
- **Quality incentives** – payment is based in part on achieving pre-set quality of care metrics across an assigned population of members.
- **Bundled payments** – fixed prospective or retrospective reimbursement for a defined bundle of services that can be furnished by different physicians (e.g., hip/knee replacement).
- **Shared savings** – potential upside-only reimbursement, in addition to fee-for-service reimbursement, when aggregate population health care costs are less than a predefined baseline amount. The “savings” are shared between the payor and the physician.
- **Shared risk** – potential upside or downside reimbursement, in addition to fee-for-service reimbursement, depending on whether aggregate population health care costs are more or less than a predefined baseline amount. The “savings” or “losses” are shared between the payor and the physician (or among physicians).
- **Full or partial capitated payments** – A per-member, per-month reimbursement to provide all (or a defined subset of) covered services without reference to volume, utilization, or costs. There is typically no separate fee-for-service payment from the payor, except for specified carved-out services.

Deciding to Contract with a Payor/Join a Network

There are many factors to weigh when deciding to contract with payors, including your existing payor mix, patient population, and which plans, and employers offer insurance/cover beneficiaries in your market. **In many markets**, health insurers are heavily concentrated, and there may be a predominant payor with which you will need to contract to serve most patients in the region.

Physicians should consider the following when deciding whether to enter a payor contract:

- Benefits of in-network status, such as securing clear reimbursement terms and rates, having access to payor’s members, and avoiding the challenges associated with out-of-network status.
- Ramifications of out-of-network status, such as payment of usual and customary charges (not billed charges), limits on out-of-network benefits, collecting from patients, and evolving laws on **surprise billing**.
- Payor’s market share (i.e., number of members affiliated with a particular payor in the market)
- Physician organization’s value proposition, including what sets the physician apart from other, similar physicians.
- Operational considerations, such as whether the physician organization’s processes align with payor requirements (and the operational or cultural costs of achieving such alignment).
 - Examples of this include utilization management processes (manual vs electronic, methods/tools for quality measurement and reporting to a payor, required arrangements with third parties (e.g., benefit managers, clearinghouses, etc.).
- Payor’s past performance.
- Payor requirements for data sharing (access and evaluation of associated privacy/security concerns).
- Volume of services with utilization management requirements (such as prior authorization).
- Payor physician profiling and measurement programs that track quality and cost for each physician. (i.e., what methodology/metrics does the payer use? How will this be publicly reported – especially to patients? What is the dispute process? How can this affect payment – e.g., does a “preferred” ranking put the physician in a different tier with more favorable patient cost share to attract more patients?)

The information described above is intended to help practices understand the overall strategic considerations involved in their payor negotiating strategy. A practice’s ability to negotiate a favorable contract will be determined in large part by the context of the negotiation, including the factors described above. While the decision to join a payor (and to negotiate with a payor) may be complex, practices can optimize their opportunities by developing a clear understanding of each party’s goals and constraints in the negotiation. Practices may also benefit from working with experienced health care counsel to assist in designing a negotiating strategy that is feasible given this overall context.

Payor Contract Review Checklist

This Checklist provides an overview of key terms and considerations when reviewing a payor contract as well as questions for physicians to ask when reviewing, understanding, and negotiating agreements.

- **Parties, Plans & Products** Does the contract clearly identify the parties to the contract? Does the contract specify plans and reimbursement methodologies covered under the contract? If the payor adds a plan to the contract, can the physician review and/or opt-out of on a plan-by-plan basis?
- **Physician Services** Does the contract clearly describe physician's services covered by the contract, along with any limitations or exclusions? Does the contract address medical necessity and coverage rules for physician's services? Does the payor have specific prior authorization policies (and transparency of policies) for services or prescriptions? What is the payor's PA process (manual vs. electronic) and are other third parties involved (benefit managers)?
- **Key Definitions** Are the key terms used in the contract clearly defined? Some examples of key terms include adverse change, affiliates, billed charges, clean claim, covered services, effective date, emergency care, enrollee/member/beneficiary, medical necessity, and payor.
- **Credentialing Requirements** Does the contract clearly indicate which party is responsible for credentialing? Are credentialing and corrective action procedures clearly described? Can physicians provide services and receive payment while their credentialing application is pending? Are payors required to notify the physician before actions disciplining or disqualifying a physician? Additional credentialing considerations include confidentiality of peer review documents, peer review organization state license requirements, and feasibility of meeting credentialing requirements (e.g., site visits, turn-around times, reporting, etc.).
- **Payment Provisions**
 - Late Payments or Non-Payment** What are the remedies or penalties for late payments (e.g., late fees, interest, etc.)? Can a physician easily identify nonpayment/underpayment? How can a physician directly enforce payment?
 - Payment methodology** Does the contract specify within how many days the payor must pay the physician? Does the contract incorporate any state prompt-pay laws? What billing forms must be used? What constitutes a clean claim? Does the contract require physicians to accept electronic payments (vs. paper checks)? Does the contract require the provider to accept virtual credit cards for payment, or to contract with any third-party EFT payment processors? Are there fees associated with receiving payments through VCC or EFT?
- Submission of claims** Does the timeframe for submission of claims coincide with physician's billing cycles? Does the payor require electronic submission of claims? If so, are practices required to submit via a particular clearinghouse? What method does the payor require for submission of associated clinical data for claims (fax, portal, email, US mail, etc.)? Aside from payment, for what other purposes does the payor use claims data?
- Enrollee Payments** Is the physician allowed to bill enrollees for coinsurance, co-payments, and appropriate deductibles at the time of service? Is the physician allowed to bill enrollees usual and customary charges for non-covered services?
- Overpayment/Offset** How are overpayments to physician treated (e.g., will overpayments be offset from future payments; will the physician receive advanced notice of such offsets)?
- Appeal** Does physician have sufficient time to evaluate and appeal a denied claim? If overpayments may be offset, will offsets begin only after an appeal concludes?
- Rates** How are rates determined (e.g., fee schedule, percentage of Medicare, other calculation)? If rates are based on Medicare, are they based on the then-current Medicare fee schedule? Does the contract allow the payor to adjust rates, and can physician dispute the change or terminate the contract? Do rates increase annually (e.g., percentage over prior rates, linked to Consumer Price Index)? Are physicians required to offer payor the lowest rates it offers any other payor?
- **Coordination of Benefits** Does the contract identify which party is responsible for coordination of benefits? Does the contract address whether recovery from all potential sources may exceed the contract price?
- **Financial Data and Audits** Is the physician required to provide financial data to payor? Is the payor's right to financial data limited to specific, relevant information? Does the obligation to share financial data apply to both parties (particularly for capitated arrangements)? Are the notice and audit timeframes addressed in the contract, and are they reasonable?
- **Policies, Procedures, Guidelines** Does the contract clearly identify all policies or procedures with which the physician must comply? Has the physician reviewed policies, procedures, or guidelines that are incorporated into the contract before signing the contract? If not, has

the physician requested policies, procedures, and guidelines from the payor and reviewed these documents prior contracting? Does the contract require notice of changes to documents that are incorporated into the contract? Can a physician terminate the contract if the terms of updated documents are not acceptable?

□ **Utilization and Quality Review**

Utilization/Quality Review Structures Are utilization review (UR) and quality review structures reasonable and clearly defined? Are each party's roles and responsibilities clearly defined? Is the UR administrator who is responsible for UR determinations identified? Does physician have a right to independent external review? Does the contract require prior written notice for amendments to UR terms? Does the practice have the ability to terminate the contract if amended terms are not acceptable? If so, how burdensome is the process (e.g., simple notice vs. mandatory arbitration)?

Prior Authorization/Concurrent/Retrospective Review

Does the contract clearly identify (or point to specific, easily accessed electronic lists) services, drugs, or supplies that are subject to prior authorization? Are procedures clear, workable, and timely (i.e. specific prior authorization processing times; urgent prior authorization process and associated processing time)? Does the payor offer electronic prior authorization processing via standard electronic transactions integrated within practice management systems/electronic health records (vs. payor portals)? Does payment continue even if an enrollee loses eligibility during a course of treatment? Are there limitations on payor's ability to deny payment, particularly if its prior authorization or concurrent review process approved the care? What are the qualifications of the medical personnel reviewing prior authorizations (Are they guaranteed to be in the same medical specialty or subspecialty)? The AMA has prior authorization resources [available](#).

Appeals and Dispute Resolution Does the contract address physician's appeal rights? Does the contract address the process for grievance or dispute resolution regarding claims or denials based on UR?

- **Term and Termination** How long is the initial term? Does the contract automatically renew? This can be problematic if payors are changing contract terms (especially rates) and changes are not transparent to the physician. Can the contract be terminated by either party without cause upon written notice (e.g., 30 to 90 days' prior written notice)? Can the contract be terminated immediately in certain circumstances (e.g., loss of license, insolvency, exclusion from federal health care programs; non-payment)? Do parties have an opportunity to cure a material breach after receiving notice of the breach? If so, how long is the cure period? Can the physician terminate

on written notice for non-payment? If so, can the physician terminate the whole arrangement due to breach by a single plan? Or, can the physician terminate his or her participation in a single plan without terminating the whole arrangement? Can the physician terminate the agreement without penalties in response to a unilateral amendment or material policy change (note that some state laws require payors to offer this option)?

- **Effect of Termination** Can the physician terminate the physician's participation in an individual plan(s) without terminating the entire contract? Which terms survive termination? Is the physician's obligation to continue to provide services time-limited, and is the payor obligated to pay the contact price during that time? Is a physician prohibited from rejoining the network after termination? What are the post-termination rates for the payor and plans that were covered by the contract?
- **Amendment** Are all changes or amendments required to be in writing and signed by both parties or can a party propose amendments unilaterally? If the latter, can the other party object and dispute the amendment or terminate the agreement? Is the physician bound by any "click-through" provisions online?
- **Assignment/Change of Control** Does the agreement terminate upon the change of control of either party? When is notice required for a change of control (e.g., new EIN/NPI, change in controlling interest)? Does the contract prohibit assignment, delegation, or subcontracting by either party without prior written notice and/or consent? Are there any exceptions?
- **Indemnification** Do the indemnification terms apply to both parties? Do the protections include agents and employees? Do the indemnification terms jeopardize physician's liability insurance coverage? Do these terms survive the termination of the contract?
- **Non-Solicitation** Does the agreement restrict the physician from contacting or otherwise soliciting his or her patients after it is terminated? Does it limit physicians' communications with ongoing patients related to utilization of other providers within a network?
- **Dispute Resolution** How are costs allocated? How are the mediator(s) or arbitrator(s) selected? Where will mediation or arbitration occur? Is arbitration binding or non-binding? What types of disputes must be resolved through arbitration?
- **Operational Considerations** Can the payor outsource functions that may affect the speed or reliability of payment or communications? Does the payor require use of third parties for any functionalities (i.e. prior authorization for certain service types with a benefit manager, or contracting with a third-party company for electronic payments)? If a third party is involved, what is the turnaround time for requested information? Are there

additional fees associated with these third parties (i.e. processing fees for electronic funds transfers, portal fees for electronic remittance advice). Does the payor require use of their proprietary portal for compliance or reporting? How does the payor use patient and physician data? Consider taking the following steps before agreeing to a payor contract: (1) review claims data for the payor (e.g., gross revenue and any recurring problems); (2) if applicable, ask different departments for their impressions of the payor (e.g., quality, finance, clinical staff); (3) consider the payor's market share and market focus; and (4) benchmark the payor against other payors.

Payor Contract – Sample Contract Language

The payor contract is the basic agreement setting out the obligations of the payor and the physician (or practice). Therefore, it is important to identify terms that are particularly beneficial to physicians or payors. The provisions described here are frequently negotiated and, as reflected below, may be written in a way that favors one party more than the other. Please note that the examples included here are intended as educational content only and may not be appropriate to use in a specific payor agreement without further review or modification. This sample language should not be construed as legal advice; the AMA does not guarantee the enforceability or appropriateness of this language when applied to any particular agreement. Physicians should seek guidance from experienced health care counsel in connection with any use of this sample language.

Eligibility

Favorable to physician:

Payor shall be responsible for identifying and verifying eligibility of Members. Payor shall provide each Member with an identification card. It is the Payor's responsibility to update and maintain eligibility files and systems to ensure that eligibility verification is timely and accurate. Physician may rely on eligibility verifications obtained from a Payor or its designee and Payor shall reimburse Physician in accordance with this Agreement even if a Member is later determined to be ineligible on the date of service.

Favorable to payor:

Physician will verify a Member's eligibility before providing a Covered Service unless the situation involves the provision of an Emergency Service in which case Physician will confirm eligibility in a manner that is consistent with Law on redeterminations of eligibility. Physician will not be reimbursed for any services furnished to a patient who was not an eligible Member on the date of service.

Overpayments and Recoupments

Favorable to physician:

Notwithstanding any other provision of this Agreement, Payor shall issue requests for overpayments to Physician within three hundred sixty-five (365) days from the date of the initial Claim payment or it shall be waived by Payor except in instances of fraud or misrepresentation by Physician. In no event shall Payor offset overpayments against amounts due to Physician without Physician's written consent.

Favorable to payor:

In the event of an overpayment, Payor will issue an overpayment letter requesting repayment of the funds. If the Physician does not timely dispute or repay the overpayment within sixty (60) days, Payor may collect the amount by offsetting or recouping from any amounts due to the Physician. Physician will promptly notify Payor and applicable governmental agencies of any overpayments identified by Physician. Notwithstanding any other provision of this Agreement, the offset and recoupment rights for an overpayment may be exercised to the time period permitted by Law.

Contract Amendments

Favorable to physician:

Any amendment to this Agreement shall require the mutual written agreement of both Parties.

Favorable to payor:

Payor may amend this Agreement upon forty-five (45) days prior written notice to Physician. The proposed amendment shall take effect unless Physician notifies Payor of its termination of the Agreement within forty-five (45) days of receipt of the notice of amendment.

Physician Manual / Payor Policy Changes

Favorable to physician:

Physician shall comply with the Physician Manual and all applicable policies of Payor in effect as of the Effective Date of the Agreement and as provided to Physician. Payor shall notify Physician at least ninety (90) days in advance of implementing any new policies or making material changes to the Physician Manual. A "material change" shall include, but not be limited to, (i) any changes to or negative impact to reimbursement to Physician; and (ii) any increased operational or administrative burden to Physician. In the event Physician objects to a material change, the change will not take effect as to Physician without the mutual written agreement of the Parties.

Favorable to payor:

Physician shall comply with the Physician Manual and all applicable policies of Payor, any of which may be amended by Payor from time to time at the Payor's sole discretion.

Special Considerations for Value-Based Agreements

Agreements with a value-based component create unique legal considerations. For example, an agreement involving value-based payment may require the physician to contract through a preferred network or submit certain additional data. It may also involve data sharing and payment terms associated with non-fee-for-service models like shared savings. Also, it is important to understand the risk arrangement being discussed as this will impact payment. (upside only? downside risk?) The AMA has made guidance applicable to value-based physician contracts available [here](#).

Examples of Significant Payor Unilateral Policy Changes

In addition to the formal contractual language described above, physicians should be aware of certain important policy changes made by payors in recent years. Policy changes are significant because, in many cases, payors may unilaterally make these changes by amending a manual or written procedure documents. Depending on the terms of the payor agreement, a physician may receive limited notice of these changes, and may not be able to effectively contest or reject the change. In some cases, a physician's only recourse is to terminate the agreement entirely due to such changes. However, other agreements may specify that changes to policies, procedures, or manuals may not take effect without the consent of the physician practice.

In some recent cases, unilateral policy changes have been associated with emerging payor practices that impact physician clinical decision-making in important ways. Some examples to be on the lookout for include:

1) Language Permitting Down coding

Certain payor agreements, policies, or manuals now contain language permitting the payor to override a service billed by a physician, and instead unilaterally pay the physician for a different service reimbursed at a lower rate. This may be true even if the physician has fully documented the medical necessity of the service, if the payor is using technology or a vendor to determine what the physician "should have" billed.

Examples of recent contractual language allowing this practice are as follows:

Example 1: *In an effort to reduce the administrative burden of requesting and submitting medical records for review, [Payor] will begin using [Proprietary Tool] which determines appropriate E/M professional coding levels based on data such as patient's age and conditions for the Medical Decision-Making key component. [Payor] will presume the provider meets the requirements of the E/M code level they have submitted related to the History and Exam key components for the initial adjudication of the claim.*

Example 2: *[Payor or affiliate of Payor] will review emergency services claims to determine appropriate use of emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the physician will receive reimbursement for screening services:*

- 1) For physician services billed on a CMS-1500 claim: If a prudent layperson review determines that the service was not an emergency, [Payor] is required to reimburse, at a minimum, for Current Procedural Terminology (CPT) code 99281, the Emergency Department Visit Level 1 screening fee.
- 2) For facility charges billed on a UB-04: If a prudent layperson review determines the service was not an emergency, [Payor] must reimburse for revenue code 451, EMTALA Emergency Medical Screening Services.

2) Language permitting or requiring bundling of distinct services

Some payors are adopting software solutions or using third-party vendors to group together physician services into bundled services. Often this is based on the payor's determination that reimbursement for distinct services is already reflected in payment for a single comprehensive code. In some cases, this means the payor may avoid separate payment for services performed and properly documented by a physician, based on software edits grouping the service into a bundled code. Physicians should understand how payors will apply these "bundling" policies and their rights to appeal or contest the decision to bundle services this way.

Example: Effective [Date], we will begin using [Software], a new clinical code editing software for medical and behavioral products. [Software] will facilitate accurate claim processing for medical and behavioral claims submitted on a CMS-1500 claim form. [Software] code auditing is based on assumptions regarding the most common clinical scenarios for services performed by a health care professional for the same patient. [Software] logic is based upon a thorough review by physicians of current clinical practices, specialty society guidance, and industry standard coding. Services considered incidental or mutually exclusive to the primary service rendered, or as part of a global allowance, are not eligible for separate reimbursement. Patients covered under [Payor]-administered plans should not be balanced billed for clinically edited non-paid services. A procedure that is performed at the same time as a more complex primary procedure, requiring little additional physician resources and/or is clinically integral to the performance of the primary procedure, is considered incidental to the related primary procedure(s) on the same date of service and will not be separately reimbursed.

3) Language on payment options

Some payors are adopting electronic payment requirements through third parties that may impose additional costs on the physician. Physicians should understand all reimbursement options from the payor and any costs associated with each reimbursement option.

Example: *[Third party vendor] offers the following payment options: (1) Electronic Funds Transfer (EFT) – EFT is a fast and reliable method to receive payments and is the preferred method for [Payor]. In order to register for [Payor] payments and choose EFT as your payment preference, visit [Third party vendor] registration page. (2) Virtual Card Payment – Standard credit card processing and transaction fees apply. Fees are based on your credit card processor's fees and your current banking rates. [Third party vendor] does not charge any additional fee for processing. For each payment transaction, a credit card number unique to that payment transaction is sent either by secure fax, or by mail. Processing these payments is similar to accepting and entering patient payments via credit card into your payment system. (3) Paper Check – If your office would prefer to receive check payments, please call [Third party support] at [customer support number].*

4) Language for required use of specialty pharmacies

An increased number of payors are contracted with a third-party specialty pharmacy to lower up-front medication acquisition costs to physicians, integrate coordination of coverage between physician, patient, and payor, assure compliance with guidelines and standards, and others. Physicians should understand options for specialty pharmacies for each payor, required use of specialty pharmacies. It is important to note that some payors may have different requirements for each plan. Physicians should check specific plan requirements prior to medication administration.

Example: *[Payor] contracts with select specialty pharmacies to obtain specialty medications for physician administration to our members. Specialty medication coverage is based on the member's benefit. Prior Authorization or Predetermination approval may still apply to specific specialty medications. In accordance with their benefits, some members may be required to use a specific preferred specialty pharmacy, or be subject to a split fill program, for benefits to apply. For more information about medical criteria, please refer to the Medical Policies. Note: Depending upon administration (physician-administered or self-administered), the member's plan will determine which benefit (medical coverage or pharmacy coverage) will cover the medication. Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.*

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