Managed Care Contract Evaluation

A step-by-step checklist to guide you through the process

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EVALUATING A MANAGED CARE AGREEMENT… STEP-BY-STEP

A Checklist to Guide You

The purpose of this contracting checklist is to enable you to undertake an organized and focused evaluation of managed care agreements with payers.

Most physicians, managers, hospital contractors and CFOs or CEOs have never had formal training in contract analysis. Worse yet, many have never done any critical analysis to understand what the contract says. Often intimidated by the language and ambiguity, they simply turn to the fee schedule page, determine if the amount described as payment for their services is adequate, sign and hope for the best.

Unlike some hospital administrators, physicians frequently verbalize frustration with their apparent lack of leverage to negotiate contracts. What they fail to acknowledge is that they have the right to:

- Ask lots of clarification questions and obtain written responses to those inquiries
- Obtain additional documentation and data
- Request and review current policies and procedures, and
- Possess enough information to model each and every fee for every service they offer

Every provider has the right to be treated with courtesy and respect instead of summarily dismissed with answers that do not explain why something is written in a certain way, or what is required of them in the contract. For example, when a physician, practice administrator or contracting manager asks the provider relations representative for clarifications, they should always ask open-ended questions (in writing, by email or regular written correspondence) rather than questions that can be easily answered with a “yes” or “no” response. Many inexperienced provider relations representatives will not be prepared to answer the questions in the checklist for which no answer exists in the contract without some research and guidance from their supervisors. As a best practice, the responses obtained from the plan should be reduced to writing so that the provider has notes from his/her research and due diligence to produce in the event of a future dispute on the same point. Upon execution, the responses should be incorporated into the contract and attached as one of the Exhibits or Attachments so that it is made a part of the Entire Agreement.
Often, the Entire Agreement reads as follows:

“This Agreement together with all Program Attachments, Fee Schedules, Exhibits, Provider Manuals, Memorandums and other writings attached hereto and incorporated herein by reference as exhibits contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied, verbal or written, regarding the subject matter.”

As you can see, without incorporating the document containing the clarifications as an Attachment or Exhibit, the provider will have made the effort to obtain and review the information without being able to rely upon those explanations, responses or additional data. The agreement -- in its vague and ambiguous form -- will supersede the clarification. Without proper incorporation into the contract, the clarifications and additional data would simply be reduced to hearsay, as if the responses had been answered over the phone or in casual conversation.

A healthy respect for the Entire Agreement paragraph is something I cannot stress enough while reviewing the checklist in order to understand the importance of obtaining the additional information in a manner in which you can rely upon your research and evaluation efforts.

Particular attention should be paid to the clarification and provision of coverage policies and fee schedules that are in effect at the time the contract is executed. The reliance upon coverage policies, coding and re-bundling policies and procedures, as well as medical necessity definitions, may only be made if incorporated *as they are* at the time of contract execution as specific Exhibits or Attachments. Failing to ensure this incorporation or annexation may result in tacit approval to changes that are made by the plan from time to time. Only your attorney will know for sure by the way it is expressed in the contract. However, you can and should do the homework so that the attorney may more effectively assist you. Inquiries should be made and responses attached so that the provider is prepared in the event of future denials. Simply obtaining these data and clarifications for review without attachment and incorporation into the executed contract is the most frustrating "Gotcha!" in denials management. When I teach denials management courses, I teach providers to obtain and review the information. However, without doing the due diligence and including those specific clarifications into the contract many providers fail to complete the process of negotiation and therefore cannot rely upon that which they read and accepted as policy. If the policy is not attached and incorporated into the Entire Agreement, no reliance is assumed. Therefore, ad hoc changes to the policies at the unilateral whim of the plan can be made without the burden of adherence to the Notice and Amendment provisions of the contract.
Remember: Providers are entitled to these data and clarifications whether they have leverage or not. Attaching these as Exhibits or Attachments to the final executed contract is essential for your provider or contracting expert to negotiate. Attachment and incorporation is the part that is going to require leverage and all providers may not be able to achieve the desired end result.

In the end, one has to ask rhetorically, "Should I sign a contract with a payer that won't stand behind its clarifications, policies and procedures and data that they have supplied to me in reliance of how my fees will be calculated and against which my claims adjudicated?" That is a business decision that each provider must make on his/her own.

Warmest Regards,

Maria K Todd, MHA PhD

PRELIMINARY QUESTIONS

List 5 points that summarize why you want this contract as part of your reimbursement strategy: *(Distill your rationale for executing this contract. You will have another opportunity to reassess your priorities post-review at the conclusion of the checklist.)*

1.

2.

3.

4.

5.

List your five major concerns with your managed care contracts: *(Don't be afraid to reveal your overall concerns in this section of the checklist. The epiphany will come post-review at the completion of the checklist. The exercise will enable you to measure their awareness of new areas of concern that relate to reimbursement and more upon completion of the contract review.)*

1.

2.

3.

4.

5.

COMPLETE CONTRACT

Do you have the complete contract and all attachments and exhibits necessary for review? *(Remember, the Entire Agreement provision may or may not assume that all of the parts of the contract may be relied upon. Read it carefully; it may require modification.)*

- ❑ Identification of the Parties
- ❑ Recitals
- ❑ Definitions
- ❑ Obligations of the Provider
- ❑ Obligations of the Health Plan
- ❑ Medical Records Policies and Procedures
- ❑ Billing, Coding, Documentation and Claim Submission Procedures
- ❑ Complete Fee Schedule(s) detailing fees for their specific services
- ❑ Utilization Management Attachments and Exhibits
- ❑ Quality Management Attachments and Exhibits
- ❑ Term and Termination Provisions
- ❑ Denials and Appeals Procedures
- ❑ List of Participating Providers
- ❑ Provider Manual
- ❑ List of Affiliated Payers and Plan Types
- ❑ Coverage Determination Policies
- ❑ Sample copies of identification cards from significant employer groups in my market
- ❑ Contact information for key support individuals and medical director

IDENTIFICATION OF THE PARTIES

(Who will owe you money? Do you really want another contract with this payer? If you already have access to patients, why do you want it? In the event that there is more than one access point, which fee schedule, policies, and procedures will prevail?)

1. Name of the Plan:_____
2. Are they a Subsidiary/ Affiliate of another plan? _____
3. Do we already have a relationship with them through another contract? ❑ Yes ❑ No
4. If yes, through which contract do they presently access our services? _____
5. Which major employers in our area offer this health plan?

   ❑ # Employees _____

   ❑ # Employees _____

   ❑ # Employees _____

   ❑ # Employees _____

   ❑ # Employees _____

6. Can I be reimbursed for all service lines that I offer?
7. Are any services I routinely offer reserved exclusively for certain providers in the network? If yes, which ones? _____

(Are there any services upon which the bulk of your income is derived that are not included in the contract? Has another provider or hospital contracted for the exclusive right to perform and be reimbursed for special services lines you offer? If not, are they interested in negotiating for that position?)

FACT FINDING

TERM AND TERMINATION

Contract Effective Date:

Contract Termination Date: _____

Notice of termination window for Termination Without Cause: _____ Days

Termination is permitted by: ☐ Plan Only ☐ Either Party

Reason(s) for Termination: ☐ Without Cause ☐ With Cause ☐ Material Breach

Material Breach Remedy Opportunity: _____ Days

Correspondence

To whom shall bills be addressed?

Billing address: _____

Corporate address: _____

CONTACT LIST

Provider Relations Contact:

Name: _____
Phone: _____
Fax: _____
Email: _____
Mobile: _____

Medical Director:

Name: _____
Phone: _____
Fax: _____
Email: _____
Secretary: _____

Claims Manager:

Name: _____
Phone: _____
Fax: _____
Email: _____
Secretary: _____

Prior Authorization Contact:

Name: _____
Phone: _____
Fax: _____
Email: _____

Electronic Billing Contact:

Name: _____
Phone: _____
Fax: _____
Email: _____

Pre-Certification / Eligibility Contact:

Name: _____
Phone: _____
Fax: _____
Email: _____
Secretary: _____

Notice Recipient:

Name: _____
Phone: _____
Fax: _____
Email: _____

TYPE OF PLANS COVERED BY THE CONTRACT

- ☐ HMO
- ☐ PPO
- ☐ ERISA Self Insured Employer
- ☐ Workers Compensation
- ☐ Motor Vehicle / No Fault
- ☐ Medicare Advantage
- ☐ Medicaid Managed Care
- ☐ TriCare
- ☐ Discount Card Arrangement (Self Pay)
- ☐ Consumer Driven Health Plan
- ☐ Continuous Discount Arranger / Silent PPO Arrangement

List some of the names of plans that may access services under this contract:

UTILIZATION MANAGEMENT PROGRAM

(*While the Fee Schedule may detail how much money will be paid, careful attention to detail in the Utilization Management program will provide insight as to "if" the money will ever be paid and under which circumstances the plan has a legitimate reason not to pay. Tacit agreement to these policies and program documents without review and clarification is the reason that many denials are upheld against the claim.)*

1. Are all utilization / coverage policies attached to the contract as Exhibits? ☐ Yes ☐ No

2. Will each payer under the contract follow one standard coverage policy? ☐ Yes ☐ No

(*It is important to inquire whether or not these coverage policies will be standardized across all plans including the ERISA payers. Or just the contracting payers own policies for their own plans, and not the network lessees?)*

3. Are stated coverage policies adequate to address the needs of my patients? ☐ Yes ☐ No

(*Smaller local health plans may actually welcome assistance with the coverage policy development in certain subspecialties. You should ask if you can be of assistance if those policies are not yet developed. If invited to meaningfully participate, you would be in a very influential position, especially in the case of new and exclusive technologies.)*

If not, what is understated or missing? _____

4. Who determines medical necessity? ☐ Attending Physician ☐ Health Plan

(Often this right is reserved for the plan and stated as such in the contract. If this is the case, attempt to negotiate that all services deemed not medically necessary are labeled "non-covered", instead of "non-allowed". This may mitigate perfunctory write offs as non-allowed services are rarely, if ever, permitted to be transferred to patient responsibility.)

5. Are services deemed not medically necessary subject to appeal? ☐ Yes ☐ No

6. Must we write off services deemed by the plan as "non-covered" or "not medically necessary" or can they be billed to the patient?

   ☐ Mandatory write-off
   ☐ Patient responsibility
   ☐ Patient responsibility but only after advising the patient in writing similar to a Medicare ABN

   Cite relevant contract provisions that support this position:

7. Is this cited elsewhere in the Provider Manual, Attachments or Policies and Procedures? ☐ Yes ☐ No If yes, note where it is mentioned:

ABOUT MEDICAL NECESSITY:

If the plan agrees that it has vetted the credentials of the physician and has determined that the physician has the requisite training and education to make all decisions related to patient care and must exercise independent, professional medical judgment as an independent contractor with respect to all such matters, then why should the plan be permitted to interfere with the physician's professional independent medical judgment with regard to treatment or utilization issues? Consider negotiating that any payment or absence of payment for services should not constitute an opinion or affirmation by plan that the services or procedures recommended or rendered by the physician are,/are not, were/were not medically appropriate, but only that the service or procedure was not a Covered Service.)

8. Under what circumstances can denied claims be presented for External Review by Regulatory authorities?

*If applicable, who pays for the proceedings? _____

(*If a claim is submitted for external review, the plan is often responsible to pay the cost of the entire proceeding whether they win or lose. The External Review mechanism is there for the benefit of the insured. While the physician may assist in the preparation of the case with the patient, the physician may not initiate the proceedings in most states. The physician's staff may assist the patient with completion of all the necessary paperwork which is usually a single page questionnaire available on the State Insurance Commissioner's website. This does not apply to ERISA plan members. For ERISA plan members, refer to your notes from the Denver managed care training on ERISA Authorized Representatives, a process that the physician can initiate in order to assist with an appeal and possibly overturn a denial.)*

9. For how long are we permitted to reopen a claim for appeal of a denial?

(At a minimum, this time frame should be no less than the time frame the plan has to ask for a refund or recalculate the benefit on a claim. As a best practice, the window of opportunity for an appeal of a denial or short- paid claim should be not less than two years from the date the claim was paid or denied.)

10. Which peer in my specialty makes final decisions of medical necessity or clinical appropriateness regarding my claims if a claim is questioned?

(*When determining who will be making decisions about medical necessity, if the health plan hires the services of a local or outside specialist as an expert, the provider should be able to request, receive and review that expert's CV as well as any opinions rendered regarding treatment rendered. If the provider perceives a conflict of interest or an inadequacy as to the expert's training or experience with the provider, the issue should be raised and any understandings negotiated documented in the contract or a memorandum referenced in the contract as part of the Entire Agreement.)*

11. Am I permitted to review and challenge expert opinions or committee decisions of denied claims?

☐ Yes ☐ No

If not, why? _____

12. Are any employer groups accessing services under this contract that do not cover specific services for their employees? (family planning, specific procedures, drug therapies)

☐ Yes ☐ No If yes, which ones? _____

AUTHORIZATIONS

(In many instances, the contract will mention the pre-authorization requirement for specialty services, diagnostic testing and treatment, in addition to pre-authorization for evaluation and management services. The procedures may often be detailed in the Provider Manual or on a website.

One would be wise to obtain a retention copy of what was on the Manual or Website the day the contract was executed so that any updates are required to go through the Notice and Amendment process as part of the Entire Agreement. This could be a "cut and paste" from the web to a paper document, or burned to a CD and labeled as an Exhibit or Attachment as a digitized document. The main point is to record what was in effect at the time the contract was executed so that no new requirements are added to the responsibilities of the physician and staff as a surprise and a new reason for a denial to be upheld.)

1. Are prior authorizations required? ☐ Yes ☐ No

If yes what is the process to obtain authorizations?

2. When is Authorization required?

   ☐ Initial referral

   ☐ Each service or procedure

   ☐ Other: (Specify)_____

3. Will a written authorization number be issued to office? ☐ Yes ☐ No
4. Are we required to submit written authorization with claim? ☐ Yes ☐ No
5. Is supporting documentation required? ☐ Yes ☐ No
6. Describe supporting documentation:
7. How long are prior authorizations valid?
8. Will the plan occasionally cooperate to provide retroactive referrals under extenuating circumstances? ☐ Yes ☐ No If not, why?
9. Describe a sample authorization number (i.e. alpha / numeric):
10. Does prior authorization guarantee payment? ☐ Yes ☐ No If not, why?

(If we think in the context of the Entire Agreement, unless the contract states "prior authorization guarantees payment," then all prior authorizations are outside the Entire Agreement because they happen after the contract is executed and are not an Exhibit or an Attachment.)

11. Are pre-authorizations able to be issued online? ☐ Yes ☐ No

    Average processing time: Average turnaround time :

BILLING AND REIMBURSEMENT

1. What is the timely filing limit to file claims when the payer is primary?
2. What is the timely filing limit to file claims when the payer is secondary?
3. When this payer is secondary, what is the maximum reimbursement amount I can receive when combined with the payment from the primary payer?
    - ☐ The maximum allowable amount payable under this contract?
    - ☐ The maximum allowable amount payable under the primary contract?
    - ☐ 100% of my billed charges.

Cite the relevant contract provisions that support or explain this:_____

(*Often the Coordination of Benefits (COB) reimbursement provisions in a contract do not match the state administrative code. In fact, most plans add restrictions to the contract that enable the plan to avoid additional payment for services that they have assumed the insurance risk of claims payment. They do this by requiring the provider to discount their fees to less than 100% of billed charges when that payer is not primary, rather than transferring the risk of additional cost to the patient – a practice that might be construed as racketeering (if they collected premium from the patient and gave nothing in exchange and then transferred financial responsibility to the patient).*

This is a matter where the provider should obtain counsel and/or comparison of the contract language with any applicable regulatory requirements from their attorney, consultant or medical society before proceeding. The cost of the consultation may be far outweighed by the ability to collect additional reimbursement to which they may otherwise be entitled through proper negotiation of this situation.)

4. What is the penalty for filing claims beyond the timely filing limit?_____

(The penalty for late filing should never be 100% if the plan cannot prove prejudice. Many states have enacted laws and/or regulations that require a showing of prejudice to the insurer to deny benefits for late notice.

Prejudice would be interpreted as the inability to verify that the claim was really the responsibility of that payer and not another party. Often, the provider unknowingly accepts a 100% penalty on late filed claims by negotiation, thereby excusing the plan from responsibility of risk for payment of late billed claims. This is a matter where the provider should obtain professional counsel and/or comparison of the contract language with any applicable regulatory requirements from their attorney, consultant or medical society or other professional association attorney before proceeding.)

5. Where in the contract is a clean or complete claim defined?
6. What is the prompt payment time limit? _____
7. What is the penalty if the claim is paid late? _____

(While the health plan may not initially offer to pay a penalty or sustain any consequence, providers should look for some deterrent for poor performance in this area either in statute, administrative code, or by negotiation if there is nothing to address this by regulation. If there is law or regulation to address this, the provider should be careful to reiterate it in the contract, and not to unknowingly forego this protection by negotiating away contract provisions to the contrary.)

8. Are ERISA Self-funded Employers required to follow the same timely payment contract provisions?
☐ Yes ☐ No If not, why? _____

(Many states have enacted laws to define a clean or complete claim and timely payment rules. Providers often unknowingly allow for a departure of state requirements enabling the plan to negotiate extensions or liberties not elsewhere provided, and excusing the plan and/or its affiliates from upholding the laws and regulations. Again, this is a matter where the provider should obtain professional counsel and/or comparison of the contract language with any applicable regulatory requirements from their attorney, consultant or medical society or other professional association attorney before proceeding.)

9. Is the fee schedule attached? ☐ Yes ☐ No

(*A word about representative or sample fee schedules:*
Because of the Entire Agreement provision, any abbreviated listing of fees in the fee schedule means that only those fees detailed in the abbreviated list are a part of the contract, and that reimbursement for all other unlisted fees are subject to the changes that the plan may establish or change from time to time in its sole and absolute discretion.)

10. Is the fee for each service for which we routinely bill able to be financially modeled?
☐ Yes ☐ No

11. Does the fee schedule list a fee for every service rendered for which we routinely bill by specific CPT and HCPCS Code? ☐ Yes ☐ No

If not, which ones are missing?

MODELING:

The contract should provide enough detail so that a fee can be calculated for every CPT or HCPCS code submitted by the physician, including those codes that have variances because of modifier use. The only codes that should not be able to be modeled would be those codes for which a fee must be determined "by report". Generally, those codes end in XXX99. For those codes, the physician might be wise to negotiate a formula into the contract for unlisted procedures or codes at a straight discount percentage from billed charges.)

12. Is there a formula stated in the contract to calculate fees not stated in the Fee Schedule?
☐ Yes ☐ No
If yes, what is that formula? _____

13. Does the fee schedule specifically address reimbursement for unavoidable injectable drug wastage?
☐ Yes ☐ No

(Physicians or office manager should attach a superbill, charge slip or a computer printout of their charges and enter the allowable amounts under each contract for each service, drug or supply. Note any that cannot be accurately modeled for reimbursement with the information provided in the contract. Only procedures ending in – 99 (By Report) should pose modeling difficulty. All other fees including those codes that are routinely submitted with modifiers should be modeled and the worksheet attached as an Exhibit to specify actual reimbursement expected under the contract.)

14. Does the contract stipulate that Medicare billing and interpretation rules for bundling and coding will apply? ☐ Yes ☐ No If not, what rules will apply?

Cite the relevant section of the contract where this is specified:

(*Most providers, including experienced hospital contractors mistakenly assume that all health plans follow Medicare guidelines and coding and bundling rules when calculating payments. This is not the case unless the contract or some other document tied to the Entire Agreement states this as an understanding within the Agreement. Physicians should always ask for written clarification if the coding and billing standards follow Medicare regulations exactly, or if not, which deviations will apply.)*

15. Can the plan unilaterally change billing and interpretation rules for bundling and coding unilaterally and arbitrarily without a formal amendment to the contract in accordance with the Notice and Amendment provisions of the contract? ☐ Yes ☐ No

If yes, how will I receive notice of such changes to policy?

(*Providers often fail to request clarification on this important privilege of interpretation. If the provider does not obtain and attach coverage, billing, bundling and other relevant rules as Exhibits or Attachments to the contract, they are not considered part of the Entire Agreement, and interpretation would be subject to the pleasure and convenience of the plan without the requirement of a formal amendment or notification to the provider other than an incidental mention on an EOB as a denial or reduction in payment. Obtain documentation for everything that relates to your revenue, and request that your attorney determine if the clarification and documentation will be enforceable if a dispute arises as incorporated.)*

16. Can the plan(s) delete or revise drug and other coverage decisions policies without providing us with advance written notice prior to the effective date of the change? ☐ Yes ☐ No

If yes, how will I receive notice of such deletions or revisions to policy?

(The plan may be able to revise coverage policies, but there are many state-required notifications that will require notice to the employer, insured or other authorized representative. Require clarification on this point, and negotiate a method for inclusion on updates to relevant policies for their specific services. In the case of ERISA plan participants, the physician will have no right to receive these notifications without possession of an Authorized Representative designation from the patient, parent or guardian.)

17. What is the procedure to follow if a claim is paid at less than the contractually stated amount?

(This procedure is often overlooked or mishandled by most billing managers. They continue to resubmit the claims to the same department that paid the claim incorrectly in the first place. A claim paid at less than the agreed upon amount may represent a breach of contract – especially if it is paid inaccurately on a repeated basis. Those claims should be submitted to the Notice Recipient with a letter requesting that full payment be made and the breach corrected within the amount of time specified in the remedy section and the root cause of the error be corrected.)

18. Does the payer require sourcing of drugs, implants, or supplies through an exclusive Provider?

☐ Yes ☐ No

((If the contract or provider manual does not specify this, the provider should ask for written clarification as to the plan reimbursement policy for physician or hospital supplied drugs or supplies for which a pass through reimbursement is anticipated. If there is none, that clarification should be attached to the contract as a formal understanding so that any change in policy in the future cannot be imposed upon the provider without a formal contract amendment and notification.)

19. If the Payer requests copies of medical records, will they pay the state statutory copy fee?

    a. If yes, how much is that fee? _____

    b. How should we bill for it?_____

    c. When should we expect payment for copies of records?

Capitation ☐ N/A

19. Will any of our reimbursement be in the form of capitation? ☐ Yes ☐ No

    If yes, for which services? _____

20. Is capitated reimbursement in the plans for any of your product lines in the near future? ☐ Yes ☐ No
    What is the minimum number of patients that will be assigned to us before a capitated reimbursement method takes effect?

21. What is the threshold dollar amount of claims paid to all providers (if any) that would transition a patient to stoploss status from the capitated risk pool? _____

(Capitation is not dead! It is thriving in certain markets and returning to others. In the event that provider fee reimbursement changes to capitation, answers to these questions should be obtained and evaluated by an experienced actuary before the physician agrees to capitation reimbursement for any services.)

QUALITY MANAGEMENT

Clinical Quality Issues

1. Must we participate in and comply with the Health Plans' Quality Management and Peer Review Programs? ☐ Yes ☐ No

   If yes, briefly cite sections where details of these programs are found:

2. What will happen if we don't agree with a particular aspect or element of the Quality Management or Peer Review Program? Can we object without being found in breach of contract?

   ☐ Yes ☐ No

   If yes, cite section: _____

3. If the plan requires the use of a designated source drugs acquisition, interpretations of lab and diagnostic testing, etc., can you review the quality and/or handling standards that address these matters with the plan to ensure your satisfaction with standards set for safety and product integrity?

   ☐ Yes ☐ No ☐ N/A

   If undisclosed and unavailable, can you ethically agree to comply? ☐ Yes ☐ No

4. Can you request and receive the designated sources' standards for drugs and supplies to ensure your satisfaction with standards set for safety and product integrity? ☐ Yes ☐ No ☐ N/A

   If undisclosed and unavailable, can you ethically agree to comply? ☐ Yes ☐ No

The physician or hospital medical staff or Chief Medical Officer can and should obtain and review these policies and procedures.

5. Is there a Provider Grievance Mechanism? ☐ Yes ☐ No

   If yes, can you meaningfully participate? ☐ Yes ☐ No

   If yes, cite section of the contract where details of this program are found:

CREDENTIALING

6. Can we begin treating patients as a participating provider before all credentialing activities are complete? ☐ Yes ☐ No

7. Is Specialty Board Certification required for empanelment with this Plan? ☐ Yes ☐ No

PAY FOR PERFORMANCE

8. Is there a Pay for Performance program established or slated for the near future?
   ☐ Yes ☐ No
   If yes, please describe: _____

9. Will the plan incorporate Episode Treatment Groups (ETGs) as part of their quality metrics?
   ☐ Yes ☐ No
   If yes, please describe: _____

10. If yes, will there be an opportunity to earn bonuses for meeting certain quality metrics and benchmarks? ☐ Yes ☐ No
    If yes, please describe:

11. Does the contract contain specifics as to how such bonuses or penalties will be calculated?
    ☐ Yes ☐ No
    If yes, cite section: _____

12. Does the contract contain specifics as to when the money shall be paid?
    ☐ Yes ☐ No
    If yes, cite section: _____

13. Does the contract contain specifics that enable us to determine exactly how much bonus or penalty is due? ☐ Yes ☐ No
    If yes, cite section: _____

14. Does the contract contain specifics that enable us to determine the penalty for late payment of any bonus or penalty? ☐ Yes ☐ No If yes, cite section: _____

TERM, TERMINATION AND CONTRACT RENEWALS

Term of the Contract

1. The initial term of the contract begins on: _____
2. The length of the initial term of the contract is : _____
3. At the conclusion of the initial term of the contract, the contract: ☐ ends ☐ rolls over.
   If applicable, the subsequent rollover terms, if any, are for what length of time?
   Cite relevant section of the contract:
4. If a rollover or evergreen feature is included, upon the anniversary of the contract what provision is in the contract for fee adjustment or escalation? ☐ Yes ☐ No
   Cite relevant section of the contract:
5. If automatic fee escalation does not take effect or is implemented late, what process is necessary to enforce the provision? ☐ Yes ☐ No
   Cite relevant section of the contract:

Termination of the Contract

6. In the event we wish to terminate the contract, may we do so without citing a cause?
   ☐ Yes ☐ No If yes, how much advance notice is required? _____
   Cite relevant section of the contract:
7. In the event the plan wishes to terminate the contract, may they do so without citing a cause?
   ☐ Yes ☐ No If yes, how much advance notice is required? _____
   Cite relevant section of the contract: _____
8. In the event that the plan terminates the contract, who notifies the patient?
   Cite relevant section of the contract:
9. In the event that either party terminates the contract, how long must we honor the fee schedule?
   Cite relevant section of the contract:
10. In the event that the plan terminates the contract, which side absorbs the cost of medical records copies for continuity of care?
    Cite relevant section of the contract:
11. Upon termination of the contract, how much time is allowed to close the books with any final auditing and finalize any outstanding payments?
    Cite relevant section of the contract:
12. In the event that a payer under the contract (who is not a signatory) habitually breaches the contract to the extent that you no longer wish to honor their status as a payer under this contract, are you permitted to terminate the individual payer without terminating the entire contract? ☐ Yes ☐ No
    If yes, cite relevant section of the contract:

13. Are you permitted to discharge a patient for the usual and customary reasons without interference or first seeking permission from the plan?

14. Which specific provisions, if any, survive the termination of the contract?

Assignment of the Contract

15. Is either of the signatories to the contract permitted to assign the contract to others without the express written consent of the other party? ☐ Yes ☐ No

16. Are there any mergers of acquisitions planned in the near future? ☐ Yes ☐ No

    If yes, and we have executed contracts with both entities, which contract and fee schedule will survive?

    Cite relevant section of the contract:

(While this will not be found in the contract, inquire and obtain a written response to the question. Careful attention should be paid to the "Assignment" paragraph, which may imply that the plan has the right to transfer or "assign" this contract to its successor in the event of a merger or acquisition, with or without the provider's express written consent. If a case like the example above arises and the provider has contracts with both plans, the provider may wish to have some say as to which contract will remain in effect, and which coverage policies will be used to adjudicate claims.)

17. If a new assignee expects discounted rates to be honored under this contract, how will we recognize their patients?

(While this will not be found in the contract, inquire and obtain a written response to the question. One best practice would be to require that the logo be present on the identification card presented by the patient in order for a discount to be applied. A few contracts throughout the country now specifically state this for the record.)

18. How will we decipher cards and model rates if multiple logos are found in the identification card?

19. Does the plan include access by entities solely involved in brokering continuous discount arrangements without the requirement of adherence to other provisions of the contract? ☐ Yes ☐ No

    If yes, can you limit or restrict their activities as they relate to your discount? ☐ Yes ☐ No

MISCELLANEOUS PROVISIONS

Notice

Is the plan required to provide notice of any contracting issues by certified mail, with return receipt requested? ☐ Yes ☐ No

Amendment

Is the plan able to unilaterally change the contract provisions, fee schedules, policy manuals and provider manuals during the term of the contract without giving you written notice and obtaining your agreement to such changes in advance? ☐ Yes ☐ No

Entire Agreement

1. Does the contract and Entire Agreement provision include the base agreement together with all Attachments, Exhibits, Fee Schedules, published Policies and Procedures, Provider Manual, and other documents from which reliance and consideration is given at the time the contract is executed?

   ☐ Yes ☐ No Cite where this is found in the contract:

2. Do you have a copy of each of these items for your files, either on a CD/DVD or printed on paper?

   ☐ Yes ☐ No If not, why not?

Dispute Resolution

1. If a dispute arises, what is the method of formal dispute resolution?

☐ Mediation
☐ Arbitration
☐ Litigation

2. If arbitration, which rules apply to the proceedings?

☐ American Arbitration Association
☐ American Health Lawyers Alternative Dispute Resolution Service
☐ Other

3. Under which state's governing law is the contract interpreted?

4. In which city and county is the dispute resolution conducted?

5. Is the dispute resolution final, conclusive and binding? ☐ Yes ☐ No

6. Who pays the dispute resolution fees and costs? ☐ Winner ☐Loser ☐ Each pays 1/2

ORGANIZE YOUR THOUGHTS

List 5 points that summarize why you still want this contract as part of your reimbursement strategy:

1.
2.
3.
4.
5.

List your five major concerns with this contract:

1.
2.
3.
4.
5.

NEXT STEPS

List follow-up actions, clarifications needed, and any change requests necessary in order to execute this contract:

What obstacles, if any, would I like to overcome in order to feel more comfortable with this contract?

NOTES

FREQUENTLY ASKED QUESTIONS:

Q: How flexible are the health plans when setting up contracts with providers?
A: Often they are not very flexible with changes to existing language unless the contract does not address a specific point that has been promised. However, they will often provide additional information that may answer many of the questions in the checklist.

Q: What recourse do providers have when dealing with denied claims?
A: The contract, Exhibits and Attachments as well as the Provider Manual will often spell out options and limitations for denials and appeals.

Q: Can contracts automatically rollover or renew without automatically increasing the fee schedule to current reimbursement rates?
A: Yes. It is important to negotiate this point into your contract if you want some escalation formula tied to the automatic renewals. Otherwise, you should not expect any automatic increases.

Q: Can you negotiate reimbursement on specific CPT Codes?
A: Yes. A best practice would be to be able to have an exact expectation of the reimbursement for every service you provide, whenever possible.

Q: How do you negotiate prompt payment?
A: First, check with your attorney or state medical association regarding any prompt payment laws that may be in effect in your state. Second, you may wish to consider negotiating a window for timely payment, in accordance with any existing state laws, together with a penalty for late payments.

Q: Can different providers within the same practice have different contracts with different rates?
A: It is possible but often proves very difficult to administrate. Typically, they all seek to have the contract modified to one standard across all providers in the group.

Q: Where can I get more information or assistance with negotiating managed care contracts?
A: Attorneys with specific subject matter expertise and insight into the operational and financial aspects of the contract (not just the legalities) are a good resource. Additionally, a wide variety of consultants are available with operational and financial expertise, knowledge of practice management and contracting trends in the marketplace. You may find good referral sources through professional associations that you or your practice administrator may belong to.

Q: How often should I review my managed care agreements?
A: At least annually if the contracts review annually. It is always a good practice to begin reviews of ongoing contracts not less than four months prior to the anniversary or renewal date.