

Managed-Care Contracts: What You Need to Know

Physicians grumble a lot about managed care, but most find they cannot practice without it—the vast majority of U.S. physicians contract with at least one health plan, according to data compiled by the Kaiser Family Foundation (KFF). In 1999, 91 percent of physicians had at least one contract with a health maintenance organization, a preferred provider organization or an individual practice association; that figure dropped to 88 percent in 2001, KFF says. Of practices with at least one contract, managed care accounted for 41 percent of practice revenue in 2001, the group says.

While it is time consuming to actually read and understand managed-care contracts, not doing so could result in lost revenue for your practice. Moreover, physicians need to monitor their managed-care relationships to ensure that the contractual obligations are being met by both parties.

With this much money on the line, it is essential that physicians understand exactly what they are agreeing to when they sign managed-care contracts. Negotiating and finalizing managed-care contracts present challenges for medical practices. While it is time consuming to actually read and understand what the contract stipulates, not doing so could result in lost revenue for your practice. Moreover, physicians need to monitor their managed-care relationships to ensure that the contractual obligations are being met by both parties.

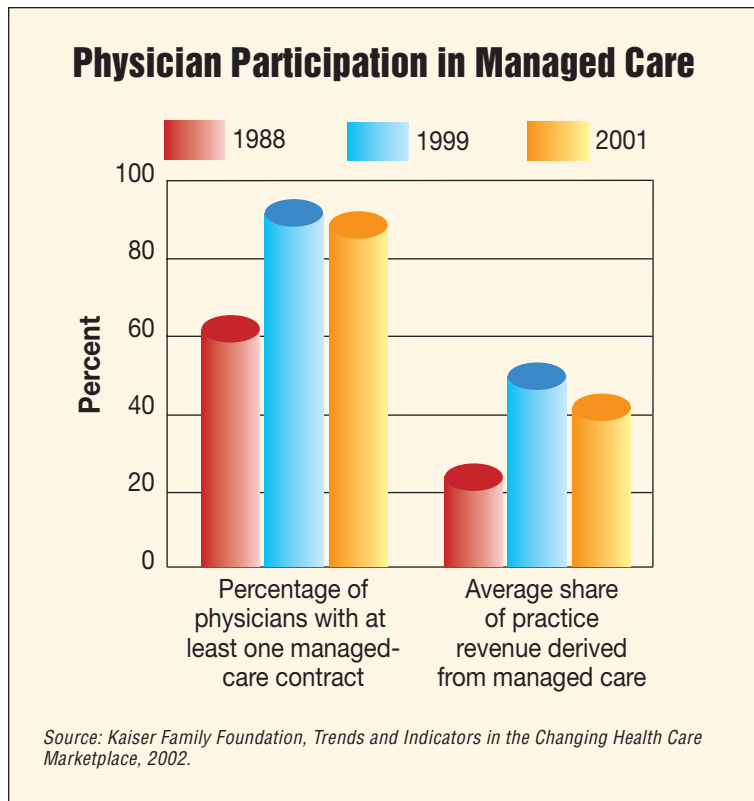
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Before you seriously pursue a MCO contract, it is important to gather information on your own practice as well as the managed-care organization (MCO) with which you plan to work. “Unfortunately, the majority of physicians sign contracts without much forethought, understanding and sometimes without even reading the terms,” says Trevor J. Stone, private sector advocacy manager for the American Academy of Family Physicians (AAFP).

It is important to determine what your goals are before signing a contract. Physicians should answer the following questions to get a better sense of how working with a particular plan is likely to affect a practice:

- Does your practice want to protect or increase revenue?



- Do you want to align with other providers in the market who already contract with the MCO?
- Do you want to foster a relationship with certain MCOs?
- Do you want to protect or increase your patient panel?

Further, look closely at your practice so that you know the patient mix in terms of payer, age, gender and health status. Do you have a payer mix that is heavy on managed care? Do you have a large percentage of older patients with more complex health problems? How would contracting with a particular health plan alter your present patient mix?

Examine, also, the MCO with which you plan to work. Try to find out why the organization is interested in contracting with you, Mr. Stone says. Health plans generally want physicians in their networks who can deliver cost-effective, high-quality care, can maximize efficiencies and are accessible to their members as well

as being liked by them. Find out, also, if this is an organization with sound finances and a good reputation among healthcare providers, employers and patients.

Under capitation, the health plan will pay you a flat rate for each patient each month, no matter how much care you provide. When considering a capitation deal, make sure the fees are set high enough so that you receive the proper compensation for patients who may require a good deal of medical care.

Types of Contracts

As you know from your work with managed-care plans, contracts generally come in two varieties: capitation and discounted fee-for-service. If you decide to sign a contract with capitation rates, keep in mind that it will provide a flat rate for each patient each month for a certain number of patients no matter how much service you provide to each patient.

It is very important that you make sure fees under capitation are set high enough so that you receive the proper compensation for patients who may require a good deal of medical care.

“Capitation is typically a better option for larger groups that have the infrastructure to manage the costs of healthcare for larger patient populations and remain a far riskier proposition for solo and small group practices,” states the American Medical As-

sociation's Model Managed Care Contract (www.ama-assn.org/ama/pub/category/9559.html). Nevertheless, if the rates are properly set, capitation provides physicians with a fixed payment each month—this can help the practice's cash flow.

When considering a capitation contract, the AMA recommends making sure the services included in the capitation rate are clearly identified and understood. It is also important to get guidance on determining if the capitation rate offered is sufficient not only to provide all covered services, but to meet the overhead requirements of your practice.

The types of services that are generally carved out of a capitation agreement include lab tests, a limited number of X-rays, preventive care visits and immunizations. The AMA recommends that any carve-outs you negotiate be listed in the contract by procedural code to avoid potential payment disputes.

Determine what services are covered in capitation and which ones will be reimbursed as “carve-outs,” Mr. Stone says. With carve-outs, physicians may identify certain services offered by the managed-care plan to patients that they wish to exclude from capitation agreements, generally because they are very high cost services. These exclusions are referred to as carve-outs because they are carved out of the capitation reimbursement.

A greater number of carve-outs could be more advantageous for the practice because these services will be reimbursed on a fee-for-service basis, says Mr. Stone. Often carved-out services include lab tests, a limited number of X-rays, preventive care visits and immunizations. The AMA recommends that any carve-outs you negotiate be listed in the contract by procedural code to avoid potential payment disputes.

In managed-care contracts, discounted-fee schedules are the most common type of compensation for physicians. The major type of discounted-fee model includes fee schedules that are based on Medicare's Resource-Based Relative Value System (RBRVS). Under this system, payments for services are determined by resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance, explains the AMA.

Does it Make Financial Sense?

Payments are calculated by multiplying the combined costs of a service by a conversion factor determined by the Centers for Medicare and Medicaid Services (CMS). They also are adjusted for geographical differences in resource cost.

Above all, the managed-care contract you sign must make financial sense for your practice. One way to determine this is to perform a cost-benefit analysis (CBA) of the contract, Mr. Stone

Insurers Reconsider Cost-Cutting Tools

Rising healthcare costs have created pressures for health plans and employers to reconsider unpopular cost-containment strategies that were scaled back after the managed-care backlash of the 1990s, according to a recent study published on the Health Affairs Website (<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.427>). The study, conducted by Glen Mays, Ph.D., M.P.H., associate professor in the Department of Health Policy and Management in the College of Public Health at the University of Arkansas for Medical Sciences, and two colleagues, identified increasing use of utilization review, hikes in out-of-pocket expenses and steering patients to more cost-effective providers.

Based on interviews with providers, insurers, employers and others in the healthcare markets, Dr. Mays and his colleagues found that plans are more often requiring preauthorization for outpatient services and specialist referrals. They also found that plans are reviewing inpatient services while patients are in the hospital in an effort to shorten hospitalizations, and they are reviewing claims to profile providers based on healthcare use and quality.

Many of these techniques were criticized during the managed-care backlash of the 1990s and were removed from plans as insurers responded to pressure from enrollees and employers. But with premiums rising at double-digit rates, some plans have now begun reintroducing the cost-control measures.

While use of these tools is on the rise, cost-saving changes in benefit design have gotten more attention, the study says. Employers and insurers have begun increasing co-payments, coinsurance and deductibles as well as offering lower-cost plans to enrollees who agree to limit their choice of providers or who select catastrophic plans with high deductibles.

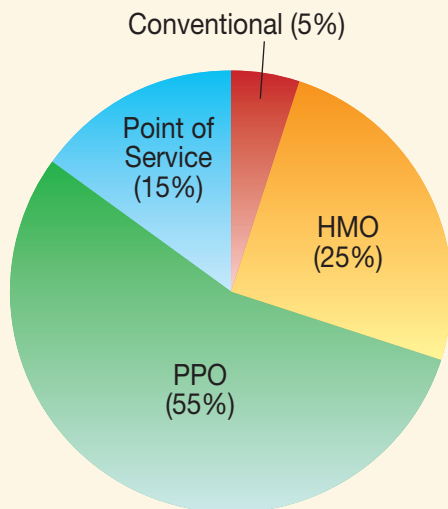
recommends. To do this accurately, you will need to determine the patient mix of your practice, such as age, gender, health status and type of payers.

You should determine what the contracted rate for the common procedure codes billed should be in order to make a profit. Usually the benchmark is what Medicare reimburses under its RBRVS arrangement. If this is the case, you want to find out the Medicare schedule year that the fee is based on. The current ones can be found on the CMS Website: www.cms.hhs.gov/providers/pufdownload/default.asp#rvu.

If Medicare does not have a relative value unit for a code, then there is no reimbursement rate for the code, explains Mr. Stone. As a result, the commercial payers can decide how the code will be reimbursed.

The insurance plan should provide you with the CPT code reimbursements for your top 25 to 50 procedure codes. If it should

Health Plan Enrollment by Plan Type, 2004



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

refuse to do so, this is a warning that you may not want to move forward with this particular plan.

You also need to know how much it costs to deliver services under each plan. This allows you to determine the net income for each health insurance plan for which you sign a contract. A recent survey by MGMA found that practices that knew their contracted rates were reimbursed at higher levels than practices that did not know them.

Mr. Stone recommends using a fee analysis spreadsheet to help you do a cost benefit analysis. A good one is located on the AAFP's Website at www.aafp.org/fpm/20041000/31cany.html. Click on "Two Helpful Spreadsheets" for the Excel download.

Compare all the MCO contracted rates across your practice's 25 to 50 CPTs and multiply them by their volume amounts. This will provide an expected amount of revenue based on the health plan's proposed fee schedule. It is very important to see a copy of the MCO's fee schedule before you sign any contract, Mr. Stone advises.

It's also important to estimate what additional administrative tasks will be necessary to follow contract guidelines, such as pre-authorizations, referrals, credentialing and quality reports.

Attorney Daniel Bernick of The Health Care Group, a practice management firm in Plymouth Meeting, Pa., says you can create your own payer matrix for existing contracts by listing the top CPT services rendered by the practice in terms of dollar volume. Then list the name of the insurance plan and what each plan paid the practice for each of those services. "This helps you determine if a specific plan is a good or bad payer," he explains.

Unfortunately, most practices never take the time to determine whether they are being compensated fairly for their services, he adds. This analysis will also help you determine how the reimbursement from a particular payer matches up to other plans with which you deal.

If you have a payer that is providing 45 percent of your business, it is generally more difficult to negotiate for higher reimbursements than it would be with a plan that provides only 3 percent of your business, says attorney Daniel Bernick with The Health Care Group, a practice management firm.

The matrix furnishes you with information that you can use to negotiate fees, which is one of the most important aspects of a managed-care contract, Mr. Bernick points out. Further, when you do your analysis, you can determine how much of your business is coming from each particular payer. If you have a payer that is providing 45 percent of your business, it is generally more difficult to negotiate for higher reimbursements than it would be with a plan that provides only 3 percent of your business, he says.

Be sure you understand the reimbursement methodology. This includes understanding the discounted fee-for-service provisions and the capitation arrangements as well as the withhold provisions and bonuses.

Capitation rates can be tricky and hard to evaluate. You might

Terms to Know When Dealing with MCOs

There are a number of terms and clauses that you need to understand in order to negotiate effectively with health insurance companies before signing a contract. If you ignore the legalese, some of the clauses can end up creating unanticipated problems. Here is a sampling of the major ones the AMA has identified as problematic in the third edition of its Model Managed-Care Contract (www.ama-assn.org/ama/pub/category/9559.html). The AMA's model is a useful guide for physicians negotiating managed-care contracts.

■ **Payer.** Watch how this term is defined. When it is defined broadly, the health plan may “sell” or “rent” its provider network to third parties. This can result in what is known as a “silent PPO,” which allows third parties to have the advantage of the plan's negotiated discounts with physicians, without the knowledge of physicians and without providing doctors with any compensation for that.

This is detrimental because silent PPOs are able to take advantage of discounts to which they are not entitled. The AMA says it has been estimated that physicians and non-physician healthcare providers nationwide have lost between \$750 million and \$3 billion annually since the practice began in the early 1990s.

■ **Indemnification and hold-harmless clauses.** The “hold-harmless” clause means that if an action or investigation is started or any other claim is made against the physician that involves the managed-care organization, the physician will have complete responsibility for any costs the organization incurs, even if the physician is exonerated. The

arrange to have the contract state that your practice will not see patients under a capitation arrangement until you have a certain number of patients in the practice. Until that happens, try to stipulate that you will be paid on a fee-for-service basis.

As part of this evaluation, try to determine whether or not a capitation or withhold arrangement placing some risk onto your practice is appropriate, says Mr. Stone. “Normally if the practice is performing efficiently, the payoff can be better when taking on some financial risk. However, knowing the anticipated patient population of the health insurance plan and insisting on appropriate stop-loss coverage levels is prudent,” he adds. Stop-loss provides protection for the physician against a financial catastrophe due to the high medical costs incurred by the MCO’s patients.

AMA warns physicians to beware of these clauses because your malpractice carrier is not likely to cover these costs—you would have to pay them personally in the event of a lawsuit.

■ **All products.** This type of clause is often mandatory and is showing up more in managed-care contracts. The clause essentially forces physicians to participate in all current, and sometimes future, products that the managed-care organization offers, on the terms and conditions directed by the organization, says the AMA.

The contract should not be construed to require physicians to participate in all products as a condition of participating in any individual product, recommends the AMA. It is important to develop separate business terms, including compensation, for each and every product.

■ **General offsets and adjustments.** The physician agrees to allow the managed-care organization to deduct monies that may otherwise be due and payable from any outstanding monies that the provider may owe to the health plan. “This provision gives the managed-care organization a free hand to do whatever accounting it desires and deduct monies from a physician or physician group in its sole discretion without a requirement to account to the physician or group and explain the deduction,” says the AMA.

■ **Emergency.** How does the health plan define emergency? It is important to determine if the definition includes the “prudent layperson” language versus “prudent physician,” which is more restrictive. The less restrictive the definition, the better for the patient and the physician, according to the AMA.

After doing the fee analysis, it will be evident if the contract rates need to be higher, he says. If the numbers indicate that it does not make financial sense for your practice, walk away.

Play Close Attention to Detail

Because of the complexity of managed-care contracts, experts recommend that physicians take time to consider a number of issues and questions before they actually sign with a plan.

For example, how does the plan define the timely filing of claims? Ninety days seems to be the industry standard for the least number of days allowed, which is normally for fully insured health benefit plans.

Prompt payment laws do not always solve the problem of delayed payments, says attorney Daniel Bernick. That is because the laws hinge on providing the payer with a clean claim. “Until the carrier considers claims submitted as ‘clean,’ your practice has not triggered the running of that deadline in the prompt-payment law,” he says.

Another important question is whether the health insurance plan has an obligation to pay you promptly. You should make certain that the contract includes a specific payment time period and that the plan agrees to pay interest if it delays payment beyond that time period.

Most states do have prompt-payment laws in effect, which require the timely payment of claims, such as within 30 days. When reviewing managed-care contracts, be sure they comply with the time frames and interest penalties designated by your state and other claims processing and payment provisions, says the AMA. To find out if your state has a prompt-payment law, go to www.ama-assn.org/ama/pub/category/14409.html.

These laws were put in place because all too often payments from carriers to physicians are delayed an inordinate amount of time. Insurance plans will claim that the delays result when practices do not submit “clean” claims. Further, they may fail to explain what is missing or incorrect in the claim, making it harder for the practice to comply. Another tactic used to delay the payment of claims is to make repeated requests for additional information over a relatively long period of time.

While prompt-payment laws may spur health plans to pay

claims in a more timely fashion, the issue remains a tough one for physicians. Some state regulators are moving to enforce state prompt-payment laws and are attempting to bring fines against managed-care companies for violations of the law.

Nevertheless, state laws don't always solve payment problems, says Mr. Bernick. That is because the laws hinge on providing the payer with a clean claim. "Until the carrier considers claims submitted as 'clean,' your practice has not triggered the running of that deadline in the prompt-payment law," he says. Keep in mind that methods to turn around claims quickly are not high on the list of priorities for payers, he adds.

To avoid problems with delays, your contract should include a provision that outlines the requirements of the prompt-payment law in your state. For example, include a provision in the contract stating that clean claims will be paid within 30 days of submissions. You can also try to include a definition of "clean claim"

Five Types of HMOs

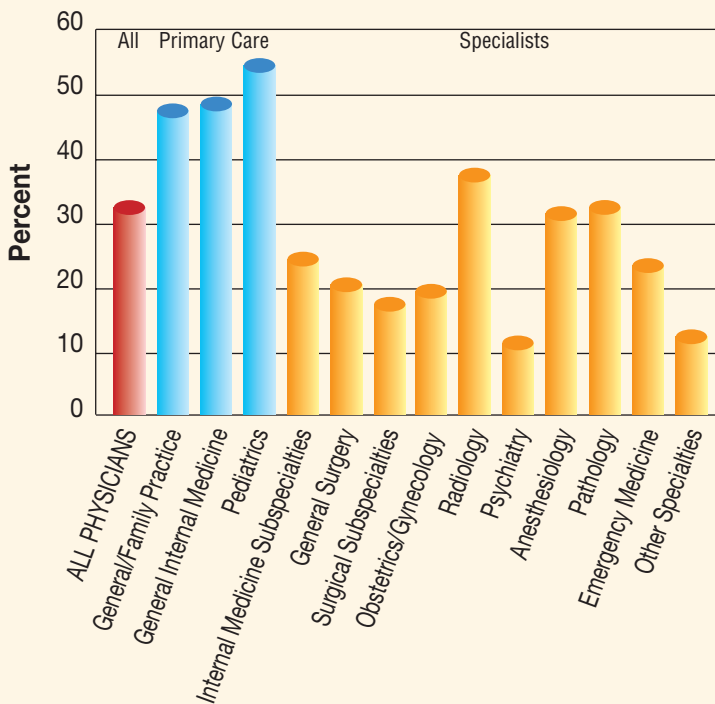
Health maintenance organizations generally come in five model types, which define the relationship between the health plan and its providers, according to InterStudy Publications, a St. Paul, Minn.-based publisher of managed-care data and directories. The five HMO models are as follows:

- **Staff Model.** An HMO that delivers health services through a physician group that is employed by the HMO.
- **Group Model.** An HMO that contracts with one independent group practice to provide health services.
- **Network Model.** An HMO that contracts with two or more independent group practices, possibly including a staff group, to provide health services. While a network may contain a few solo practices, it is predominantly organized around groups.
- **IPA Model.** An HMO that contracts directly with physicians in independent practices and/or an HMO that contracts with one or more associations of physicians in independent practice. This label can also apply to an HMO that contracts with one or more multi-specialty group practices, but is predominantly organized around solo/single-specialty practices.
- **Mixed Model.** An HMO that uses a combination of the contracting model types listed above.

Primary-Care Doctors More Likely to Have Capitated Contracts

While most physicians hold managed-care contracts (88% in 2001), a much smaller proportion, 32%, had capitated contracts in 2001. About half of primary-care physicians had a capitated contract in 2001, compared with between 11% and 37% of other specialists.

Percentage of Physicians With Capitated Contracts, by Specialty, 2001



Source: Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace, 2002*, citing data from the American Medical Association, 2001 Patient Care Physician Survey.

in the contract. It can say, for example, that a clean claim constitutes “no material omission of information needed to pay the claim,” Mr. Bernick says.

Further, if the carrier believes that the claim is not clean, the contract should stipulate that the insurance plan is obligated to notify the practice within a certain period, such as three to five business days, that the claim submitted is not complete or clean, or requires further supporting documentation. Mr. Bernick also recommends stipulating that once the claim is clean, it will be paid within 20 business days from the time it becomes clean.

One way to avoid potential problems with claims is to have the MCO run some sample CPT combinations that the practice bills in order to identify any claim-editing questions, such as bundling, not paying for certain modifiers or the need for additional information, advises Mr. Stone.

The overall best protection for your practice is doing due diligence yourself with regard to the payer, he adds. For example, if you haven’t dealt with this health insurance plan before, it is a good idea to ask around and find out exactly what the payer is like to work with and if it has earned a reputation for paying claims promptly or not.

You also want to know if the MCO accepts electronic claims. Claim filing is more cost effective when done electronically, yet there are health plans that will not accept electronic claims, Mr. Stone says.

Be wary of managed-care contracts that state that the plan’s medical director will determine what is “medically necessary,” which will override the physician’s clinical judgment. This kind of definition, which lacks a clear role for the treating physician, is seen as harmful to both patients and physicians.

Common Pitfalls

No matter how well prepared you are when reviewing a contract, keep in mind that there are always pitfalls to avoid. If you want to boost the profitability of your practice, it is crucial to discover these problems before you sign. But even after you sign, it makes sense to review your contract to see if it is possible to negotiate to improve reimbursements and shorten the time you have

to wait for claims to be paid.

If you locate potential pitfalls, you essentially have two options: you can try to negotiate to change the contract terms or decide not to sign (or to drop) a plan if you determine the contract is not financially beneficial to your practice.

Find out how the contract defines “medical necessity.” Generally, managed-care organizations will not pay for care that it does not consider “medically necessary,” says the AMA.

Be wary of managed-care contracts that state that the plan’s medical director will determine what is “medically necessary,” which will override the physician’s clinical judgment. This kind of definition, which lacks a clear role for the treating physician, is seen as harmful to both patients and physicians. If possible, try to have that type of language removed from the contract so that the payer does not have the sole discretion in determining whether the services are deemed to be medically necessary, says Mr. Bernick. “Medically necessary” should be defined as those services deemed to be appropriate in the judgment of the provider. “The physician is the ultimate one who knows what is necessary for the patient,” he points out.

The AMA recommends a “prudent physician” standard when defining medical necessity. It should be defined as “healthcare services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate in terms of type, frequency, extent, site and duration, and c) not primarily for the convenience of the patient, physician or other healthcare provider.”

You also want to know your rights and obligations under the contract if you decide to voluntarily drop a specific plan. Mr. Bernick recommends having a no-cause termination provision on both sides, which provides 90 or 120 days to end the contract.

It is also important to have the ability to get out of a contract in the event you discover the payer is difficult to work with or has cut its rates so that it is no longer profitable to work with the plan. Most contracts will require that you inform the plan in writing of your intentions.

What You Need to Know About an MCO

There are a number of details to find out about a managed-care organization before you decide to sign with them. For example, it is important to know how long the MCO has been present in your local market and nationally. If it has an extensive track record, it is more financially established and less likely to face solvency problems.

Weiss Ratings, a Jupiter, Fla.-based firm, regularly evaluates the financial stability of HMOs and other insurance companies. To check out the financial stability of a plan and make sure you won't face a financial risk for uncompensated care, go to www.weissratings.com/HL_Health.asp. The site rates health plans from strongest to weakest. It is a good idea to periodically monitor the financial condition of the plan.

Here are some other important factors to consider:

■ **Is the MCO vying for a competitive edge against other health plans?** If it is, it may help you determine how driven the MCO is in adding your practice to its network, which will help you with negotiating rates.

■ **Is the organization for profit or not for profit?** Keep in mind that not for profits still have to make money to survive, but the mission is generally more community minded.

■ **Is the MCO accredited by the National Committee for Quality Assurance?** NCQA is a private, non-profit organization dedicated to improving healthcare quality. NCQA accreditation is a sign of quality and a selling point to employer groups who purchase insurance plans for their employees.

■ **Why is the MCO approaching your practice?** Try to find out if there is a need for more of your specialty type in the MCO's network. If so, this may help when negotiating rates with the plan.

You also want to know the size of the employer group with which the plan usually has contracts. If it provides coverage for small-sized employer groups, there are more risks involved because there are fewer insured over which the financial risks of a health event can be spread, says Trevor J. Stone, private-sector advocacy manager for the American Academy of Family Physicians.

Another point to investigate is whether the contract is exclusive or open—can you sign this contract and also work with other competing MCOs? An open contract for smaller physician groups makes sense, he says. Exclusive contracts may reimburse at higher levels than open contracts do because there is less care to other providers to manage. This means there are fewer resources needed to manage a larger provider network.

Another important bit of information to know is the actual term of the contract and how it is renewed. Some contracts renew automatically. “It may be best to sign a one-year contract so you can analyze the impact of the new contract on your practice,” says Mr. Stone.

Further, he says it is a good idea to at least review an active contract annually. It is important to know whether the managed-care organization is obligated to provide notice of your rights to terminate every year, advises the AMA.

When reviewing your contract terms, be sure to ask about the length of time for providing notices of substantive contractual changes and try to find out how these changes will be communicated to you. Will you receive a letter from the plan informing you or will you have to check the plan’s Website or its newsletter?

Be sure to find out how much time you have to actually submit a claim to a plan, says Mr. Bernick. It is important to have the ability to submit claims for at least 90 to 120 days after the date of service and not a period that is less than that, he adds. Normally, you will be submitting claims more promptly than

that, but there are occasions when you might discover that a claim hasn’t been submitted.

It also pays to be on the lookout for clauses that provide for retrospective audits or look-back periods and what the health insurance plan can do as a result of these audits or look backs. For example, does the contract say the plan can “offset” alleged “overpayments?” Some payers may automatically deduct current payments if an internal audit shows, for example, that there were historical overpayments.

In other cases, you may receive a letter or statement from the plan indicating that it overpaid by a certain amount and the reason it determined an overpayment was made, for example, that the claim was not coded correctly.

It is in the practice’s interest to have the shortest possible look-back period so that the physicians do not end up having to pay back the plan for claims that were made several years ago. A good safeguard is to make sure the contract sets a six-month limit on the insurer’s ability to audit or look back on physician claims. Some of the contracts have a one-year limit, says Mr. Bernick.

Health Plans Offer Bonuses for Quality Care

Health plans increasingly are dangling a carrot—higher payments—to get physicians and hospitals to improve patient care, according to a 2004 study by the Center for Studying Health System Change (HSC).

“Pay-for-performance initiatives are just getting off the ground in most communities, but they can provide a springboard for broader acceptance of tying physician and hospital payments to quality improvement,” said Paul B. Ginsburg, Ph.D., president of HSC, a non-partisan policy research organization funded principally by The Robert Wood Johnson Foundation.

The study is based on HSC’s 2002-03 site visits to 12 nationally representative communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. “Health plan-based quality incentive programs exist in seven of the 12 HSC communities, and most programs are sponsored by major health plans—those with large market share and, therefore, significant influence over providers,” said Bradley C. Strunk, an HSC research analyst and coauthor of the study.

Quality incentive programs across the HSC communities varied on three key design features: quality measurement, incentive payment structure and incentive size:

- While plans use different methods to measure quality with little standardization, commonly used indicators include patient satisfaction and preventive care use, since this information can be collected easily. Use of more sophisticated outcome-and-process measures, such as the specific care a patient receives, is less common.
- Incentive payments can take a variety of forms but almost always represent “upside” risk to providers. In other words, the providers risk losing a bonus, but base payment rates are not threatened.
- Incentive payments typically are modest compared with a provider’s total revenue from a health plan—usually about 1 percent to 5 percent of total payments.

Interviews with plans, providers and purchasers suggest that plans have been the prime movers behind quality incentives in the 12 communities, and many of the programs focus on promoting the practice of evidence-based medicine. Providers remain cautious about the design and implementation of incentive programs, the study says, but some are willing to participate and, like health plans, view quality incentives as a way to promote the practice of evidence-based medicine.

“A year should be the maximum that a payer is allowed to look back and claim they overpaid you,” he says.

The AMA offers this advice with regard to look backs or audits: “The contract should state that the managed-care organization should notify the physician within 15 days to request additional information if the claim is not considered ‘clean,’ and to provide the reason for the claimed deficiency. In addition, the contract should state that all payments to

It is in the practice’s interest to have the shortest possible look-back period so the physicians don’t end up having to pay back the plan for claims that were made several years ago. “A year should be the maximum that a payer is allowed to look back and claim they overpaid you,” says attorney Daniel Bernick.

physicians will be final unless adjustments are requested in writing by the plan within 90 days after receipt.”

As you look for other potential pitfalls, Mr. Stone advises you to be wary of contract language that says the health insurance plan will “pay the lesser of billed charges or the approved fee schedule.” For example, if you charge \$50 for a particular service, which is less than the contracted rate of \$65,

you will be paid only your lower billed amount of \$50. “This is one reason to review and adjust your billed charges on a regular basis,” he points out.

To find Medicare’s current reimbursement rates for the geographical area in which you are located, go to “Medicare Physician Fee Schedule Look-Up” at www.cms.hhs.gov/physicians/mpfsapp/step0.asp. It is also possible to find the current relative-value units Medicare assigns to each code.

When reviewing your contract terms, be sure to ask about the length of time for providing notices of substantive contractual changes, and try to find out how these changes will be communicated to you. Will you receive a letter from the plan informing you, or will you have to check the plan’s Website or its newsletter?

Sometimes a managed-care contract will say that the payer has the right to amend the agreement unilaterally, says Mr. Bernick. You should request that no amendments can be made to the contract unless agreed to by both parties.

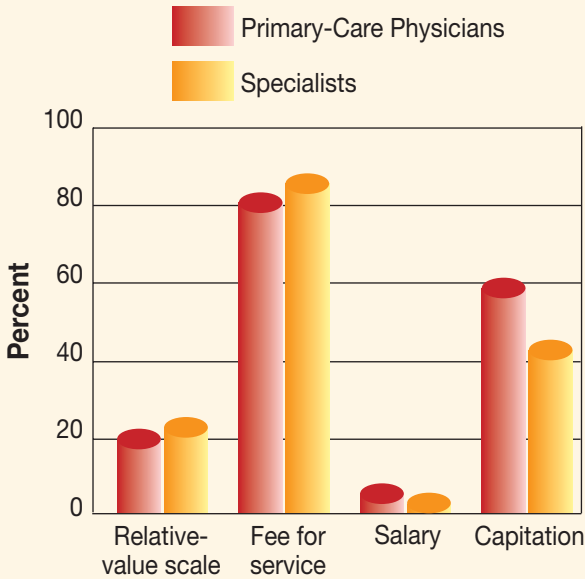
The AMA recommends finding out what services are to be

covered in the contract. Make sure the services are well defined; if they are not, the contract will end up working more to the advantage of the managed-care company “by giving it a wide berth to deny requested services as not covered,” the AMA says.

The contract you sign should be set up between the managed-

Method of Physician Reimbursement by HMOs, 2001

Fee for service is the most common payment method used by HMOs for both primary-care physicians and specialists. Its use increased from 1997 to 2001, from 33% to 80% for primary-care physicians and from 49% to 85% for specialists.



Note: Data show the percentage of HMOs using various methods for any portion of physician reimbursement.

Source: Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace, 2002*, citing data from InterStudy Publications.

care plan and your medical group and not with individual doctors, recommends Mr. Bernick. “There are different rights and obligations in the document that are appropriate for the practice as a whole to fulfill, but not for the individual doctor,” he adds. For example, there may be an obligation to take care of patients after the contract ends, and that obligation should fall to the practice, he says.

It also is a good idea to determine what you need to know if you are thinking about joining the health insurance plan’s

Try to determine if the MCO’s policies on appeals are clear and fair. For example, what are the filing deadlines? You also want to be sure the MCO provides you with the telephone numbers and addresses needed to make your appeal. Also, do you know whom to contact at the MCO when a claims issue arises?

provider network. Another issue to nail down is the volume, gender and age range of patients you are likely to see if you join its network. If the volume isn’t likely to be significant, the added administrative expenses and discounted fees may mean it is not worth joining, says Mr. Stone.

Be sure you have information on the following:

■ **A list of all participating providers.** This will help you de-

termine whether an ancillary provider or specialist to whom you normally refer is part of the plan’s network.

■ **Formulary details.** If most of the drugs prescribed by the practice are non-formulary or require prior authorization, additional administrative time will be required of your practice.

■ **Requirements on prior authorization list.** If the MCO requires preauthorization for a commonly ordered test or procedure, phone calls and clinical data sharing are necessary prior to scheduling a test. Preauthorization will require some administrative time on the part of the physician’s referral and/or clinical staff.

■ **Instructions on referrals.** Does the health plan require gatekeeper referrals to specialists? You need to take into account the administrative time that is needed for referrals.

Experts say that, in order to make the best decision possible about whether or not to sign a contract, you should hire a consultant or attorney to review the fine print before signing.

Appealing a Decision

There are times when you may want to appeal a managed-care decision. Keep in mind that procedures vary by health insurance plan, so it is important to know the appeals process of each plan before signing the MCO contract.

The AMA says that if the contract refers to administrative policies and procedures, you should review these procedures specifically to determine your appeal rights.

Try to determine if the policies surrounding the appeals process are clear and fair. For example, what are the filing deadlines? You also want to be sure the MCO provides you with the telephone numbers and addresses needed to make your appeal. Also, do you know whom to contact at the MCO when a claims issue arises?

Other issues to nail down include the number of appeal levels and whether the internal appeals process includes an independent review.

If you are engaged in an appeal, Mr. Stone recommends that you always document the sequence of events as they occur. Be sure to communicate clearly, concisely and calmly. Also, be persistent if your grievance is not resolved to your satisfaction.

Further, it is important to have a contract that provides the “option of arbitration,” says Mr. Stone. This grants the physician the right to seek arbitration, which is normally pursued following the exhaustion of the payer’s internal appeals process.

Find out how the individual arbitrators are selected and whether the American Arbitration Association rules are followed. It’s also a good idea to find out how the arbitration costs are divided. You also want to be sure that the decision made by the arbitrators is mutually binding so that it will be followed.

Other considerations that are important include the turnaround time for the plan to respond to you and whether the arbitration decision is mutually binding. Further, is there an expedited appeals process for pre-clinical consideration?

Keep in mind that some plans are beginning to insert provisions in contracts that prohibit a physician from consolidating his or her arbitration claim with those of other physicians with similar claims. “This is another attempt to limit a physician’s ability to participate in class-action lawsuits,” says the AMA.

If you are not satisfied with an MCO appeal decision it is always possible to file a complaint with your state insurance commissioner. For the name and address of your state's commissioner, go to www.naic.org/state_contacts/sid_websites.htm.

Terminating a Contract

In addition, if the dispute involves a small amount of money, the AMA says that a small-claims court action may be a viable option. These courts exist in every state in the U.S. and allow you to sue for under \$2,500 for the payment of less than \$200 in filing and other administrative fees.

Before you drop a contract, make sure you understand what your contract says about your obligations if you terminate. For example, you may be required to continue to care for a plan's patients until another doctor can be found to see those patients even though the contract is no longer in effect.

If, after careful analysis, you decide that a particular managed-care plan is not meeting the needs of your practice, you should consider dropping the contract. Most contracts stipulate conditions under which either party can terminate the contract. The two main categories are "for cause" and "without cause."

"For cause" terminations allow either the physician or MCO to end the contract if a certain provision under the contract is met. One example is if the physician loses his or her license because of negligence. Termination "without cause" is not as clear. You want the contract to require the MCO to provide the reasons for termination in writing along with allowing you to review materials that were the basis for the decision.

Before you drop a contract, make sure you understand what your contract says about your obligations if you terminate. For example, you may be required to continue to care for a plan's patients until another doctor can be found to see those patients even though the contract is no longer in effect.

Under what conditions would you move to drop a plan? This may occur, for example, when you discover that your practice is not breaking even financially with a particular plan, says Mr. Stone. You may also feel the need to drop a contract when you find that the services provided by the health insurance plan are

poor. For example, does it pay claims too slowly or does it always pay claims incorrectly? In addition, does your staff spend too much time trying to deal with these problems? You should also watch to see if you are receiving a significant number of denials for preauthorization requests even when medical necessity is present, says Mr. Stone.

It also may be time to leave the plan if it breaches its obligations under the contract or creates an unsustainable increase in administrative costs, he adds.

Before you take steps to leave a plan, consider the situation in your local market. If you leave one health plan, are you going to be able to replace patient volume some other way? You want to be sure you know the risks of dropping any plan as well as the importance of each plan to your practice. In some situations, you may be able to negotiate with the plan to improve reimbursements. This is especially true if your practice is the only one providing a certain specialty in your area.

Once you do leave a plan, be sure to send a letter to affected patients explaining why the practice will no longer be accepting the plan and what the consequences will be.

Deciding on whether a contract is appropriate for your practice is a difficult task, but if you apply the guidance offered here, you are sure to make a good decision.