asim
american society of internal medicine

September 11, 1996

Karen Ignagni
President
American Association of Health Plans
1129 20th Street, NW, Suite 600
Washington, DC 20036

Dear Ms. Ignagni:

On behalf of the American Society of Internal Medicine (ASIM), I am writing you to share the contract provisions that we believe should be included in all managed care contracts between network model health maintenance organizations (HMOs) and other HMOs that contract with individual physician practices and those physicians. We have developed this criteria at the behest of the 1995 ASIM House of Delegates which asked that ASIM pursue the development of a standardized physician managed care contract format and promote its universal utilization by the managed care industry.

The enclosed document describes the information that ASIM believes should and should not be included in a standardized managed care contract. This information was derived from ASIM's award winning text, *The Internist's Guide to Negotiating Managed Care Contracts and Capitation Rates.*

ASIM encourages the American Association of Health Plans (AAHP) to endorse these concepts and to promote them with your membership. We believe that these concepts will promote appropriate patient care.

Sincerely,

Alan R Nelson MD

Alan Nelson, MD
Executive Vice President

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STANDARDIZED MANAGED CARE CONTRACT FORMAT

The American Society of Internal Medicine (ASIM) believes that the information indicated below should be included in a standardized managed care contract format. This information should be contained in all managed care contracts between network model health maintenance organizations (HMOs) and other HMOs that contract with individual physician practices and those physicians. This information was derived from ASIM's award winning text, *The Internist's Guide to Negotiating Managed Care Contracts and Capitation Rates*. This list was created at the behest of the ASIM House of Delegates.

Information that should be included in managed care contracts or incorporated documents

1. Legal identification of the parties to the contract--the managed care organization (MCO) and the physician practice should be clearly identified in the beginning of the contract.

2. The contract should specify the legal relationship between the contracting physician and the MCO.

3. Definitions of terms used in the contract should be made in the beginning of the contract.

4. The services that the physician is expected to provide under the contract should be described. The covered and non-covered services in the contract should be specifically identified.

5. All the managed care products (HMO, POS, PPO, etc.) that the physician must serve under the contract must be clearly identified.

6. The compensation arrangement (capitation, discounted fee-for-service, etc.) must be clearly described.

7. The compensation schedule must be included with the contract whether it be a capitation or fee-for-service fee schedule. If the physician is paid on a capitated basis and certain services fall outside of the capitation amount and are paid on a fee-for-service basis, those services and their payment rates should also be identified. The contract should also indicate how often the compensation arrangement will be updated--preferably on an annual basis.

8. All payment incentive systems, such as withholds, risk-sharing pools, and bonus systems must be clearly explained in the contract.

9. The regular payment dates for claims submitted or capitation payments should be outlined in the contract.

10. The contract should state that physicians paid under a capitation arrangement will receive fee-for-service payments until a certain minimum enrollment level (such as 100 patients) is attained in the physician's patient panel. Once the minimum level is attained then the capitation payments should occur.

11. The MCO should offer stop-loss reinsurance and clearly express the terms of the stop-loss in the contract.

12. "Most favored rate" setting contract clauses should not be included in managed care contracts. Physicians should not be obligated to lower their fees if they accept a larger fee discount from another insurer.

13. Panel closing procedures should be clearly explained. The physician should be allowed to close his/her panel at any time--with proper notice.

14. The managed care contract should describe the procedure a physician should follow to terminate a patient from his/her patient panel. Physicians should be able to retain the right to terminate a relationship with a patient.

15. The contract should describe when the physician must be available to MCO patients (for example, is 24 hour call coverage required?).

16. The MCO's referral and authorization process should be clearly outlined in the contract. Services that have to be preauthorized should be specifically listed.

17. The patient's financial responsibility (copays and deductibles) should be included with the contract.

18. Referral for laboratory services should be clearly described in the contract. Patient access to "stat" laboratory testing should be maintained in the physician's office, if such testing facilities are available.

19. The contract should specify the procedure that must be followed when a patient is seeking services from an emergency room or an urgent care center and what the physician's corresponding responsibilities are in terms of preauthorization or health plan notification.

20. The contract should explain whether or not the physician is held responsible for instances where patients refer themselves without the physician's approval. This is particularly important when the physician is in a risk-sharing agreement and referrals are deducted from the risk-sharing pool.

21. If the MCO uses a drug formulary, the contract should indicate this and the formulary should be made available to the physician prior to signing the contract.

22. The MCO's quality assurance and utilization review (QA/UR) program should be briefly described in the contract. The physician should have the right to review the QA/UR program at any time, in detail, if the physician chooses.

23. The contract should indicate the physician's responsibility in-terms of determining patient's insurance eligibility. It should also indicate how often the MCO will provide the physician with updated information to verify patient eligibility. This should occur at least on a monthly basis.

24. The contract length or term should be clearly stated in the contract. Contracts are usually one year in length and are renewed automatically each year.

25. The possible reasons for contract termination "for cause" should be specifically cited in the contract. If the contract can be terminated "without cause" then it should be available for the physician and the MCO, not just the MCO. The termination provision should also indicate how the other party is to be notified and how far in advance of termination.

26 The contract should indicate if there are post termination responsibilities for the physician. Often contracts contain a "tail coverage" that indicates that a physician may have to continue treating MCO patients up to one year after termination in order to assure continuity of care for

patients and that adequate coverage can be found to replace the terminated contract.

27. The contract should not hold the MCO harmless for actions of the physician. Contractual indemnification is inappropriate. MCOs should be held liable for actions of their participating physicians, particularly if the situation involves a dispute over utilization or access to certain medical services.

28. The contract should not contain gag clauses. The physician should retain the right to speak freely regarding treatment options and the MCO benefits that the patient receives.

29. The contract should indicate how the MCO grievance procedure works. An internal MCO structure should exist to allow a physician to appeal an MCO decision regarding patient access or insurance coverage for a particular service.

30. Arbitration and mediation services should be indicated in the contract. If the MCO and the physician cannot reach agreement on a particular appeal, then such services should be made available.

31. The method and timeframe for data collection and billing requirements for the physician and the MCO should be indicated in the contract.

32. An indication of how coordination of medical benefits for persons with secondary insurance should be handled by the physician and the MCO should be described in the contract.

33. The contract should contain a provision that states that all contract changes should be made only after prior notification of at least 30 days is sent to the physician.

34. The MCO credentialing, facility review, medical record review standards should be described in the contract or incorporated documents. The physician should be able to review these standards at any time.

35. All documents incorporated to the contract by reference must be provided to the physician prior to the contract being signed. Similar to the contract, these documents cannot be unilaterally changed without prior written notice.

36. The contract should be signed by the physician, an MCO representative, and a witness.

37. Both the MCO and the physician should retain a copy of the contract.

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