Capitated Contract Checklist - Reprinted with Permission

Contents

I. Use of this Document
   Calculating Capitation
II. Contracting Tips
III. The Checklist
    1. Recitals
    2. Definitions
    3. Provider Obligations
    4. Plan Obligations
    5. Term and Termination
    6. Legalese
    7. The Payment Addendum
    8. Risk Pools and Incentives
    9. Most Favored Nations
IV. Explanations

I. Use of this Document

This document is provided as a service to physicians, medical groups and provider networks who are entering into capitated service agreements with health care payers. It is intended as a guideline to some of the operational pitfalls and intricacies of capitated relationships.

This tool may be copied and distributed, electronically or otherwise, only if any such copies contain the complete document, including copyright, identifying marks, and this disclaimer.
The author makes no claim to the completeness of this document as a comprehensive analysis of all the issues involved in capitated contracting. Updates and input from users of this document are welcome, and will be included in subsequent releases.

Laws and regulations vary considerably by state. This tool is not intended to be in any way authoritative on issues of regulation or legality. Use of a local health care attorney for such review is highly recommended.

**II. Contracting Tips for Physicians**

One of the great lies, and the one most often told in managed care, is “This is our standard provider contract.” Many physicians interpret that statement as meaning that the contract is some form of neutral agreement, or a document developed to balance the rights of the contracting parties, much like a Standard Industrial Lease. Nothing could be further from the truth.

The capitation contract presented to a provider by an HMO was written by the health plan’s attorneys. It is intended to maximize the HMO’s rights, and minimize their liabilities. Since the contract is the single governing force over what will presumably be a multi-year relationship, accepting the “boilerplate” version presented by the health plan ensures that they will have maximum control of the funds, the patients, and any changes or amendments.

Getting a professional HMO contract manager to even consider changes in a contract may be a challenge. Customized contracts do not make their lives simpler. I have never figured out why some contract negotiators act personally insulted at a request for modification, but many do. Some others are too lazy, or too unfair, to admit that both sides have a right to impact the structure of the business relationship.

Always remember: you may have to walk away. If the contract is critically flawed, and a plan steadfastly refuses to address the issues, then you can do serious and permanent damage to your practice by entering into a unreasonable risk agreement.

At some point in your negotiation you may run into one of the following pressure tactics. I have seen each used dozens of times, in all areas of the country. I haven’t yet run across the Health Plan Contract Managers’ Handbook of Negotiating Ploys, but from their consistency of tactics, I’m beginning to suspect that one exists.

**Ploy #1: “Let’s discuss price first, the rest will take care of itself.”**
Nominal capitation rate may be the least important thing in a contract. The scope of services, obligations, term and termination and lots of other areas can make
the contract a winner or loser regardless of payment rate. Don’t get hung up on the dollars until you are clear on what will be required for the money.

**Ploy #2: “We’re ready to pay, the check is cut.”**
A favorite tactic is to keep reminding you of how much your practice would have received if you had already signed the agreement. This is often done when the HMO’s legal department is holding up a contract while they try to figure out how to rewrite it around your requests for change. Don’t do something you’ll regret for years to come for the sake of one month’s payment.

**Ploy #3: “This can’t be changed, it’s a legal requirement”**
Make the negotiator define the requiring statute. A *statutory* requirement is necessary in the contract according to state or federal law. A *legal* requirement is frequently jargon for something the health plan’s lawyers told them not to give away.

**Ploy #4: “Over ______ (fill in the number) other doctors have already signed this agreement without any problem.”**
So? Like your mother said: “If all the other kids jumped off a cliff, would you?”

**Ploy #5: “If this isn’t signed by Friday, you’ll miss the printing of our new Provider Listing”**
Maybe true, often not. With today’s computer typesetting, additions can be made later, and Plans print new listings more often. (They’re probably going to get your phone number wrong in the first one anyway.)

**Ploy #6: “If we could just talk directly with the physicians, we could settle this.”**
Consider using a professional when dealing with professionals. Doctors don’t negotiate contracts for a living, but HMO Contract Managers do. At least once in every single negotiation the HMO will try an end run around your negotiator. If they are offering to let you strike a deal with their Medical Director or U.R. Nurses, fine. If they are asking you to get your negotiator out of the process so their negotiator can run the show- beware!

All set? Thus armed, let’s look at the contracts.
III. The Checklist

1. Recitals

☐ 1.1 Correct definition of provider entity?
☐ 1.2 Consistent use of identifying terms?
☐ 1.3 Correct singular and plural designations?
☐ 1.4 Is the purpose of the contract stated?

2. Definitions

☐ 2.1 Is the definition of “Emergency” acceptable?
☐ 2.2 Are authorized services limited to “appropriate”, or is availability considered?

3. Provider Obligations

☐ 3.1 Are you financially liable for out of area services?
☐ 3.2 Are your current reporting forms satisfactory under this agreement?
☐ 3.3 Is the authorization process described in the contract really in use?
☐ 3.4 Are any rules enforced through the contract attached as exhibits?
☐ 3.5 Is their any protection against dumping of expensive care?
☐ 3.6 Will final treatment decisions be made by a physician?
☐ 3.7 Are you responsible for supervising the HMO’s utilization department?
☐ 3.8 Are you financially at risk for other providers’ compliance?
☐ 3.9 Are you obligated to cover the HMO’s compliance requirements? (Advance Directives)
☐ 3.10 Are malpractice minimums defined?
☐ 3.11 Are financial penalties defined, and limited in scope?
☐ 3.12 Is your financial liability for other providers limited to authorized services?
☐ 3.13 Is the contract you are signing the document that defines the services to be delivered?
☐ 3.14 Is your obligation limited to the services for which you are paid?
3.15 Can payment be denied for medically necessary services?
3.16 Can you refer outside of network for subspecialist care?
3.17 Is reasonable time allowed for claims submission?

4. Plan Obligations
4.1 Is there language covering the provision of eligibility?
4.2 Is member data sufficient for your purposes?
4.3 Do you have the plan codes and benefit tables?
4.4 Does the contract obligate payment?
4.5 Is the provider liable for the cost of the Plan’s marketing decisions?
4.6 Will the plan tell you how you stand in relation to other providers?
4.7 Can the plan renege on a promise to pay?
4.8 Who really has the authority to authorize services?

5. Term and Termination
5.1 What notice is required for renegotiation of rates?
5.2 Does a “without cause” clause suit your needs?
5.3 Are terms of breach defined for both parties?
5.4 Is nonpayment considered breach of contract?
5.5 Is there a methodology to notify of breach, and fix the problem?
5.6 What are the treatment obligations after the contract?
5.7 Do you have the right to accrued incentives if terminated?
5.8 Can you opt out if the plan changes policies outside the contract?

6. Legalese
6.1 Does the plan have the sole right to change contract terms?
6.2 What forces outside the contract can change its terms?
6.3 Does the contract restrict changes in ownership?
6.4 Is documentation of notice required?
Capitated Contract Checklist

6.5 Is there an alternative dispute resolution process?
6.6 Who is the arbitrator?
6.7 Does arbitration cover malpractice claims?
6.8 Are both parties indemnified?
6.9 What is the controlling legal venue?

7. The Payment Addendum
7.1 Are you capitated for the actual number of patients assigned?
7.2 Are you protected against the risk of low enrollment?
7.3 What is your stop-loss coverage?
7.4 What costs are used to calculate stop-loss limits?
7.5 Is a CPT code service matrix attached?
7.6 Do you have the right to supervise claims paid from your pools?
7.7 Are copayments part of the contracted compensation?
7.8 What is your compensation for inappropriate referrals?
7.9 What is the limit on retroactive adjustments?
7.10 Can fees be renegotiated without canceling the contract?
7.11 When is the capitation payment due?
7.12 What is the premium base for calculating payment?
7.13 How often are risk pools distributed?
7.14 Do risk pools accrue interest?
7.15 Are risk pools separated by contracted provider?
7.16 Are contingency funds limited?
7.17 Are funds cross-encumbered?
7.18 Who gets COB moneys? 
IV. Explanations

1. Recitals
The recitals, or “whereases” begin each contract. In some regions, they are still used to outline the reasons for the relationship (since A wishes to sell services to B, and B wishes to purchase them from A). In most contracts, however, the recitals are reduced to a preamble, defining who the parties are.

☐ 1.1 Correct definition of provider entity?
Is the definition of your contracting entity (Physician, partnership, medical group, IPA, PLLC, Professional Association, partnership, etc.) correct?

☐ 1.2 Consistent use of identifying terms?
Is the defined title of the contracting entities (e.g. “provider”) used consistently throughout the contract? Many contracts are the result of endless rewrites, and terms can change from section to section.

☐ 1.3 Correct singular and plural designations?
Is the defined title of the contracting entity correctly singular or plural? If this needs to be modified, check all areas for appropriate language. For example, if the contract is with a group, is should not refer to “physician” in some sections, and “group” in others.

☐ 1.4 Is the purpose of the contract stated?
Define the objective of the contract. Stating that the purpose of the agreement is “to promote high quality medical care” can avoid later charges that its purpose was to reduce services.

2. Definitions
Depending on the plan, these can amount to a few items, or go on for pages. Key focus points:

☐ 2.1 Is the definition of “Emergency” acceptable?
“Emergency” There is no one accepted language for defining emergency. Is it limited to life threatening events? What if the patient is merely in great discomfort? What if they are simply very insistent about receiving care immediately? Make sure you can live with this guideline, it may become a material financial issue.

☐ 2.2 Are authorized services limited to “appropriate”, or is availability considered?
“Appropriate” An increasing number of contracts allow the plan to make decisions on medical appropriateness, and appropriate levels of service. If there are financial implications to service levels (use of a hospital bed vs. a SNF bed, for example), make sure they only apply if the preferred service is readily available.
3. Provider Obligations

☐ 3.1 Are you financially liable for out of area services?
What is the geographic area of your responsibility? Avoid “out of area” liability, especially if the plan adjudicates out of area claims on your behalf.

☐ 3.2 Are your current reporting forms satisfactory under this agreement?
What forms are required? Make certain that the plan will accept your standard claims forms (HCFA 1500) and ask to see treatment authorization requests and referral forms.

☐ 3.3 Is the authorization process described in the contract really in use?
How does the contract define the authorization process? While most plans have telephone authorization, many contracts require a written auth, leaving the physician responsible to follow up on whether the HMO U.M. department mailed the documentation.

☐ 3.4 Are any rules enforced through the contract attached as exhibits?
Most contracts require the providers to agree to abide by other policies, procedures and regulations. Have these attached as exhibits to the agreement, and specify that material changes in policy require the same notice process as any other change in the contract.

☐ 3.5 Is there any protection against dumping of expensive care?
You may have to accept transfer of patients from another provider. Who has financial responsibility for continuing treatment of an existing condition? (Yes, Virginia, physicians do dump patients on each other).

☐ 3.6 Will final treatment decisions be made by a physician?
Who has final decision making authority over treatment? Most plans specify the medical director, but some permit physician override by the U.M. “Department.”

☐ 3.7 Are you responsible for supervising the HMO’s utilization department?
Do not accept responsibility for supervising treatment or procedures outside your practice, such as the number of inpatient days authorized or assistance in surgery.

☐ 3.8 Are you financially at risk for other providers’ compliance?
Watch for language that makes the provider responsible for events outside his control, such as financial responsibility for an extra med/surg day when it was caused by a lack of available SNF beds.

☐ 3.9 Are you obligated to cover the HMO’s compliance requirements? (Advance Directives)
Many plans are now including language requiring every provider to obtain Advance Directive, pursuant to the Patient Self Determination Act. You should know that this is legally the plan’s responsibility, but many avoid the unpleasant topic at enrollment, and try to make it the physicians’ responsibility. Directives are
required for facility admission and prior to surgery, there is no regulatory requirement to have them in office charts.

☐ **3.10 Are malpractice minimums defined?**
Many contracts require malpractice insurance in amounts acceptable to the plan. Get the required limits in writing, preferably as part of the contract.

☐ **3.11 Are financial penalties defined, and limited in scope?**
Watch for financial penalties for noncompliance. These are usually not in the financial section, but rather in the sections dealing with UM and QA cooperation. Avoid giving unilateral right to the plan to assess unspecified financial penalties.

☐ **3.12 Is your financial liability for other providers limited to authorized services?**
If the contract permits the plan to reduce your payment by amounts paid to other providers for services you are supposed to cover, make certain that it only applies to services which you authorized, or for which you were unavailable. Plans will frequently pay for an out of plan visit (with your money), which should not be covered, in order to avoid patient complaints.

☐ **3.13 Is the contract you are signing the document that defines the services to be delivered?**
Make sure that the services to be provided are regulated by the contract you are signing. It sounds funny, but some contracts obligate the physician to comply with the service agreement between the plan and the employer.

☐ **3.14 Is your obligation limited to the services for which you are paid?**
On a similar note, make sure you are obligated to provide services for which you are being paid. Some contracts obligate you to provide any services for which the plan was paid.

☐ **3.15 Can payment be denied for medically necessary services?**
While it is reasonable to require pre-authorization for services, it’s nice to have language that permits payment in absence of authorization if the service was medically necessary. Many plans, however, regard that kind of language as the first crack in the UM dam, and won’t agree.

☐ **3.16 Can you refer outside of network for subspecialist care?**
Make sure that any limiting of referrals to other contracted providers acknowledges medical appropriateness and availability.

☐ **3.17 Is reasonable time allowed for claims submission?**
Watch for short time limits on submission of claims. Ninety days is reasonable, but should include language permitting a longer term if the patient presented incorrect payer information (e.g. Medicare card).

4. Plan Obligations

☐ **4.1 Is there language covering the provision of eligibility?**
Is the plan required to provide accurate eligibility? Ask to see a sample eligibility statement. Be wary of those that just show a summary of members (e.g. ABC Plan Senior Year Plus: 12,430 members) Many contracts avoid any mention of eligibility lists, format and accuracy entirely. Ask if capitation checks and eligibility are from the same database, or if they are estimated monthly and reconciled at some future date.

4.2 Is member data sufficient for your purposes?
What data will be supplied on eligible members? Is it transferable electronically? Is it sufficient for your needs? Does it show which plan/product they are covered under? In a full risk contract, are patient addresses supplied?

4.3 Do you have the plan codes and benefit tables?
HMO’s sell many different forms of coverage. Some have as many as 300 variations. Frequently, a plan reduces benefits to quote competitive premium, but neglects to notify the provider that they don’t have to deliver full services. Demand the benefit structure for every patient you will cover under a full risk contract.

4.4 Does the contract obligate payment?
Is the plan required to pay you? It sounds obvious, but it’s frequently missing. Is payment due in a specific time? Are there any penalties for late payment?

4.5 Is the provider liable for the cost of the Plan’s marketing decisions?
Is the plan liable for any decision to grant services or pay claims when there is no medical necessity? Many contracts forbid physicians from “social” or “marketing” authorizations, but permit the plan to pay for the same kind of decisions on their part from joint funds.

4.6 Will the plan tell you how you stand in relation to other providers?
What reports does the plan provide? Will they show comparisons to other providers? Is there ranking or scoring within the plan? Will you be informed of your standing if there is?

4.7 Can the plan renege on a promise to pay?
Is authorization of a service a guarantee of payment? Some contracts permit the plan to deny authorized services retrospectively, even if they agreed to the medical necessity at the time of authorization.

4.8 Who really has the authority to authorize services?
Who grants authorization? Watch for plans where the UM department typically grants auths, even though the contract specifies that the physician must receive authorization from the Medical Director or Primary Care Provider. You could be leaving the door open to retroactive denials for “failing” to get “proper” authorization.

5. Term and Termination
The length and expiration of a contract are matters for careful consideration. Many plans use notice and renewal provisions to keep costs down, or to lower them further from year to year.

☐ 5.1 What notice is required for renegotiation of rates?
Watch for excessively lengthy notice requirements, especially those that require all new contract terms to be agreed before notice. A 180 day notice requirement specifying new terms agreement prior to expiration of the notice term, for example, could be demanding negotiation of 2008 rates in the beginning of 2006.

☐ 5.2 Does a “without cause” clause suit your needs?
“Without Cause” clauses are a business decision for the provider. If you are signing with a new plan and unsure of their potential utilization, you may want one. If you are entering a strategic long term relationship with a major payer, you may not. A “Without Cause” provision negates any other term in the contract. If there is a 60 day notice clause, you have a 60 day contract, regardless of any other language.

☐ 5.3 Are terms of breach defined for both parties?
What is considered termination “with cause?” Is breach of contract defined for both sides, or just for the provider? Is breach by a single physician (e.g. loss of staff privileges) considered breach by the whole group?

☐ 5.4 Is nonpayment considered breach of contract?
Specific material breach should include nonpayment, or a pattern of late or incorrect payment.

☐ 5.5 Is there a methodology to notify of breach, and fix the problem?
Is there a provision for curing breach? The provider should be noticed of any breach, and have a reasonable time to address the problem. The notice should be in the same form as any other contract notice (registered mail). Avoid giving the right to immediately terminate upon breach, which leaves you in an appeal situation without revenues.

☐ 5.6 What are the treatment obligations after the contract?
What is the continuing treatment requirement? Most states require some continuity of care after termination, but 6 months is a reasonable limit. Does the contract specify how you are to be paid for post termination treatment? Payment should revert to fee for service. It could be disastrous if you are capitated for two or three chronically ill patients.

☐ 5.7 Do you have the right to accrued incentives if terminated?
Make sure that the plan is obligated to account for all incentives at termination, and pay them within a specific period of time. Many contracts allow the plan to keep accrued risk pool funds at termination.

☐ 5.8 Can you opt out if the plan changes policies outside the contract?
Do you have the right to terminate quickly if the plan institutes a major change in policy? The provider manual or Quality Assurance program can have a substantial impact on the way you run your practice.

6. **Legalese**
Be aware that some plans bury critical language in the legal provisions, on the correct assumption that many providers skip over the “boilerplate.”

- **6.1 Does the plan have the sole right to change contract terms?**
  Watch for unilateral modification rights. This is a clause that allows the plan to change the terms of the contract without your agreement, or by simply providing notice of the change. These clauses render the rest of the contract moot. NOTE: Many states require language allowing modification of a contract in the event of a legislative change.

- **6.2 What forces outside the contract can change its terms?**
  Be aware of non-contract powers of modification. Some contracts require the provider to abide by anything the plan puts out “from time to time”, including marketing materials.

- **6.3 Does the contract restrict changes in ownership?**
  Is the contract binding on successors and assigns? If it isn’t, and if the plan merges, you could be canceled. Usually this is one sided, and needs to be rewritten to apply to both parties. It may require plan approval for assignment, in which case you may not be able to sell or merge your practice without plan approval.

- **6.4 Is documentation of notice required?**
  What is the notice requirement? It should specify certified mail or the equivalent. Watch out for notices that become effective “when mailed.”

- **6.5 Is there an alternative dispute resolution process?**
  What is the alternative dispute resolution method? You probably can’t afford to out-litigate an HMO. Is arbitration available? Who selects the arbitrator? Who pays? If the two sides split costs, does the arbitrator have the right to award expenses as part of the decision?

- **6.6 Who is the arbitrator?**
  Many providers and plans are shifting to the National Health Lawyer's Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration as more appropriate than the Commercial Arbitration Rules of the AAA.

- **6.7 Does arbitration cover malpractice claims?**
  Do NOT agree to arbitration of malpractice claims under any circumstances.

- **6.8 Are both parties indemnified?”**
Capitated Contract Checklist

Are you indemnified for litigation resulting from the health plan’s representations or actions? Does the indemnification cover defense of malpractice claims resulting from the plan’s refusal to authorize care?

☐ 6.9 What is the controlling legal venue?
Make certain that the agreement is regulated under the laws of the state your practice is in, rather than where the HMO is headquartered.

7. The Payment Addendum
The body of a capitated contract defines the working relationship between payer and provider. The payment addendum defines how the work performed will be paid for. Regardless of the language in the contract body, you can undo every negotiated advantage by accepting a payment addendum that is too loosely written.

☐ 7.1 Are you capitated for the actual number of patients assigned?
Is “per member per month” appropriately defined? The number of members should include all those eligible to receive service under the contract. Avoid language that appears to make the health plan’s statement of capitation or EOB the defining payment document, regardless of actual eligibility.

☐ 7.2 Are you protected against the risk of low enrollment?
Is there a minimum number of guaranteed members? A low enrollment guarantee can save you from owing the HMO money at the end of the month. If you must take risk from the first member, specify that your risk is limited to the cap payment (specialists) or tops out with a payment schedule, such as 10% of cap monthly (full risk contracts). Try to get a fee for service minimum equivalent (70%) until you have sufficient lived to cover risk.

☐ 7.3 What is your stop-loss coverage?
Are you covered by stop loss insurance? Does the plan provide it as part of the contract, or is there a separate premium deduction? Some HMOs mark up stop loss premium as much as 300%.

☐ 7.4 What costs are used to calculate stop-loss limits?
How is the stop loss limit calculated? Actual fees? Third party standard? If you are subcapitating specialists, watch out for calculations that only allow for the amount actually paid. You could wind up negotiating increased subcaps without recourse to the plan.

☐ 7.5 Is a CPT code service matrix attached?
ALWAYS get a service matrix included as part of the contract. The service matrix should define the procedures included under capitation by CPT code, and specify that those not listed are not included. Require mutual agreement before any new service is considered part of the contract.

☐ 7.6 Do you have the right to supervise claims paid from your pools?
Capitated Contract Checklist

Make certain you have the right to audit any claims paid from the incentive pools for out of area or out of network providers.

7.7 Are copayments part of the contracted compensation?
Make sure payment rates account for the expected copayments. Copays should not be deductible from capitation payments, and cap rates should be automatically renegotiated if the plan reduces member copays.

7.8 What is your compensation for inappropriate referrals?
Specialists should include separate language defining payment above and beyond capitation for inappropriate referrals. One methodology is to bill Medicare rates for patients sent back to the primary care provider without a treatment plan.

7.9 What is the limit on retroactive adjustments?
Are retroactive payment adjustments limited? We suggest a three month maximum for retroactive disenrollments, along with a health plan obligation to assist in collection of any fees incurred by an ineligible patient during that time.

7.10 Can fees be renegotiated without canceling the contract?
Are price increases built in to the renewal structure? Be careful to note the required termination dates if that is the only way to reopen the price negotiations.

7.11 When is the capitation payment due?
What is the payment date? If you are contracting for $250,000 per month, the difference between payment by the 5th and payment by the 20th amounts to $6,000 a year in interest expenses.

7.12 What is the premium base for calculating payment?
If the contract is for a percentage of premium (commercial) or percentage of Medicare reimbursement (senior), determine what constitutes the base premium. Some plans use a “medical” premium, which may exclude administrative costs or certain benefit carve outs, dramatically lowering the dollars used in your capitation calculation.

7.13 How often are risk pools distributed?
When are risk pools and incentives distributed, or accounted for? After an initial period, pools should be distributed quarterly. Balances should always be accounted for monthly. What is the maximum delay before reconciliation and distribution?

7.14 Do risk pools accrue interest?
Many plans make a fortune from investing provider withholds and risk pools. One west coast, publicly held HMO reported 52% of their profit came from interest on provider funds that had not been disbursed.

7.15 Are risk pools separated by contracted provider?
Are risk pools specific to your contract and patients? Avoid getting lumped into some general budget where you will have little or no effect on utilization.

7.16 Are contingency funds limited?
Any reserve should contain a maximum (per member or percentage of capitation revenue). Unlimited reserve funds can grow, outside your reach, until the contract terminates, and can be a great source of investment income for the plan.

☐ 7.17 Are funds cross-encumbered?
Are your funds cross-encumbered? Watch for provisions that allow decapitation for risk pool deficits, or cross over between plans (e.g. commercial and senior) to make up shortfalls.

☐ 7.18 Who gets COB moneys?
Who has the right to collect from additional payers (COB)? Some contracts require the physician to inform the plan, and allow the plan to offset compensation. If you don’t have the right to keep additional collections, make it plain that you will not assist the plan in collecting the information from patients.

Comments and additions are welcome! Please send any new and interesting twists from the ever changing contract world to:

John F. Dini  
MPN Incorporated  
4143 Gardendale, Suite 100  
San Antonio, TX 78229  
Tel: (210) 615-1800  
Fax: (210) 615-1865  
Email: jdini@mpninc.com  
URL: www.mpninc.com