Analyzing Managed Care Contracts

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Contract Review

- The delivery of healthcare services in the United States is continuing to undergo dramatic restructuring.
- It is imperative that physicians carefully review and understand any managed care contract they are considering signing.
First, you must accept the fact that the rules have changed for all of us.

And second you must know enough about the fee schedules presented to you.

It is not enough to review a summary of the contract terms.

Provisions in the contract that are often glossed over at the time of signing can suddenly spring to life in new and often unpredictable ways when a controversy arises that requires interpretation or clarification.

Physicians should insist on obtaining copies of MCO policies & procedures.
Physicians also need to know their patient mix and understand the economic impact of any contract on their practice.

You can say “NO” to a contract, particularly if it constitutes a small percentage of your patient base.

“Progress always involves risk; you can’t steal second base and keep your foot on first.”

- Fredrick Wilcox
Negotiation

- Negotiating with MCO’s may be harder than ever, but that doesn’t mean you should accept their fees hands down.
- Before we get to asking questions about a MCO contract, we must first understand what certain clauses mean so that we may ask the **RIGHT** question!

Refer to Handouts

- See handout: Addendum – Physicians Beware of these Common Managed Care Contract Clauses
Physicians around the country are extremely frustrated by the lack of transparency in the claims adjudication and payment process, including the application of customized code edits that are inconsistent with the CPT® codes, guidelines and conventions.

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As of January 1, 2006, Virginia enacted a law that requires health plans to disclose all of their downcoding and bundling edits and requires an appeal mechanism for physicians to contest the bundling and downcoding policies of the plan.

In 2002, Georgia ordered by the court to disclose it’s fee schedule and precise methodology used in payment.
Rental Network of a PPO

- Another cause of physician frustration with discounted fee-for-service arrangement is “rental network” PPO’s. A physician practice will receive an EOB that lists payers that the staff has never heard of and rates that are either the lowest contracted rate or an ever lower rate.
- A “rental network” PPO is not really a managed care product. It is best described as a process.

Rental Network CONTINUED

- The AMA has developed model state legislation to address the issue of unfair renting of physician discounts.
- Six state currently have laws that place limits on PPO rental networks: California, Kentucky, Louisiana, North Carolina, Oklahoma, Texas
  
  http://www.ama-assn.org/go/psa
  
  (Under “Prompt payment/Payment hassles)
CPT RVU’s

FOR EXAMPLE:

CPT CODE 99213 – EST. PATIENT OFFICE VISIT – THE CALCULATION IS:

- RVU for WORK = .67 X GPCI OF 1.000 = .6700
- RVU FOR P.E. = .69 (Non-Facility) x GPCI OF .873 = .6024
- TOTAL RVU’S FOR 99213 = 1.3065 UNITS

THE (GPCI) IS THE GEOGRAPHIC ADJUSTMENT WHICH MAKES THE VALUE OF A 99213 DIFFERENT FOR VARIOUS REGIONS OF THE COUNTRY.

THE TOTAL RVU’S ARE THEN MULTIPLIED BY MEDICARE’S CURRENT CONVERSION FACTOR = $38.0870 X 1.3065 = $49.76

THE CONVERSION FACTOR CONVERTS THE RELATIVE VALUE UNITS INTO ($).

THEREFORE, EACH TIME YOU PROVIDE THE SERVICE FOR CPT CODE 99213, THE PRACTICE PRODUCES 1.3065 UNITS WORTH $38.0870 EACH.

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Using RVUs to calculate costs

- Can your practice generate a profit with the conversion factor that the Managed Care Co. is offering? Use the RVUs to find out.
- Each time you perform a procedure, you produce a unit – an RVU. Produce a spreadsheet as follows:
  1. Column I - List all the CPT Procedure codes for the year. (99202 99203......)
  2. Column II - Frequency each code was charged. (Can get from Computer Reports)
  3. Column III - Relative Value Unit for each Code. (Established by CMS)
  4. Column IV - Frequency x RVU = Units produced for the year for that procedure

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Using RVUs CONTINUED

5. Add up all of the RVU’s the Practice produced = your production for the year.
6. From your financial statements, determine the total costs of operating your practice for the year.
7. Divide your total costs by your RVU production for the year. This gives you the Cost per RVU. This is your Conversion Factor.
8. Compare this cost to the reimbursement (Conversion Factor) offered per RVU by the Ins. Co.
   - If you accept a conversion factor from a managed care co. less than your cost per RVU, you will lose money each time you bill that Co. for that CPT.
   - Can your Practice generate a profit with the fee schedule proposed in the Contract?

The Importance of Market Analysis

- How many of the patients you are currently seeing are using this plan?
- What are the plan’s projections for the next 5 years, and how are they going to accomplish their goals?
- Will the plan allow you to utilize all of your in-house procedures?
- What labs and other ancillary services are on the plan?
- What hospitals and outpatient facilities are included in the plan?
Market Analysis CONTINUED

- How many covered lives in the plan in your area?
- What are the demographics of the Plan’s members?
- Are there any “Carve Outs” in the Plan?
- Which other Specialists and Primary Care Physicians are contracted with the Plan?
- What hospitals and/or ASC participate in these plans?
- What is the Plan’s goals for future enhancements?

Fee Schedule Development

- How often do you review your Standard Fee Schedule? How is it developed?
- Do you have a worksheet that compares plans?
- Do you utilize a National Fee Analyzer?
- Do you have an Insurance Catalog detailing special features of each plan – a contact person, contact #, etc.?
- Do you review your fee schedule annually with your Office Mgr/Administrator, etc.?
- Do you keep a log of denials or underpayments for each carrier?
Fee Schedule Development CONTINUED

- Do you analyze your top 25-50 procedure codes as to reimbursement on a monthly basis?
- Do you know what happens in your office when you receive less than the allowable for the procedure performed? Is it written or adjusted off or is there an adequate Appeal process?
- Does your computer system have the ability to input each Fee Schedule?
- Are you pulling and analyzing the pertinent reports monthly?
- Do you analyze monthly the adjustments that are being made on accounts? Do you analyze the average % of such adjustments monthly?
Now that you have a sample of your fee analysis for your top codes, in comparison by payers, let’s look at the **inconsistencies** in how individual payers reimburse you.

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**Ammunition**

Create your own ammunition

To construct a spreadsheet that you can use for health plan negotiations, select your top 25 codes, in terms of revenue. Add your charges and Medicare allowable for procedures and E&M services, available on the website of the Centers for Medicare & Medicaid Services (www.cms.gov). To find fee allowables, go to the CPT site and type: “Clinical Laboratory Fee Schedule” in the search engine.

<table>
<thead>
<tr>
<th>Billing Code/ Description</th>
<th>What Medicare allows</th>
<th>What you charge</th>
<th>As % of Medicare</th>
<th>As % of Medicare</th>
<th>As % of Medicare</th>
<th>As % of Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241 Initial visit, ext, pat, level 3</td>
<td>$95.50</td>
<td>$95.20</td>
<td>100%</td>
<td>$62.98</td>
<td>64.0%</td>
<td>$61.29</td>
</tr>
<tr>
<td>99242 Initial hospital, level 2</td>
<td>119.00</td>
<td>119.00</td>
<td>100%</td>
<td>123.95</td>
<td>103%</td>
<td>136.85</td>
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<tr>
<td>99242 Initial visit, new pat, level 2</td>
<td>62.15</td>
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<td>100%</td>
<td>65.26</td>
<td>105%</td>
<td>70.91</td>
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<td>99354 Procedure, ext, age 40-64</td>
<td>25.22</td>
<td>158.86</td>
<td>100%</td>
<td>104.25</td>
<td>105%</td>
<td>104.25</td>
</tr>
<tr>
<td>99355 Procedure, ext, age 65+</td>
<td>24.01</td>
<td>39.41</td>
<td>100%</td>
<td>25.86</td>
<td>105%</td>
<td>24.63</td>
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1 | National average based on the 2007 Medicare fee schedule. Medicare doesn’t pay for routine preventive care office visits, but any additional the Medicare allowable factor (275K) is $202.5K in 2017 by the relative value units for each code to calculate a hypothetical fee. Remember to adjust the value PPO percentage based on the type of practice: primary care (3%), clinical lab (5%), and medical specialty (10%). Then add the product to the practice revenue and professional liability, which is a summary of fee schedule.
Find the Bargaining Points in your spreadsheet

- Once your fees are in order, study payer reimbursements, looking for discrepancies and low fees that you’re now prepared to negotiate.
- Health Plan A, for example, may consistently pay 105% of Medicare, while Health Plan B comes in at 130%. One obvious goal is to pressure Health Plan A to catch up.

Bargaining Points CONTINUED

- Not every insurer pays the same Medicare multiple across the board, and this inconsistency creates another issue for the bargaining table.
- Health Plan C may pay only 105% of Medicare for CPT 99213, and a generous 140% for CPT 99202.

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Bargaining Points CONTINUED

- When you point out that the 99213 allowable is falling behind, the health plan may simply chalk it up to an error and raise the reimbursement.
- You won’t get anything if you don’t ask
- You must do your homework first!

Models for discounted Fee-For-Service payment

- The reimbursement is a “% of Medicare.” This is determined by relying on Medicare RBRVS and Medicare conversion factors and then determining a % of the Medicare fee schedule (e.g. 110% of Medicare).
- The reimbursement is based on RVU’s. Some use the Medicare RVU system and some use other systems. The MCO then assigns it’s own conversion factor, creating it’s own fee schedule.
The fee schedule is a percentage discount (e.g. 20%) off of physician’s billed charges.

It’s important that physicians understand the payment methodology that underlies a fee schedule. Physicians need to understand whether the payment they receive is sufficient to cover expenses and to generate a reasonable income.

Another tactic to lower your overall reimbursement - the inconsistent Medicare multiples which typically does not stem from an innocent mistake. It’s called in the industry “rate averaging, or weighting, that shortchanges physicians on bread-and-butter services.
“A payer will say that its rates, on average, represent 150% of the Medicare fee schedule. But they just so happen to pay 100% for a 99213 office visit, which I bill every day, and 200% for ear lavage, which I do five times a year.”

- Scott Rigby, who lectures to fellow internists and residents about practice management.

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Physicians must keep in mind that overall reimbursement is determined by multiplying utilization rates by the reimbursement.

The challenge is to convince the payer to use one reasonable Medicare multiple for all codes or in a code series, or at least nudge up the multiple for the low-paying ones.
Contract Negotiation

- Whether you’re signing up with a new health plan or renewing an existing contract, seize the opportunity to negotiate.
- If you are renewing, ask the health plan whether it intends to propose a new fee schedule or stick with the current fee schedule.

Contract Negotiation CONTINUED

- Start the process at least 3 or 4 months before the renewal date.
- Most contracts automatically renew unless doctors give notice of termination 90 to 120 days beforehand. This term can be found as an “evergreen clause” or “in perpetuity clause”.

Contract Negotiation CONTINUED

- A head start provides enough time to crunch your numbers, schedule meetings with the insurer, deal with stalling tactics, and if need be, file notice that you’re walking out.

Have Your Answer Ready

**When you hear this...**
“Im not authorized to make that decision”

**Say this...**
“Who should I be talking to?”

**When you hear this...**
“I’ll get back to you on that”

**Say this...**
“When can I expect a response?”
When you hear this...
“We can’t afford that”

Say this...
“You earned ___ million (or billion) dollars last year.”

When you hear this...
“We can’t send you rates for thousands of codes”

Say this...
“Send me the rates for my top 25 codes”

20+ Questions to Ask before Signing the Contract

1. Are third party administrator, network brokers or repricers defined as a “Payer” in this contract?
2. Does this contract subject the “Provider” to a ‘rental network PPO’ or a silent PPO”?
3. Is this contract subject to an “All Products” provision?
4. What is the methodology used for “General Offsets and Adjustments”? 
5. Is there a “Comparable Provider Rate” or “Most-favored nations” provision?
6. What year of Medicare fee schedule is being used?
7. What is the precise methodology used in payment?
8. Is “rate averaging or weighting” used in your formula of payment?

9. Is Medicare’s Coding Edits used or does the plan have it’s own coding edits, or a coding companion guide?
10. How do I access information and how often are the edits revised?
11. What are the steps to be taken for litigation?
12. Will the Provider and Non-Physician Providers be allowed to give advise or counsel to the enrollee concerning his or her current health plan options?
13. Is there a “hold harmless” clause?
14. Does the plan carry re-insurance?
15. Are your stop-loss provisions per enrollee based on total dollars or on a case by case basis?
16. What is the definition of catastrophic illness and the protocol for reporting?
17. Will “consideration privileges” be granted in the event the credentialing process is longer that 90 days?

18. How long must we see enrollee’s after termination of this contract?
19. Is there a cap on damages in the event liability?
20. Does this contract differ in statute of limitations from the state in which the “Provider” is practicing?
21. Who is the Medical Director and the Director on the Panel of my specialty? What is their location, phone number and email address?
My Dad had a sign in his office when I was growing up that read:

“I may look busy, but I’m only confused”

Questions?
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Charge Medicare</th>
<th>Previous Medicare</th>
<th>Current Medicare</th>
<th>Proposed Medicare</th>
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Create your own ammunition

To construct a spreadsheet that you can use for health plan negotiations, select your top 25 codes, in terms of revenue. Add your charges and Medicare allowables for procedures and E&M services (available on the website of the Centers for Medicare & Medicaid Services (www.cms.hhs.gov/pfslookup); for lab test allowables, go to the CMS site and type “Clinical Laboratory Fee Schedule” in the search engine. Then add the health plan allowable and multiple of Medicare for each of the codes for the main insurers you contract with. The allowable, which you can glean from explanation-of-benefit statements or insurance contracts, is the sum of what you receive from the payer and the patient’s co-pay. Below you’ll find a sample spreadsheet with a partial list.

<table>
<thead>
<tr>
<th>Billing Code/Description</th>
<th>What Medicare allows¹</th>
<th>What you charge</th>
<th>Your fee as % of Medicare</th>
<th>Health Plan A Allowable</th>
<th>As % of Medicare</th>
<th>Health Plan B Allowable</th>
<th>As % of Medicare</th>
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<tbody>
<tr>
<td>99213/Office visit, est. pat., level 3</td>
<td>$59.50</td>
<td>$95.20</td>
<td>160%</td>
<td>$62.48</td>
<td>105%</td>
<td>$61.29</td>
<td>103%</td>
</tr>
<tr>
<td>99222/Initial hospital care, level 2</td>
<td>119.00</td>
<td>190.40</td>
<td>160</td>
<td>124.95</td>
<td>105</td>
<td>136.85</td>
<td>115</td>
</tr>
<tr>
<td>99202/Office visit, new pat., level 2</td>
<td>62.15</td>
<td>99.44</td>
<td>160</td>
<td>65.26</td>
<td>105</td>
<td>87.01</td>
<td>140</td>
</tr>
<tr>
<td>99396/Preventive care, est. pat., age 40-64</td>
<td>99.29²</td>
<td>158.86</td>
<td>160</td>
<td>104.25</td>
<td>105</td>
<td>104.25</td>
<td>105</td>
</tr>
<tr>
<td>93000/ECG</td>
<td>24.63</td>
<td>39.41</td>
<td>160</td>
<td>25.86</td>
<td>105</td>
<td>24.63</td>
<td>100</td>
</tr>
</tbody>
</table>

¹National averages based on the 2007 Medicare fee schedule ²Medicare doesn’t pay for routine preventive care office visits, but you can multiply the Medicare conversion factor ($37.8975 in 2007) by the relative value units for such codes to calculate a hypothetical fee. Remember to adjust the work RVU component by multiplying it by the so-called budget neutrality adjuster (.8994) and rounding the product to two decimal places. Then add the product to the practice expense and professional liability RVUs to arrive at the total RVU figure.
Analyzing Managed Care Contracts

Supplemental Handout
Model Managed Care Contract

With annotations and supplemental discussion pieces

Fourth Edition 2005
Many managed care agreements contain clauses that are harmful to physicians. Many of these are discussed in the AMA Model Managed Care Contract and the Supplements. The following nine provisions are examples of some provisions that physicians often agree to that create unanticipated problems. Physicians should know how to recognize these provisions and understand the consequences of agreeing to them. The term “provider” is used in the addendum instead of “Medical Services Entity,” because that is the term typically found in these contracts.

**EXAMPLE 1: Payer.** “Payer” means an employer, trust fund, insurance carrier, health care service plan, trust, nonprofit hospital service plan, a governmental unit, any other entity which has an obligation to provide medical services or benefits for such services to Enrollees, or any other entity which has contracted with MCO to use MCO’s provider network.

**CONCERN:** This definition of “Payer” is broad enough to allow the managed care organization (MCO) to “sell” or “rent” its provider network to third parties, thus creating, what is sometimes referred to as a “rental network.” This practice allows third parties to exploit the MCO’s negotiated discounts with physicians without the knowledge of those physicians. For more information about “rental networks,” see Supplement 3.

**EXAMPLE 2: All Products.** MCO has and retains the right to designate Provider as a Participating Provider or non-participating provider in any specific Plan. MCO reserves the right to introduce new Plans during the course of this Agreement. Provider agrees that Provider will provide Covered Services to Members of such Plans under applicable compensation arrangements determined by MCO. Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, regardless of whether Provider is a Participating Provider in such Plan.

**CONCERN:** “All products” provisions force physicians to participate in all current (and sometimes future) products that the MCO offers, on the terms and conditions dictated by the MCO. “All products” provisions have become an increasingly contentious issue in contract negotiations with MCOs. At least seven states have passed legislation limiting their use. The AMA is concerned that MCOs may use “all products” provisions to force physician participation in government programs, including the new Medicare Advantage plans. For more information about “all products” provisions, see Supplement 2.

**EXAMPLE 3: General Offsets and Adjustments.** Provider agrees to authorize MCO to deduct monies that may otherwise be due and payable to Provider from any outstanding monies that Provider may, for any reason, owe to MCO. Provider agrees that MCO may make retroactive adjustments to the payment outlined in Exhibit B.

**CONCERN:** This provision gives the MCO a free hand to do whatever accounting it desires and deduct monies from a physician in its sole discretion without a requirement to account to the physician and explain such deductions. This provision also could be used to justify the practice of “retrospective audits,” in which
the MCO conducts an audit—often several years after services were rendered—and determines there has been an "overpayment." The MCO then unilaterally off-sets the overpayment from reimbursement otherwise due. For more information about retrospective audits, see Supplement 7.

EXAMPLE 4: Comparable Provider Rate. If Provider, accepts at any time, payment from another Payer of like or lesser total reimbursement than provided in this Agreement, then the Provider agrees to give written notice of the new rate to MCO and to enter immediately into good faith negotiations with MCO regarding revision of MCO rate. If Provider fails to notify MCO of the fact that it accepted a lower rate, MCO may terminate the agreement, or MCO may deem any past savings amount that it would have realized had the new rate been timely disclosed to it as a recoverable amount to be repaid or require that the revised compensation reflect unrealized past savings.

CONCERN: This provision is an example of a most-favored nations (MFN) provision. A most-favored nations provision requires physicians to give the contracting insurer the benefit of the lowest rate he/she negotiates with any insurer. Most-favored nations provisions had virtually disappeared from physician contracts but they have started reappearing in the past few years. The AMA believes that most-favored nations provisions are anticompetitive, particularly when they are used by a health insurer with a significant market share. In a series of cases and enforcement actions, the federal antitrust enforcement agencies have recognized the potential for MFN clauses to deter competition. If you receive a contract that appears to have a most-favored nations provision, alert your state medical association and the AMA.

EXAMPLE 5: CPT Codes. Provider agrees that if MCO reassigns or re-bundles CPT codes, it will accept the applicable MCO Compensation for these services or procedures as reassigned or rebundled by MCO as payment in full.

CONCERN: This provision gives the MCO complete discretion to arbitrarily downcode, reassign or bundle CPT codes reported on physician claims. These practices are widely employed throughout the industry and are used to save MCOs money while depriving physicians of payment for services and procedures they have provided. Physicians should be reimbursed for the services and procedures they provide. When physicians contract to permit these unfair practices, they have limited ability to challenge the practices.

EXAMPLE 6: Litigation. In the event of any litigation between the parties arising out of or related to this Agreement, the prevailing party shall be entitled to recover from the other party its reasonable attorney’s fees and cost of litigation, including, without limitation, any expert witness.

CONCERN: This provision is designed to further deter a physician from bringing a legal action to enforce his or her rights. Physicians are already deterred by the legal war chests MCOs have available to fight lawsuits. By requiring the physician to pay attorneys fees and other costs of litigation if the MCO prevails in the lawsuit, this provision attempts to intimidate physicians from initiating litigation.

EXAMPLE 7: Noninterference with Members. During the term of this Agreement, Provider and its Qualified Physician shall not advise or counsel an Enrollee to disenroll from MCO’s Plan and will not directly or indirectly solicit any Enrollee to enroll in any other health care service plan or insurance program.
CONCERN: This provision has the potential to function as a “gag clause” and inhibit legitimate patient-physician communication. It ignores the reality that patients frequently turn to their physician first to discuss health care coverage options. This is particularly the case when the patient learns that his or her current health plan coverage is limited or that a particular specialist is not in the network. Under this provision, any explanation or discussion of these important patient care issues could be deemed as advice or counsel that could cause the patient to disenroll from the MCO.

EXAMPLE 8: Indemnification and Hold Harmless. Provider agrees to indemnify and hold harmless and defend MCO from and against any and all loss, damage, liability and expense, including reasonable attorneys fees attributable to any and all acts and omissions of the Provider.

CONCERN: This “hold harmless” clause means that if an action or investigation is commenced or any other claim is made against the physician that involves the MCO, the physician will have complete responsibility for any costs the MCO incurs, even if the physician is ultimately exonerated. These clauses are particularly dangerous because MCOs are being named in lawsuits with increasing frequency. Physicians must be aware that most professional liability policies will not defend or indemnify a person who is not a party to the contract, so the physician would most likely have to cover these costs personally. The AMA strongly opposes “hold harmless” provisions.

EXAMPLE 9: Termination Without Cause. This Agreement may be terminated without cause by either party by written notice given to the other party at least one hundred twenty (120) days in advance of such of termination. In such cases termination will occur on the last day of the month in which the one hundred and twentieth (120th) day following such notice occurs. Upon said termination by Provider, the rights of each party hereunder will terminate with respect to subscriber groups enrolled by the MCO after the MCO receives Provider’s notice of termination. However, this Agreement will continue in effect with respect to Enrollees existing prior to the MCO’s receipt of such notice until the anniversary date of the MCO’s contract with the subscriber group or for one (1) year, whichever is earlier, unless otherwise agreed to by the MCO. If termination is by the MCO, the rights of each party will terminate on the effective date of termination.

CONCERN: While this termination “without cause” provision theoretically allows either party to terminate with 120 days notice, upon close inspection it requires the physician to continue providing services for one year or more after giving notice. Any termination “without cause” provision should be truly mutual. For more information about terminations “without cause,” see Supplement 10.

EXAMPLE 10: Liability. Notwithstanding anything herein to the contrary, MCO’s liability, if any, for damages to Provider for any cause whatsoever arising out of or related to this Agreement, regardless of the form of the action, shall be limited to Provider’s actual damages, which shall not exceed the amount actually paid to Provider by MCO under this Agreement during the twelve (12) months immediately prior to the date the cause of action arose. The MCO shall not be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach or disagreement or any action, inaction, alleged tortious conduct, or delay by MCO.
CONCERN: Physicians should beware of clauses like this that limit the physician’s damages in a lawsuit to the amount of payment received from the MCO in the previous year. This is another tactic designed to effectively strip the physician of real remedies in litigation with the MCO. Given that litigating against a large MCO can cost significant sums, this limitation is clearly designed to chill the physician from bringing any lawsuit. Also, there is no attempt to make the limitations on remedies mutual.

EXAMPLE 11: Limitation on Action.
Notwithstanding anything herein to the contrary, no action, regardless of form, arising out of or relating to this agreement may be brought by Provider more than twelve (12) months after such cause of action has arisen.

CONCERN: The statute of limitations for actions on contracts such as this varies from state-to-state but generally extend for five (5) years. There is no rational reason why MCOs should seek special treatment not available to others in limiting such actions to a twelve (12) month period.
"Analyzing Managed Care Contracts"