DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE
GUIDELINES AND TECHNICAL ADVICE TO HMO APPLICANTS REGARDING PROVIDER CONTRACTS

The following items listed below correspond to the Bureau of Managed Care requirements outlined in the crosswalk form for provider contracts contained in Appendix 6. Please note that in addition to required elements, there are also several items offered as technical assistance for the HMO applicant corporation's consideration for inclusion in provider contracts. Those items marked with an asterisk indicate "suggested but not required" points.

1) **The contracts must contain the NAIC/NAMCR member financial hold harmless language.**

"(Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency or breach or this agreement, shall (Provider) bill, charge, collect a deposit from, or have any recourse against subscriber/enrollee or persons other than HMO acting on their behalf for services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with the terms of (applicable Agreement) between HMO and subscriber/enrollee.

(Provider) further agrees that (1) the hold harmless provision herein shall survive the termination of the (applicable Provider contract) regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

Any modification, addition, or deletion to the provisions of this section shall become effective on a date no earlier that fifteen (15) days after the Secretary of Health has received written notice of such proposed changes."

2) **The contracts must contain explicit language giving "the HMO, the Pennsylvania Department of Health, and any external quality review organization approved by the Department of Health, access to member medical records."**

Since the Bureau requires on-site inspection of PCP offices and review of medical records as a part of the credentialing process, the contract should specify the HMO's right of access to the physician's office.

Eventually, in-office review of specialist medical records may be required as a part of a growing and more sophisticated quality assurance system, so these provisions should also be in the specialist contract.

3) The contracts must contain wording that the provider agrees to "participate in and abide by the decisions of the HMO's quality assurance system and member grievance system".

4) The contracts must specify that the "HMO has the right to immediately terminate the provider if the provider is found to be harming members".

5) The contracts must require that "physicians have full admitting privileges at a Plan participating hospital", and require physicians "to immediately notify the Plan if his/her hospital privileges are lost or substantially diminished".

6) The PCP contract must contain a definition of PCP found in DOH regulations, ("24 hour a day, 7 day a week availability", responsibility for continuity and referrals, etc.). PCP's should be limited to "family/general practice, general internal medicine and pediatrics or perform the functions of a primary care physician at least 50% of the time in which he/she engages in the practice of medicine". We will permit an HMO to have an option whereby a female subscriber may select a participating OB-GYN (in addition to her PCP) to provide routine OB-GYN services. If this option is chosen, the application should specify how the OB-GYN will routinely provide feedback to the subscriber's PCP on the OB-GYN care provided, and any services provided by the OB-GYN beyond "routine" care must be approved by the subscriber's PCP. Generally, an OB-GYN will not be considered a PCP.

7)* Any arbitration provisions within the contract to settle disputes between the HMO and its providers will be reviewed closely. If included, arbitration provisions must specify that "no regulatory order or requirement of the Department of Health shall be subject to arbitration". This is to prevent a provider, who receives an order from the HMO, for example, to participate in an external quality review, to delay compliance by asking that the matter be arbitrated.

8)* Generally, HMO's impose many additional rules, regulations and guidelines on providers. It would be appropriate that the contract request providers to "comply with the rules and regulations of the HMO" as they may be, for example, set forth in the physician or provider manual.

9) A PCP contract usually will require a PCP to "make referrals to Plan participating providers and to seek Plan or Medical Director approval for a referral to a non-participating provider". Please note that it is the Bureau's strong belief that if a PCP issues a referral to a non-participating provider without obtaining the necessary prior approval of the HMO, the HMO members must be held financial harmless for that referral. The member should not be punished for failure of the PCP to abide by the HMO's requirements.

10) Provider contracts will usually state that the contract is subject to the laws of Pennsylvania. Under no circumstances will we permit HMO provider contracts to be subject to the laws of another state.

11) Reimbursement systems must be included as an exhibit or appendix. In order for a provider contract to be approved, related reimbursement systems must be fully disclosed, reviewed and found acceptable by the Bureau. Incentive systems and risk pools should be fully explained in the filing.

12) A PCP contract, especially if the PCP is capitated, must define (in an exhibit or attachment) exactly what services are covered under the capitation payment.

13) In reviewing the contracts, the Bureau will be especially concerned about any provision which might diminish the authority of the HMO over the provider. For example, the provider should not be held to "community standards", but to "HMO standards".

14) If the provider contract mentions anything about serving ASO (Administrative Service Only) of self-funded business, there must be a statement that DOH authority continues over the quality assurance system, health service delivery system, and member grievance system for members enrolled in the HMO through self-funded accounts.

15) The contract should specify that it may be automatically amended without provider consent to meet regulatory requirements.

16) A captive provider, dissatisfied with an HMO but unable to terminate participation, has the capacity to harm HMO patients, the HMO and the HMO's reputation. Therefore, a provider should be able to terminate participation with no more than 60-90 day notice to the HMO.

SUBSTANCE ABUSE PROVIDER CONTRACTS

If the applicant HMO plans to subcontract for substance abuse services, provider contracts need the following additional language:

1) "The substance abuse subcontractor must use ASAM, Cleveland or Department of Health approved criteria for substance abuse placement decisions relating to level of care."

2) "The substance abuse provider/facility must be licensed by the Pennsylvania Department of Health Office of Drug and Alcohol Programs (ODAP)."