Managed Care Contract Compliance Worksheet	
Payer:	**Date:**

Provisions	Comments
Implementation Timeline • Must meet the requirements for new contracts on or after January 1, 2008 • Existing contracts must meet the requirements on the anniversary date or phased in throughout the year, *but* no later than December 31, 2008 **NOTE**: The Act does not require renegotiation of a contract in existence prior to 1/1/08 and the required disclosure can be done via a notice to the provider. ***Reference: C.R.S. 25-37-101(1)***	Effective date of contract: ________/_______/____ Date contract reviewed: _________/_______/_____ *Domestic Non-profit health plans:* *There are two health plans that fall into this category – Rocky Mountain Health Plans and San Luis Valley Health Plan. They must come into compliance with this Act within 12 months after the applicable date (no later than 12/31/2009).*
Summary Disclosure Form - Provides a *reasonable summary* of the following contract provisions: • Compensation and payment terms; • Category of coverage; • Duration of contract; • How the contract may be terminated; • Identity of the claims processor; • Internal dispute resolution mechanism; • The subject and order of any contract addenda. • Grounds for termination; • Any utilization review or quality improvement programs (policies and procedures should be made available upon request). ***Reference: C.R.S. 25-37-101(3)(a)(I)- (VI) & (c)(d)***	
Manner of payment ***Reference: C.R.S. 25-37-101(4)(a)(I)***	a. Fee for service ____ b. Capitation ____ c. Risk ____ d. Other ____
Fee Schedule • Health plan is required to provide the codes reasonably expected to be billed by the health care provider. • Provider can request additional codes not included in the initial payer listing. • May be provided electronically • Providers can request a written copy twice a year ***Reference: C.R.S. 25-37-101(4)(a)(II)(B)(C) & (D)***	Fee schedule with appropriate codes attached? Y N Additional codes requested? Y N (Attach list)
Methodology used to calculate fee schedule a. Relative value unit system b. Conversion factor c. Or, percentage of Medicare payment system (% of the Medicare RBRVS unit value times conversion factor calculated amount – or – % of the Medicare Professional Fee Schedule	

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allowance as published on their disclosure report) d. Name, version, edition or publication date of any applicable relative value system e. Any applicable adjustment factors such as geographic or site of service; f. AWP or ASP for in office injectibles or immunizations; g. Clinical lab fee schedule if payer allows lab to be performed in the physician's office; h. Supplies, unlisted procedures, if allowed how paid – invoice, acquisition cost, dollar maximum, percent of billed charge; i. Any date by which compensation or fee schedules maybe changed by such methodology if allowed for in the contract. That is, when the methodology used is based on a published fee schedule (e.g. RBRVS) the date by which these allowances will be updated must be specified in the contract. **Note**: If a specific date is not specified any future updates to the fee schedule will be considered a Material Change if they result in decreased compensation. ***Reference: C.R.S. 25-37-101(4)(a)(II)(A)***	
Edits - Pre-payment – payer must state the effect of edits, if any, on payment or compensation. Can meet this requirement through web based query function, customer service, other. ***Reference: C.R.S. 25-37-101(4)(a)(III)***	
Material Change • A change to a contract that DECREASES the payment or compensation • An Administrative Change that INCREASES the provider's administrative expense OR adds a new category of coverage • Requires 90 days prior written notice and must be conspicuously entitled "Notice of Material Change to Contract". (Not envisioned to be a notice by post card or bulletin.) • Providers can object to the change IN WRITING within fifteen (15) days. Since written notification is important for both parties, the correct mailing addresses for receipt of such notices should be clearly identified in the contract for both the provider and the insurance company. • If a provider objects to the addition of a new category of coverage, the change shall not be effective and that objection is not grounds for termination of the contract. ***Reference: C.R.S. 25-37-101(7)(a)(b)(c)(d)***	***Special Note: Changes to an edit program or specific edits are NOT considered a material change, however, he payer must provide physicians with notification of these changes and the information must be sufficient to determine the effect of the change on reimbursement. This may be communicated in a bulletin/newsletter, fax, notice on the web site, other.***

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Third Parties, Rental Networks, Affiliates Payers are directed not to sell, rent or give its rights to physicians' services unless the following are met: a. The entity is acting as a third party administrator for an employer or other entity providing coverage for its employees or members pursuant to the terms of the contract or; b. The third party accessing the services under the terms of the contract is an affiliate or subsidiary of, or is under common ownership or control of the entity executing the contract – a complete list of affiliates and clients **MUST** be made available to the providers of service or; c. The contract specifically provides that it applies to network rental arrangements and; d. Individuals receiving services under the contract are to be provided with appropriate identification stating where claims should be sent and where inquiries should be directed and; e. The third party accessing the services through the contract is obligated to comply with all applicable terms and conditions of the contract. ***Reference: C.R.S. 25-37-101(10)(a)(b)(d)(e)***	
Closing the Practice to New* Patients This is allowed with 60 days' written notice. Payer must specify how and or to whom the notification should be submitted. ** CPT definition of a new patient (3 yrs)* ***Reference: C.R.S. 25-37-101(12)***	
Waiver of Rights As a condition of contracting the provider cannot be forced to waive any right or benefit under state or federal law or regulation. ***Reference: C.R.S. 25-37-101(11)***	
Compliance Monitoring Physicians are allowed to share their contracts with a third party for the purpose of ensuring compliance with C.R.S. 25-37-101. ***Reference: C.R.S. 25-37-101(14)***	***CMS can act in a third party capacity to assist with issues of compliance only after the practice has performed a complete evaluation and made the discovery of possible non-compliance on the part of the payer.***
Binding Arbitration Allows disputes for breach of contract to be settled by binding arbitration or as otherwise agreed to in the contract. ***Reference: C.R.S. 25-37-101(4)(a)(II)(B)(C) & (D***	

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Enforcement of the Act Provides for either arbitration or civil action, as mutually agreed upon, and shall include: a. Private Rights of Action; b. Equitable relief, including plan wide injunctive relief; c. Reasonable costs, attorney's fees and damages for a prevailing provider; d. Prior decisions may be used as persuasive evidence in future cases; e. Decisions shall be made available to anyone with a reason to know. ***Reference: C.R.S. 25-37-101(20)(a(I))(II)(III)(IV) & (b)***	
Other Provisions: ***Reference: C.R.S. 25-37-101***	

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