

Contracting & Credentialing

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Meet Your Presenter

- Manager, Physician Practice Development, American Medical Association
- Education
 - B.S. Health Systems Management, Loyola University Chicago
 - MBA, Entrepreneurship, Pepperdine University.
- 10+ years of health care administrative experience in private practice, including managing business and clinical operations, as well as consulting knowledge for largescale health systems.



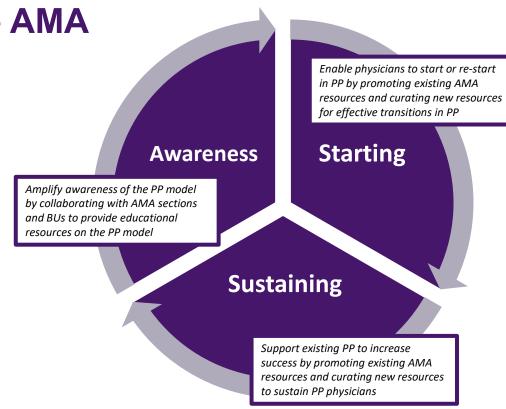
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Private Practice at the AMA

Objective: Physicians have the exposure, tools, and information needed to choose the practice setting that is right for them and leads to their professional satisfaction and long-term practice sustainability.



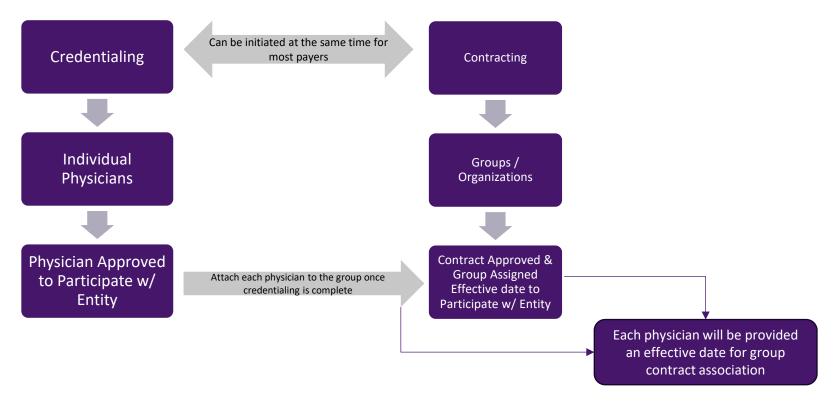
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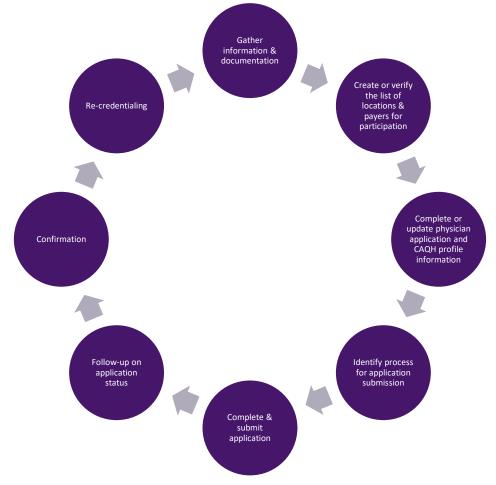
Agenda

- Physician Credentialing & Contracting
 - 8 STEPS to Credentialing and Contracting
 - Common roadblocks
- Basics of Contracting
 - Payer Types, Products & Reimbursement Models
 - Important Contract Terms
 - Contracting Trends
 - Common Value-Based Care Approaches

Overview of Physician Credentialing



8 STEPS to Credentialing



Common Roadblocks

Incomplete applications

Incorrect information on application

Expired documentation

Differentiation of Individual and Group NPI

Follow-up on application status

Basics of Payer Contracting

- ERISA Self-Funded Employee Benefit Plan/Union Trust An employer-sponsored health benefit plan where financial responsibility for overall cost of care lies with the employer instead of with an insurer. ERISA plans are usually exempt from state insurance laws (e.g., prompt pay laws).
- Third Party Administrator An entity that contracts with ERISA plans to administer the health plans, including claims adjudication and payment, utilization management, physician contracting, and other administrative functions necessary for plan operations.
- Fee-for-Service Government Programs Medicare, Medicaid,
 Workers' Compensation, Veterans' Administration, etc. The terms of
 such plans are typically set by the government entity and there may
 be little room for a physician or practice to negotiate
 anything different.
- Health Maintenance Organization (HMO) HMOs contract with a network of health care providers that have agreed to the HMO's reduced payment structure or fee schedule. Subject to few exceptions, care provided under an HMO is covered only if a member sees physicians within the HMO's network.
- Preferred Provider Organization (PPO) A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of "preferred" providers. These preferred providers agree to the PPO's payment structure, or fee schedule, for services. PPOs also offer coverage for services provided by nonpreferred (non-contracted) physicians.

- Exclusive Provider Organization (EPO) EPOs are similar to PPOs, however, EPOs typically require members to receive services only from participating physicians.
- Point of Service (POS) A POS plan is a hybrid PPO/HMO which provides the flexibility of a PPO while retaining cost controls. For example, POS plans may offer coverage for services provided by non-preferred (non-contracted) physicians, but only upon a referral from a PCP.
- Leased Network/Contracting Networks Physician networks are typically organized and managed by entities other than insurers. The network contracts with physicians to form a network that insurers pay to access, including self-funded plans and their TPAs.
- Accountable Care Organization (ACO)Clinically Integrated
 Network (CINs) The voluntary networks of providers are typically
 organized and managed by health care providers (e.g., health
 systems) instead of insurers with the goal of delivering high-quality,
 coordinated care. The ACO or CIN may contract with insurers on
 behalf of the physicians and may require the physician to adhere to
 ACO or CIN clinical guidelines for care.
- Health Care Sharing Ministries A nonprofit ministry that solicits contributions for sharing of health care costs among members.
 Health Care Sharing Ministries are not "insurers" but are recognized under the Affordable Care Act as satisfying the requirement for individual coverage.



Contracting Considerations

- Volume of payer's members in your market
- Understand ramifications of out-of-network status
- Practice priorities
- Practice's unique approach and value proposition
- Payer's past performance

Physicians should consider the following when deciding whether to enter a payor contract:

- Benefits of in-network status, such as securing clear reimbursement terms and rates, having access to payor's members, and avoiding the challenges associated with out-of-network status.
- Ramifications of out-of-network status, such as payment of usual and customary charges (not billed charges), limits on out-ofnetwork benefits, collecting from patients, and evolving laws on surprise billing.
- Payor's market share (i.e., number of members affiliated with a particular payor in the market)
- Physician organization's value proposition, including what sets the physician apart from other, similar physicians.
- Operational considerations, such as whether the physician organization's processes align with payor requirements (and the operational or cultural costs of achieving such alignment).
 - Examples of this include utilization management processes (manual vs electronic, methods/tools for quality measurement and reporting to a payor, required arrangements with third parties (e.g., benefit managers, clearinghouses, etc.).
- · Payor's past performance.
- Payor requirements for data sharing (access and evaluation of associated privacy/security concerns).
- Volume of services with utilization management requirements (such as prior authorization).
- Payor physician profiling and measurement programs that track quality and cost for each physician. (i.e., what methodology/metrics does the payer use? How will this be publicly reported – especially to patients? What is the dispute process? How can this affect payment – e.g., does a "preferred" ranking put the physician in a different tier with more favorable patient cost share to attract more patients?)

Private Practice Toolkit: Payor Contracting 101 (PDF)



- Eligibility
 - o Protection from retro-eligibility changes
- Medical Necessity
 - Be wary of definitions that are overly restrictive, give blanket discretion, or include a technical component
 - Ensure definition considers aspects specific to patient conditions and services provided
- Authorization
 - Ensure your processes, timing and documentation meet payer's requirements, or mutually revise terms terms for process
 - Seek protection for unauthorized services by adding retrospective review for medical necessity process rather than technical denial



Private Practice Toolkit

Payor Contract – Sample Contract Language

Eligibility

Favorable to physician:

Payor shall be responsible for identifying and verifying eligibility of Members. Payor shall provide each Member with an identification card. It is the Payor's responsibility to update and maintain eligibility files and systems to ensure that eligibility verification is timely and accurate. Physician may rely on eligibility verifications obtained from a Payor or its designee and Payor shall reimburse Physician in accordance with this Agreement even if a Member is later determined to be ineligible on the date of service.

Favorable to payor:

Physician will verify a Member's eligibility before providing a Covered Service unless the situation involves the provision of an Emergency Service in which case Physician will confirm eligibility in a manner that is consistent with Law on redeterminations of eligibility. Physician will not be reimbursed for any services furnished to a patient who was not an eligible Member on the date of service.

Private Practice Toolkit: Payor Contract-Sample Contract Language (PDF)



- Service Locations
 - Clearly include applicable locations of offices/clinics in agreement
- Policies & Provider Manuals
 - Understand external contract documents
 - Contract terms prevail over manuals
 - Guard against unilateral changes of material terms that impact reimbursement or increase resource obligations
 - Require written notice, opportunity to object, no amendment without mutual execution, or process to make whole
- Patient Responsibility & Non-Covered Services
 - Clearly specifies and permits patient responsibility without special conditions
 - Experimental/investigational



Private Practice Toolkit

Payor Contract – Sample Contract Language

Physician Manual / Payor Policy Changes

Favorable to physician:

Physician shall comply with the Physician Manual and all applicable policies of Payor in effect as of the Effective Date of the Agreement and as provided to Physician. Payor shall notify Physician at least ninety (90) days in advance of implementing any new policies or making material changes to the Physician Manual. A "material change" shall include, but not be limited to, (i) any changes to or negative impact to reimbursement to Physician; and (ii) any increased operational or administrative burden to Physician. In the event Physician objects to a material change, the change will not take effect as to Physician without the mutual written agreement of the Parties.

Favorable to payor:

Physician shall comply with the Physician Manual and all applicable policies of Payor, any of which may be amended by Payor from time to time at the Payor's sole discretion.

Private Practice Toolkit: Payor Contract—Sample Contract Language (PDF)



- Audits
 - Negotiate terms, standards, process and scope
 - Timing
 - Prerequisites
- Termination Rights
- Appeals and Dispute Resolution
 - Avoid technical pre-conditions to dispute resolutions
 - Avoid contractually shortened statues of limitations



Private Practice Toolkit

Payor Contract Review Checklist

Appeals and Dispute Resolution Does the contract address physician's appeal rights? Does the contract address the process for grievance or dispute resolution regarding claims or denials based on UR?

□ Term and Termination How long is the initial term? Does the contract automatically renew? This can be problematic if payors are changing contract terms (especially rates) and changes are not transparent to the physician. Can the contract be terminated by either party without cause upon written notice (e.g., 30 to 90 days' prior written notice)? Can the contract be terminated immediately in certain circumstances (e.g., loss of license, insolvency, exclusion from federal health care programs; non-payment)? Do parties have an opportunity to cure a material breach after receiving notice of the breach? If so, how long is the cure period? Can the physician terminate on written notice for non-payment? If so, can the physician terminate the whole arrangement due to breach by a single plan? Or, can the physician terminate his or her participation in a single plan without terminating the whole arrangement? Can the physician terminate the agreement without penalties in response to a unilateral amendment or material policy change (note that some state laws require payors to offer this option)?

Private Practice Toolkit: Payor Contract Review Checklist (PDF)



- Addition of New Facilities/Physicians or Acquisitions
 - Terms that support growth/expansion
 - Auto-addition upon notice and completion of credentialing
 - Contract rates for acquisition of another contracted provider? For how long?
- Payment Terms
 - Claim submission and payment timeframes, content of clean or complete claim, interest on late claims, billing codes, coding edits
 - Overpayments and offsets
 - Avoid payer unilateral right to modify reimbursement



Private Practice Toolkit

Payor Contract Review Checklist

Payment Provisions

Late Payments or Non-Payment What are the remedies or penalties for late payments (e.g., late fees, interest, etc.)? Can a physician easily identify nonpayment/underpayment? How can a physician directly enforce payment?

Payment methodology Does the contract specify within how many days the payor must pay the physician? Does the contract incorporate any state prompt-pay laws? What billing forms must be used? What constitutes a clean claim? Does the contract require physicians to accept electronic payments (vs. paper checks)? Does the contract require the provider to accept virtual credit cards for payment, or to contract with any third-party EFT payment processors? Are there fees associated with receiving payments through VCC or EFT?

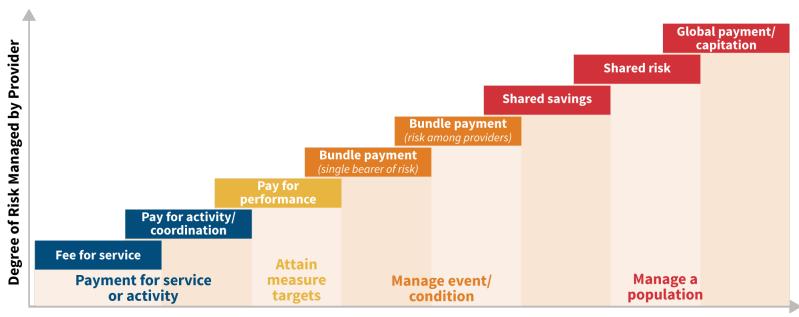
Private Practice Toolkit: Payor Contract Review Checklist (PDF)



Contracting Trends

- Commercial payers implementing VBC arrangements
- Looking to the physician to accept more responsibility and risk
- Models that address non-medical matters such as social determinants of health, housing instability, food insecurity, social isolation
- Requires collaboration with other physicians and payers (individual, organizational, or regional levels)
- Continued push to drive down costs in health care
- Population Health through proactive care coordination/case management and clinically integrated networks (CINs)

Common VBC Approaches



Level of Provider Sophistication and Transformation

https://www.theactuarymagazine.org/value-based-care-framework/

AMA Credentialing and Contracting Resources



services. This Payor Contracting Toolkit, provided by the American Medical Association, is designed to help physicians evaluate contracts with payors, understand the differences among payors, and develop a basic working knowledge of the range of insurance products and payment models associated with the contracting process. The materials in this toolkit are for education and informational purposes only and should not be considered legal advice. Physician practices should consult their own health care counsel or other advisors to evaluate specific agreements or contracting opportunities with payors



The payor contract is the basic agreement setting out the obligations of the payor and the physician (or practice) Therefore, it is important to identify terms that are particularly beneficial to physicians or payors. The provisions described here are frequently negotiated and, as reflected below, may be written in a way that favors one party more than the other Please note that the examples included here are intended as educational content only and may not be appropriate to use in a specific payor agreement without further review or modification. This sample language should not be construed as legal advice; the AMA does not guarantee the enforceability or appropriateness of this language when applied to any particular agreement. Physicians should seek guidance from experienced health care counsel in connection with any us-

Favorable to physician:

Payor shall be responsible for identifying and verifying eligibility of card. It is the Payor's responsibility to update and maintain eligibility accurate. Physician may rely on eligibility verifications obtained from a Payor or its designee and Payor shall reimburse Physician in accordance with this Agreement even if a Member is later determined to be ineligible on the date of service.

Favorable to payor:

Physician will verify a Member's eligibility before providing a Emergency Service in which case Physician will confirm eligibility in eligibility. Physician will not be reimbursed for any services furnished to a patient who was not an eligible Member on the date of service.

Favorable to physician: Notwithstanding any other provision of this Agreement, Payor shall

sixty-five (365) days from the date of the initial Claim payment or it misrepresentation by Physician. In no event shall Payor offset

Physician's written consent. Favorable to payor:

In the event of an overnayment. Payor will issue an overnaymen

timely disnute or renay the overnovment within sixty (60) days. Paul may collect the amount by offsetting or recouping from any amounts due to the Physician Physician will represely potify Payor and applicable governmental agencies of any overpayments identified b Physician. Notwithstanding any other provision of this Agreement, the offset and recoupment rights for an overs

Favorable to physician:

Any amendment to this Agreement shall require the mutual written Favorable to payor:

Payor may amend this Agreement upon forty-five (45) days prior written notice to Physician. The proposed amendment shall take effect unless Physician notifies Payor of its termination of the Agreement within forty-five (45) days of receipt of the notice

Favorable to physician: policies of Poyor in effect as of the Effective Date of the Agreement and as provided to Physician. Payor shall notify Physician at least ninety (90) days in advance of implementing any new policies o making material changes to the Physician Manual. A "material change" shall include, but not be limited to, (i) any changes to a negative impact to reimbursement to Physician; and (ii) any eased operational or administrative burden to Physician. In the event Physician objects to a material change, the change will not



make these changes by amending a manual or written procedure documents. Depending on the terms of the payor ment, a physician may receive limited notice of these changes, and may not be able to effectively contest or rejec



This Checklist provides an overview of key terms and considerations when reviewing a payor contract as well as questions for physicians to ask when reviewing, understanding, and negotiating agreements.

- the navny adds a plan to the contract, can the physician socies and for opt-out of on a plan-by-plan basis?
- physician's services covered by the contract, along with any necessity and coverage rules for physician's services? Does the payor have specific prior authorization policies (and transparency of policies) for services or prescriptions? What is the payor's PA process (manual vs. electronic) and are other third
- parties involved (benefit managers)? Key Definitions for the key terms used in the contract clearly affiliates, hilled channes, clean claim, covered services, effective necessity and navor.
- Credentialing Requirements Does the contract clear indicate which party is responsible for credentialing? Are credentialing and corrective action procedures clearly payment while their credentialing application is pending? Ar disciplining or disqualifying a physician? Additional review documents, peer review organization state license
- requirements (e.g., site visits, tunn-around times, Late Payments or Non-Payment What are the remedies
- Payment methodology Does the contract specify within how many days the payor must pay the physician? Does the

billion forms must be used? What constitutes a clean claim? provider to accept virtual credit cards for payment, or to contract with any third-party EET payment processors? Are

Submission of claims Does the timeframe for submission of claims coincide with physician's billing cycles? Does the payor require electronic submission of claims? If so, are What method does the payor require for submission of etc.)? Aside from payment, for what other purposes does

Enrollee Payments is the physician allowed to bill enrollee for coinsurance, co-payments, and appropriate deductibles at the time of service? Is the physician allowed to bill encollees usual and customary charges for

treated (e.g., will overpayments be offset from future payments; will the physician receive advanced notice of such offsets)? Appeal Does physician have sufficient time to evaluate and

offsets begin only after an appeal concludes? Rates How are rates determined (e.g., fee schedule, percentage of Medicare, other calculation)? If rates are to adjust rates, and can physician dispute the change or necreetane over prior rates. linked to Concurrer Price rates it offers any other navor?

- Payor Contracting 101 (Webinar)
- Payor Contracting 201 (Webinar)
- Private Practice Toolkit: Examples of Significant Payor Unilateral Policy Changes (PDF)
- Private Practice Toolkit: Payor Contract Review Checklist (PDF)
- Private Practice Toolkit: Payor Contract—Sample Contract Language (PDF)
- Private Practice Toolkit: Payor Contracting 101 (PDF)



Questions?



Thank you!





Physicians' powerful ally in patient care