CHECKLIST OF **KEY ISSUES** FOR MANAGED CARE PROVIDER AGREEMENTS

INTRODUCTION

This Checklist of Key Issues for Managed Care Provider Agreements ("Checklist") was developed as a tool to assist PPS members understand and negotiate key terms in third-party payer agreements. The Checklist offers guidance, Payer-Friendly provisions, and Provider-Friendly provisions which can serve as a reference point during the review and negotiation of these agreements. Please note that this checklist does not address many issues governed by state and/or federal laws and regulations applicable to third-party payer agreements. Please consult with a qualified health lawyer for guidance concerning any legal and regulatory compliance issues.

PRIVATE PRACTICE SECTION, APTA

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
PAYERS/AFFILIATES/PRODUCTS			
Payers			
"Payer" and/or "Plan Sponsor" should be narrowly defined so that undisclosed plans, third-party administrators, billing review agents, and other pricing consultants cannot access the contractual benefits and discounts. Please remember that Payer may not be the contracting party but instead an entity with a separate agreement with the contracting party for purposes of accessing Provider discounts. *For purposes of these examples, the contracting entity is referred to as "Network."	"'Payer' or 'Plan Sponsor' is an entity obligated to provide reimbursement for Covered Services to Covered Individuals under a Plan and authorized by Network to access Provider's Services under this Agreement. Only the following entities may be a Payer or Plan Sponsor: Network; Network's Affiliates; or any entity receiving administrative services from Network or one of its Affiliates.	"'Payer' or 'Plan Sponsor' means an employer, other ERISA plan sponsor, union trust, or association that has a contract with Network and accepts fiduciary responsibility for an established Benefit Program. In no event shall any of the following entities be considered Plan Sponsors or Payers under this Agreement and in no event shall any such entity be entitled to access this Agreement unless and until the parties hereto expressly agree in writing: (a) entities that primarily issue or administer health benefits for persons who reside permanently outside of the United States; (b) no-fault insurance programs; (c) workers' compensation programs; (d) entities for whom Payer does not provide both claims processing and utilization management services; or (e) other than Payer, any insurer, TPA, utilization review agent, preferred Provider organization, preferred network entity, or sponsor of any discount card program."	"'Payer' or 'Plan Sponsor' means any entity, public or private, contracted with Network or an Affiliate and responsible for paying for Covered Services, including but not limited to self-funded Plans, Plan enrollees, fully insured Plans, third-party administrators, and consultants."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
Affiliates			
An "Affiliate" of Payer can typically access the rates, terms, and conditions set forth in the Agreement. Therefore, the term should not be defined so broadly as to allow Payer to "rent" its negotiated discounts to undisclosed third parties (i.e., to "silent PPO's"). This can undermine Provider Agreements with other Payers who have agreed to pay higher rates for Covered Services.	"For purposes of this Agreement, 'Affiliate' means those entities that are owned by or under common control with Payer."	"For purposes of this Agreement, Affiliate means Payer and its affiliates listed in Exhibit __ attached hereto. Only the Affiliates listed in Exhibit __ shall be entitled to participate in the rights, duties, and obligations of this Agreement."	"For purposes of this Agreement, '"Affiliate"' means any entity designated as affiliated with Payer for purposes of the Agreement."
Products			
"Products" should be defined narrowly so as to be clear which products the Agreement covers. Networks often include a provision that would allow the Network sole discretion as to whether to include or exclude a Provider in new Plans or Products. The agreement should be limited to specific Products and allow Providers to opt in or opt out of participating in additional Products.	"Provider agrees to participate in the Products listed on Exhibit __. Network may amend products listed in Exhibit __ to include any new products upon sixty (60) days' notice to Provider."	*Provider-friendly addition:* "Persons not enrolled in a Product listed in Exhibit __ shall not be entitled to access this Agreement. Exhibit ___ may be amended only upon mutual written consent of the parties."	"'Product' means the health maintenance organization (HMO), preferred provider (PPO), or other types of health care or administrative services products and programs that are provided or arranged for by Network and that Provider is agreeing to participate in hereunder. Network may add or remove Products at any time and from time to time. At Payer's sole election, Provider shall be required to participate in any new Product or Program offered by Payer on the same terms and conditions as set forth under this Agreement or as may be specified in any amendment hereof."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
COVERED PERSON/COVERED SERVICES			
Covered Person			
"Covered Person" a/k/a "Beneficiary" a/k/a "Enrollee" means a person entitled to receive benefits under a given Plan.	*Neutral*: "'Covered Person' means an individual who is eligible, as determined by Plan, to receive Covered Services under a health benefit plan." *Alternative*: "Enrollee means a person who, at a time that services are rendered, is eligible to receive Covered Services under the terms of the applicable Payer's benefit plan."		
Covered Services			
"Covered Services" should include *all* services that Provider is capable of providing, licensed to provide, and intends to provide. Beware of a definition that contains unwanted "carve-outs" for certain services that are to be exclusively provided by a lower-cost Provider.	"'Covered Services' means medically necessary health care services, as determined by Plan and described in the [applicable plan policy], for which a Covered Person is eligible."	"'Covered Services' means those health care services, equipment, and supplies that are covered under an [applicable plan policy]. Provider shall be entitled to provide all Covered Services that it is licensed to provide."	"'Covered Services' means health care services rendered to Covered Persons for which reimbursement is required by Plan."
Emergency Medical Services			
"Emergency" or "Emergency Medical Services" tends to be defined fairly consistently in most Agreements, as the federal government and many states have adopted similar definitions. However, it is not uncommon for a Plan to insert additional requirements in the	"'Emergency" or 'Emergency Medical Services' means, unless otherwise defined in a [applicable plan policy] or required by statute or regulation, a serious medical condition resulting from injury or sickness that arises suddenly and requires immediate medical	"'Emergency' or 'Emergency Medical Condition' shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) that would lead a prudent layperson to believe that	*See Common Provision.*

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
definition in order to maximize the Plan's discretion to determine whether the condition was, indeed, an emergency. Plans cannot legally require Providers to seek pre-authorization before evaluating and treating an Emergency Medical Condition. However, it is not uncommon for Payer to require Providers to notify Payer of an emergency room visit within 24 hours (or a set amount of time) as a condition of payment.	treatment to avoid serious physical impairment or loss of life for which Covered Individual secures medical attention immediately after onset (usually within 24 hours)."	the absence of immediate medical attention could result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions that: (a) there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) a transfer may pose a threat to the health or safety of the woman or the unborn child."	
MEDICAL NECESSITY OR MEDICALLY NECESSARY			
Agreements often state that "Medical Necessity" will be defined by each applicable plan policy. It is far preferable to have a single definition for the term to be applied uniformly across all Plans that contract with Payer. Providers should ensure they have a contractual right to appeal an adverse Medical Necessity determination and that the Provider Manual sets forth a procedure for doing so. Optimally, Payer should not be able to reverse a Medical Necessity determination for a pre-authorized service unless the information provided at the time of pre-	"Unless otherwise set forth in the [applicable plan policy] or otherwise required by statute or regulation, "Medically Necessary" means a health service that is compensable, as determined by Network or its delegate, for the treatment of injury, sickness or other health condition and is: (a) appropriate and consistent with the diagnosis or symptoms; (b) consistent with accepted medical standards; (c) not investigational or experimental; (d) not excessive in scope, duration, or intensity; (e) provided in a safe and appropriate setting given the nature of the diagnosis and severity of the symptoms; and (f) not provided solely for the convenience of the Covered Individual or Provider."	*APTA Definition:* "The Medical Necessity of physical therapist services is determined by a licensed physical therapist based on the results of the physical therapists's evaluation. Medically Necessary physical therapy services improve, maintain, or slow the decline of the current level of function, or prevent, minimize, slow the progression of, or eliminate impairments of body functions and structures, activity limitations, or participation restrictions." *Provider-friendly addition:* "Notwithstanding anything contained herein to the contrary, if Provider renders a Covered Service to an Enrollee after having obtained prior authorization from Payer,	*Plan-friendly additions:* "… not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results and, in the context of inpatient services, the Member's medical symptoms or condition requires that the diagnosis, treatment, or service cannot, with reasonable safety, be provided as an outpatient." "Notwithstanding anything contained herein to the contrary, Payer may retroactively deny or adjust payments to Provider if Payer subsequently determines that a service was not Medically Necessary despite any prior determination or

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
authorization was materially inaccurate or incomplete.		Payer may not retroactively deny or adjust payment for the Covered Service after it was rendered unless: (a) the information provided at the time of authorization varies materially from the information in the patient's medical record; (b) there was fraud; or (c) the Beneficiary's eligibility for coverage has been retroactively terminated not more than __ days prior to the date of service."	authorization given by Payer with respect to such service."
TERM			
The length of term, renewal provisions and termination provisions should be considered collectively. Initial terms are typically 1-3 years and often include a provision for automatic renewal for additional terms. The longer the term(s), the more important it is to include a termination for convenience provision because, absent such a provision, a Provider may have to wait until a term expires before extricating itself from an unfavorable Agreement.	"The term of this Agreement shall commence on the Effective Date and shall have an initial term of __ years. After the initial term, the Agreement will automatically renew for consecutive __ year terms unless terminated as provided herein." *This precludes termination for convenience during the initial term.	"The term of this Agreement shall commence on the Effective Date and continue until terminated as provided herein." *This is favorable provided there is a provision allowing termination for convenience.	"The term of this Agreement shall be __ year(s), commencing on [Date]. Notwithstanding the foregoing, Provider may terminate the Agreement pursuant to Section __ [relating to "for cause" termination]."
TERMINATION			
<u>Termination for Convenience</u>			
A termination without cause provision allows both parties flexibility in responding to unsatisfactory performance by the	"After completion of the initial term of this Agreement, either party shall have the right to terminate this Agreement at any time without	"Either party shall have the right to terminate this Agreement without cause at any time upon __ days'	"After the end of the initial term, either party shall have the right to terminate this Agreement without cause upon at least ___ days'

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
other party or a change in business operations. As both parties will need to address patient notice and transfer of care issues, most Agreements allow termination for convenience only upon 90-180 days' written notice. Post-Termination Obligations are discussed below.	cause upon __ days' advance written notice to the other party."	advance written notice to the other party."	advance written notice, effective at the end of the current renewal term." *Alternative - Unilateral*: "Payer shall have the right to terminate this Agreement without cause at any time upon __ days' advance written notice to Provider."
Termination for Cause			
Inclusion of a termination for cause provision is necessary to ensure that each party can terminate the Agreement in the event the other party breaches its responsibilities, becomes insolvent, loses accreditation, or other issues arise. If a party terminates the Agreement for cause, the termination is typically effective immediately, upon written notice. Please note that Government Plans require the inclusion of a number of the provisions included in the common example in order for one or both parties to maintain regulatory compliance.	"This Agreement will terminate upon the occurrence of any of the following events: (a) either party materially breaches a warranty, covenant, or obligation set forth herein, and the breaching party fails to cure the breach within __ days after receiving written notice of such breach from the non-breaching party; (b) immediately if either party commits any act or conduct for which his/her/its license(s), permits, or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide health services are lost or voluntarily surrendered; (c) immediately in the event either party's insurance coverage as required under this Agreement lapses for any reason and is not immediately replaced; (d) immediately in the event Provider and/or Provider's employees, contractors, subcontractors, or agents are identified as ineligible	*Provider-friendly addition:* Opportunity to Cure. If there are issues that can be cured, it is preferable to include a provision(s) that allows the breaching party thirty (30) days to do so, before the agreement is terminated.	Unilateral Right to Terminate. Provisions that give the Network a unilateral right to terminate the Agreement for cause should be rejected. Each party should have termination rights in the event of a breach, material non-compliance, or other bad action by the other party.

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
	persons on the General Services Administration list of Parties Excluded from Federal Programs and/or HHS Office of Inspector General List of Excluded Individuals/Entities, and in the case of an employee, contractor, subcontractor, or agent, fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement; (e) upon written notice in the event either party commits a fraud or makes any material misstatement(s) or omission(s) on any documents related to this Agreement that it submits to the other party or to a third party; (f) upon written notice, in the event Provider is convicted of a felony; (g) upon written notice, if Network reasonably believes, based on Provider's conduct or inaction, that the well-being of patients may be jeopardized."		
Post-Termination Continuation of Care			
Providers should be aware of continuing obligations after termination and limit them as much as possible. Government Plans require a contracted Provider to continue to treat enrollees for a specified period of time in certain instances (e.g., inpatient hospitalization, an ongoing course of treatment, the last trimester of pregnancy).	"Unless otherwise set forth in the Plan or required by statute or regulation, Provider shall, upon termination of the Agreement for reasons other than the grounds set forth in the 'Termination for Cause' provision, continue to provide and be compensated for Covered Services rendered to Covered Individuals under the terms and conditions of this Agreement until	"In the event of termination of this Agreement at the end of the term or otherwise, Payer shall reimburse Provider in accordance with the terms of this Agreement for all services rendered to enrollees who were under the care of Provider as of the date of termination. Provider shall continue to provide necessary services to such enrollees at the rates provided for herein during the	Some Agreements do not include a limit on the maximum number of days the care must continue. Therefore, a Provider could be required to continue providing services to the Covered Individual over an extended period of time absent the availability of an alternative Network Provider.

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
If these obligations seem particularly onerous, determine whether they are required by regulation or simply by Payer's preference.	the earlier of: (a) __ days; (b) the Covered Individual has completed the course of treatment; or (c) reasonable and medically appropriate arrangements have been made for a new Network Provider to provide health services to the Covered Individual."	remaining course of treatment until the earlier of: (a) the end of such course of treatment; (b) the 31st day after termination; or (c) the date Payer transfers patients to an alternate Provider. Treatment provided after the 31st day following termination shall be reimbursed at Provider's then-current full charge for the services rendered."	
PROVIDER CREDENTIALING			
Payer's credentialing standards along with the process for appealing an adverse credentialing determination are typically set forth in the Provider Manual. Therefore, it is important for Providers to review these requirements. Some Agreements immediately terminate if Provider fails to meet all of Payer's credentialing criteria. It is preferable for Provider to have a grace period to become compliant before termination.	"When applicable, Provider will participate in and cooperate with Payer's credentialing program, as described in the Provider Manual. Provider shall promptly notify Payer of any material changes in Provider's certification, licensure, or other qualification status. Provider shall cooperate fully with Payer and its designees to assist Payer in determining whether Provider meets Payer's recredentialing standards."	"If Provider fails to satisfactorily complete and pass Payer's initial credentialing process or subsequent recredentialing activities, Payer may terminate this Agreement upon __ days' written notice to Provider provided, however, that Provider will have __ days to become in compliance with such credentialing activities."	"This Agreement will immediately cease to be effective if Provider fails to satisfactorily complete and pass Payer's initial credentialing process or subsequent recredentialing activities."
QUALITY ASSURANCE AND UTILIZATION REVIEW PROGRAMS			
State law typically governs the confidentiality of quality and utilization reviews. Disclosure of confidential QA/UR information to a third party may be in violation of the law, regulations, and/or accreditation standards. Therefore, Providers should beware of clauses that require blanket disclosure of information to these programs.	"Provider agrees to abide by the terms of the Provider Manual and to comply with Payer's quality improvement and utilization review programs."	"Provider shall cooperate with Payer's quality assurance and utilization review programs to the extent that such programs are consistent with community standards and the standards and requirements of organizations to whose jurisdiction Provider may be subject and are not materially inconsistent with the express terms of this Agreement. Upon reasonable	"Provider agrees to participate in and cooperate in all respects with Payer's quality review and utilization review programs and also agrees to comply with all decisions rendered by Payer in connection with such programs. Provider shall provide to Payer, within __ calendar days of receipt of written request, all medical and other records requested by Payer pursuant to its

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
		request, Provider shall furnish Payer with summaries of or access to records maintained by Provider and required in connection with such programs. Anything herein to the contrary notwithstanding, except as required by law or court order, Provider shall not be required to provide materials prepared or maintained by a peer review committee or any peer review documents. Payer shall maintain the confidentiality of all such information obtained from Provider and shall disclose it to third parties only upon Provider's advanced written consent or as required by law or court order."	quality review or utilization review programs."
SUBCONTRACTORS			
Providers who intend to provide Covered Services through subcontractors need to clearly understand any limitations imposed under the Agreement. All professional Providers (employed or subcontracted) will be required to meet Payer's credentialing criteria and provide services in a manner consistent with the terms and conditions of the Agreement.	"Provider may subcontract the provision of Covered Services so long as such subcontractor is acceptable to Payer. Provider shall provide Payer with at least __ days' notice of any subcontractors with whom Provider may contract to perform Provider's obligations under this Agreement. Provider shall require such subcontractors to abide by the terms and conditions of this Agreement and will indemnify Payer and Covered Individuals for any failure of a subcontractor to so comply. If Payer has a direct contract with the subcontractor, the direct contract will prevail over this Agreement."	"If any of the Covered Services are to be provided by a subcontractor, Provider and the subcontractor shall enter into a written agreement that expressly provides that the rendering of Covered Services by the subcontractor is subject to the terms of this Agreement. Each subcontractor shall meet Payer's or Provider's credentialing requirements prior to the subcontract becoming effective. Provider agrees to be solely responsible to pay any subcontractor permitted under this Agreement, and Provider shall hold and ensure that subcontractors hold Payer and Enrollees harmless from and against any and all claims that may be made by such subcontractors in connection with Covered Services rendered to	"Provider shall certify to Payer, prior to the effective date of any subcontract and upon written request, that any subcontracts with other Providers rendering services to Enrollees comply with requirements of this Agreement. Notwithstanding the existence of Provider's subcontracts, Provider shall remain responsible for satisfying the obligations set forth in this Agreement. If any of Provider's subcontracts are terminated, Provider shall remain financially responsible for Covered Services provided to Enrollees under this Agreement. Provider subcontracts shall be terminable by Payer at any time for any reason."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
		Covered Individuals under any such subcontract."	
CLAIMS			
Pre-Authorization			
Most Payers require Providers to verify a Covered Person's eligibility before providing services in every situation, except emergencies. Federal law prohibits a requirement for pre-certification of emergency services. Beware that some third-party administrators will include criteria in addition to those of the Payer when making pre-authorization determinations. Therefore, we suggest addressing this in the Agreement.	"Pursuant to the then-current policies and procedures, Provider shall establish a Covered Person's eligibility for services before rendering services, except in the case of an Emergency Medical Condition."	"Provider shall use reasonable efforts to verify the eligibility of Enrollees using Payer's telephonically or electronically available system before providing Contracted Services or promptly thereafter." *Proposed Addition:* "Pre-authorization determinations shall be based upon Payer's criteria."	"Except in an Emergency, prior to rendering services, Provider will follow Payer's verification and authorization procedures to verify that a person is a Covered Person and the services to be provided constitute Covered Services. Provider acknowledges that: (a) presentation of an identification card is not sufficient proof of eligibility; (b) verification of eligibility by Payer is based on information available to Payer from its customers on the date Provider seeks verification; (c) the eligibility of a Covered Person may change between the verification date and the date of service; and (d) Payer's eligibility verification shall not under any circumstances be deemed as a guarantee of payment of the claim. In the event services are rendered to an individual who is not a Covered Person, based on an erroneous confirmation of enrollment by Payer, Provider may bill the individual directly for such services."
Clean Claims			
Payers will only pay for claims containing all required information, on the required form, and submitted through the appropriate channel.	"Clean Claim means either the uniform bill claim form or electronic claim form in the format prescribed by Payer submitted for payment	"For purposes of this Agreement, a Clean Claim means a claim that contains all of the HCFA 1500 (or successor standard) mandatory data	"For purposes hereof, a Clean Claim means, a claim that: (a) is submitted within the timeframes set forth in Payer's then-current policies; (b)

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
These requirements should not include ambiguous criteria that could allow Payer to unreasonably reject or delay payment of claims. If applicable, the Medicare or state statutory definition of "Clean Claim" should be used.	along with all information required by Payer for processing, including all information and documentation related to coordination of benefits and third-party liability."	elements and is submitted within the timeframes set forth herein."	contains appropriate and sufficient information to allow Payer to pay the claim; (c) does not involve a coordination of benefits issue or subrogation; (d) is submitted in accordance with the formatting and submission requirements that may be established by Payer from time to time; and (e) has no defect, error, or other impropriety that may prevent timely processing."
Claims Submission			
Payers typically require Providers to submit claims for payment within 60-180 days from the date a service is rendered, and some Payers impose severe penalties for late claims submission. The number of days to submit a claim should be clearly articulated in the Agreement, and Providers should not be penalized for claims filed after the deadline if there is just cause for the delay (e.g., coordination of benefits, acts beyond Provider's control, or an inability to identify the patient as a Covered Individual).	"Provider will submit Clean Claims for payment within 90 days from the date that services are rendered. Claims received after this 90-day period will be denied for payment, except for claims that involve a third-party payer. If Payer is not the primary Payer, then the 90-day filing limit will begin on the date Provider receives the claim response from the primary Payer."	"Provider shall submit claims for reimbursement no later than 90 days from the date the services are rendered or, involving a third-party payer or coordination of benefits, from the date the claim response is received from a primary Payer. Provider acknowledges and agrees to a 20% reduction in amounts due the Provider under the Agreement if the Provider submits claims for which the Payer is primary more than 90 days but no later than 180 days from the date of service and that Payer may deny claims for which Payer is primary if such claims are not submitted within 180 days from the date of service, unless Provider demonstrates just cause for the delay. The foregoing notwithstanding, no claim or payment shall be denied or reduced based upon a failure to submit a claim within a designated period if the delay resulted from: (a) an act or omission of Payer or of any third	"Provider shall submit claims for billable Covered Services within one year from the date of service or, in those instances in which Payer is the secondary Payer, one year from the date of service or __ days from the date that Provider receives notice of payment decision from the primary Payer, whichever is later. Provider shall submit claims for encounter information for Capitated Services within __ calendar days from the date of service or, in those instances in which Payer is the secondary Payer, __calendar days from the date that Provider receives a notice of payment decision from the primary Payer. Payer may deny any claims submitted: (a) after one year from the date of service; (b) in those instances in which Payer is the secondary Payer, one year from the date of service or __ calendar days from the date upon which Provider received notice of payment decision from the payment Payer, whichever

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
		party and beyond Provider's control; or (b) the inability to properly identify the patient as a Covered Individual through no fault on the part of Provider."	is later; or (c) greater than __ calendar days after Payer has requested additional claim information from Provider."
Timely Payment of Claims			
Providers should ensure the Agreement includes a provision requiring Payers to pay Clean Claims within a given time period (e.g., 30 days from receipt of the claim). Medicare Advantage Organizations are required to pay 95% of Clean Claims submitted by contracted Providers within 30 days of receipt. Many states also have "Prompt Pay" requirements for HMOs and/or health plans.	"Payer will use best efforts to make payment within the timeframes set forth in the Provider Manual."	"Where Payer is the primary Payer, Payer shall pay Provider for Covered Services provided to Covered Individuals as set forth under Exhibit __ (fee schedule) within __ days after receipt of a Clean Claim. Where Payer is the secondary Payer, Payer shall pay Provider within __ days after receipt of a Clean Claim and a notice of payment decision from primary Payer."	"Payer shall use reasonable efforts to process Clean Claims within __ calendar days of receipt."
Coordination of Benefits/Subrogation			
"Coordination of Benefits" occurs when an individual is covered by multiple Plans and Payers must allocate payment responsibility for a particular claim. "Subrogation" occurs when an individual receives Covered Services resulting from an injury or condition caused by a third party's negligence or a work-related occurrence. These Payers typically pay higher rates for Covered Services than those negotiated by the Network or Plan. Therefore, Providers should try to prevent being contractually prohibited from collecting or	"Provider agrees to cooperate with Payer regarding subrogation and coordination of benefits and to notify the Plan promptly upon learning that a Covered Individual's claim may involve coordination of benefits or subrogation. When a claim is subject to payment by two or more sources, and Payer is not the primary source, payment for a Covered Service shall be based upon Payer's rate for the service reduced by any amount paid for the service by the other source(s). Provider shall not bill the Covered Individual for the difference between the fees set	"If Payer has primary responsibility for payment, Payer shall reimburse Provider the amounts due under this Agreement without delay or offset payments due or received from any party with secondary responsibility. If Payer has secondary responsibility for payment, Provider may collect combined payments from all Payers in amounts up to, but not exceeding, Provider's full billed charges. Payer, however, shall have no obligation to pay Provider in excess of the amount payable under this Agreement in the absence of other coverage."	"Provider agrees to cooperate with Payer in the collection of reimbursement from third parties for purposes of subrogation. When a Covered Individual is covered for services rendered by Provider under any other legal or contractual entitlement, Payer may be entitled to any sums recovered from such entities, consistent with federal and state laws."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
retaining any amounts paid by the other third-party Payer(s) in excess of Plan rates. State law often dictates both coordination of benefit obligations and subrogation rights.	forth herein and Provider's billed charges."		

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
PAYMENT			
Fee-for-Service			
Providers should analyze discounted fee clauses and fee schedules on a case-by-case basis, as agreements with Payers who will provide access to larger patient volumes may justify larger discounts and/or lower rates. Note that although fee-for-service remains a common payment method, we expect many Payers and Providers to move toward value-based or bundled payments. Payment provisions may need to be updated accordingly.	Discounted Fees. "Payer shall pay to Provider an amount equal to __% of Provider's usual and customary charges for Covered Services." Fee Schedule. "For Covered Services, Payer shall pay to Provider the amounts specified in the Provider Fee Schedule attached hereto as Exhibit __."		"Payer shall pay to Provider an amount equal to the lesser of: (a) the fee amount set forth in the Medicare Fee Schedule; or (b) __% of Provider's usual and customary charges for Covered Services as set forth on Exhibit __ attached hereto [Provider fee schedule] rendered by Provider to Enrollees. Any changes in the Medicare Fee Schedule during the course of a given Agreement year shall be automatically applied on a retroactive basis to January 1 of the current Agreement year."
Case Rates			

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
A "case rate" is a flat fee for a patient's treatment based on the presenting diagnosis. The fee encompasses all services required for the patient during a specified period of time or a single episode of care. Evaluating case rates requires Providers to estimate the average cost per case for each diagnosis code. It is very important to clarify which items and services are included within the case rate. Because a case rate may not adequately account for unanticipated therapy visits or a variation in the intensity of services, Providers should seek to include a mechanism to address outliers.		"Payer shall pay to Provider the Case Rate listed in Schedule __ based on the ICD-10 code to which the Covered Person is assigned for all Covered Physical Therapy Services rendered to the Covered Person from the date of admission to the date of discharge (the" Episode of Care"). The Case Rate specifically excludes (insert the specified items and services to be excluded) and/or the services provided in excess of the Charge Outlier Threshold (as defined). " "Charge Outlier Threshold shall mean if the total charges for the Episode of Care are greater than 150% of the relevant Case Rate, then the payment for such claim shall be equal to the relevant Case Rate plus 75% of the total charges for Covered Services in excess of 150% of the relevant Case Rate."	""Payer shall pay to Provider the Case Rate listed in Schedule __ based on the ICD-10 code to which the Covered Person is assigned for the Episode of Care (as defined). The Case Rate includes all Covered Services rendered to the Covered Person provided by Provider during the Episode of Care."
Most-Favored Nation Status			
A "most-favored nation" clause requires Provider to ensure that the contracted Payer receives pricing that is no greater than that paid by other Payers. Many states have banned most-favored nation clauses. Providers should be aware of their state law and seek to exclude a most-favored nation clause from an Agreement.	"Provider represents and warrants that it has not agreed to accept from any other Payer a reimbursement rate that is less than what is offered by Payer under this Agreement. If Provider offers a better reimbursement rate to any other Payer, Provider must provide prior written notice of such an offer to Payer and give Payer the option to accept the reduced reimbursement rate. Thereafter, at Payer's option, Payer may accept the reduced		*See Common Provision.*

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
	reimbursement rate or it may terminate the Agreement immediately upon written notice to Provider."		
Audit Rights			
Typically, a managed care contract gives Payers broad authority to audit Provider's medical records and claims to determine the medical necessity and appropriateness of the services provided. Payers will declare and seek recoupment for any overpayments discovered during the audit. Therefore, Payer's audit rights should be limited to a reasonable time and scope. Additionally, Provider should be entitled to receive a copy of the audit results and to recoup any underpayments discovered as a result of the audit.	"Payer or its designee shall be entitled to audit, inspect and examine Provider's documentation reasonably related to Provider's performance under the Agreement."	"Upon __ business days' notice and during normal business hours, Payer shall have the right to examine and audit Provider's records that directly relate to claims paid within __ months of the date of notice. Such audits will be conducted in a manner as to cause minimal disruption to the business of Provider. Payer shall provide to Provider a summary of the final results of such audit within __ days from completion of the audit and a complete copy of the audit report, upon request."	"Provider acknowledges and agrees that Payer or its designees shall have the right to audit, evaluate, and inspect any pertinent books, contracts, computer, or other electronic systems, including medical records and documentation, related to Provider's services hereunder. This right shall exist through 10 years from the date of termination or expiration of this Agreement, or the date of completion of any audit, whichever is later."
OVERPAYMENTS/UNDERPAYMENTS			
Overpayments			
"Overpayments" should be clearly defined in the Agreement so Providers know what will need to be repaid.	"Overpayment means any payment or portion thereof that was made by Payer to a Provider for which such Provider had no entitlement or that was made in excess of the amount due under this Agreement."		"Overpayment means: (a) any erroneous or excess reimbursement received by Provider as the result of Payer's application of an incorrect payment rate; (b) any duplicate payment for the same Covered Service; (c) any payment for services furnished to a patient who was not an Enrollee on the date of service; or (d) any payment that was made contrary to any of Payer's payment policies or procedures."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
Underpayments			
"Underpayments" are not typically defined in Provider agreements. However, it is important for Providers to include a provision allowing for remediation of any underpayments made under the agreement.		"Underpayment means any payment or portion thereof that was made by Payer to a Provider in an amount less than the amount due under this Agreement."	
Payment Corrections			
Many Agreements address only Payer's recoupment of overpayments. They should also include a mechanism for Provider's recoupment of underpayments. Any time limit for asserting such claims should be applied uniformly (i.e., if Provider must assert claims of underpayment within X months, then Payer should have the same period of time to assert claims of overpayment).	"Provider shall refund to Plan all duplicate or erroneous claim payments regardless of cause, with or without request from Payer. In lieu of a refund, Payer may offset future claim payments."	"Either party may request an adjustment to correct an overpayment or underpayment by giving the other party written notice within 6 months after the date upon which the claim at issue was paid, together with substantiating documentation. If the parties do not reach agreement on the requested adjustment within __ business days after the written request for adjustment was made, then the aggrieved party may initiate a formal appeal in accordance with Section __. Within 30 days after the final determination of the existence and amount of an overpayment or underpayment, the liable party shall pay the adjustment in full. Payer shall not be permitted to offset any overpayment against any current amount due unless Provider specifically agrees in writing to such offset or fails to refund the overpayment within the 30-day period specified above."	*See Common Provision*.

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
Payer Recoupment by Set-Off			
A "Set-Off" provision allows Payer to recoup any amount it allegedly overpaid to Provider by deducting such amount from any payments Payer owes (or will owe) to Provider. Providers should seek to limit this right by prohibiting Payers from setting off disputed overpayments during the dispute resolution process.	"Payer shall be entitled to offset against any payments due and payable to Provider under this Agreement an amount equal to any overpayments made by Payer to Provider."	"Payer shall have no right or authority to set off the amount of any alleged erroneous payment or overpayment against any amounts otherwise owed to Provider by Payer." *Alternative*: "If Payer reimburses Provider for services that Payer determines, after reasonable investigation, are overpayments, Payer may send a written demand for recoupment setting forth the amount of the overpayment and the reason for the recoupment. If Provider fails to repay any undisputed overpayment within 45 days from receipt of the demand, Payer may set off such amount(s) against any other amount(s) owed to Provider by Payer. However, if Provider disputes the overpayment, by written objection sent within 30 days from receipt of Payer's demand, Payer shall not offset any disputed amount(s) during the pendency of the dispute resolution process."	"If Payer reimburses Provider for services, supplies, or products that Payer determines, in its sole discretion, are not Covered Services, were not rendered to a member, which represent a duplicative billing, an overpayment, or an incorrectly made payment due to coding, billing, preauthorization, or payments that are calculated to cover the services of Providers other than Provider which Payer has been advised remain unpaid, or any other violation of a policy or procedure of Payer relating to claims submission, claims payment or billing matters, Payer may, in its sole discretion, set off such amount(s) against any other amount(s) owed or that may be owed in the future."
HOLD HARMLESS			
A provision that prohibits Provider from holding a Covered Individual liable for Payer's obligation(s) is included in virtually all Provider Agreements. CMS and/or the state mandates that such a provision be included by Medicare Advantage,	"Provider shall not hold any Covered Individual liable for payment of any fees that are the legal obligation of Payer. In no event, including but not limited to non-payment by Payer, Payer's insolvency, or breach of this Agreement, shall Provider bill,		"Provider shall not hold any Enrollee liable for payment of any fees that are the legal obligation of Payer. In no event, including but not limited to non-payment by Payer, Payer's insolvency, or breach of this Agreement, shall Provider bill,

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
Medicaid, and other governmental plans.	charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Enrollee or person other than Payer acting on an Enrollee's behalf, for services provided pursuant to this Agreement. The foregoing shall not prohibit collection of supplemental charges or copayments on Payer's behalf made in accordance with the terms of any agreement between Payer and its Enrollees."		charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, an Enrollee or person other than Payer acting on an Enrollee's behalf, for services provided pursuant to this Agreement. The foregoing shall not prohibit collection of supplemental charges or copayments on Payer's behalf made in accordance with the terms of any agreement between Payer and its Enrollees."
INSURANCE			
An Agreement should require both parties to carry professional liability insurance coverage, general liability coverage, and directors and officers insurance coverage, as applicable. Many states have statutory requirements governing the types and coverage limits of insurance to be maintained by Providers and Insurers. Generally, the Agreement should not require Providers to carry professional liability coverage in an amount exceeding a statutorily required amount.	*Provider Coverage:* "Provider shall self-insure or maintain policies of general liability and other insurance in amounts acceptable to Payer as shall be necessary to insure against claims for damages occasioned directly or indirectly in connection with the use of any property and facilities provided by Provider and activities performed by Provider in connection with this Agreement. Evidence of all such policies shall be provided to Payer on request. Provider shall notify Payer within __ days of any change in coverage." *Network Coverage:* "Network shall self-insure or maintain coverage of comprehensive general liability and other insurance as shall be necessary to insure Network and its agents and employees, acting within the scope of their duties, against claims, liabilities or judgments arising out of the performance of any service provided	*Neutral:* "Throughout the term of this Agreement, each party shall maintain, at its sole cost and expense, general liability and professional liability insurance coverage through commercial insurance or a self-insurance program in the amount of $__ per claim and $__ in the annual aggregate, as may be necessary to protect the party and its respective employees, agents, or representatives in the discharge of its or their respective responsibilities and obligations under this Agreement. A party shall provide written evidence of such insurance upon the request of the other party." *Provider-Friendly Addition:*	*Unilateral:* Some Agreements address insurance coverage requirements only for Providers and fail to include reciprocal requirements for Network/Payer.

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
	under this Agreement by Network, its agents, or employees."	"Provider shall not be responsible for any actions of the Payer, including without limitation, any liability relating to medical necessity, utilization review or coverage decisions or determinations made by the Payer relating to a Covered Person. "	

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
RECORDS, MAINTENANCE, AND ACCESS			
The contract should clearly establish: (i) who owns the physical records re a patient; (ii) who is responsible for obtaining patient consent for disclosure of the records; (iii) the terms on which such information will be shared; and (iv) who will bear the cost of copying records.	"Provider shall prepare and maintain appropriate medical, financial, and administrative records related to Covered Services rendered under this Agreement. All of Provider's records on Covered Individuals shall be maintained in accordance with prudent record-keeping practice and as required by applicable federal and state laws and regulations." "To the extent provided by law, the parties agree to keep confidential and not disclose patient identifiable information to any third party, without the prior written consent of the Covered Individual, except that information required for utilization management, quality improvement and claims adjudication will be released to Payer or its designees."	"Upon enrollment and before requesting medical records from Provider, Payer shall obtain from Covered Individual, or his/her legal representative, written authorization for release of Covered Individual's medical records in accordance with applicable state and federal law, and Payer shall hold Provider harmless from any liability in connection with Provider's release of medical records to Payer and any subsequent disclosures by Payer." "Payer will pay for copies of records at a rate of $0.__ per page, unless a different rate is specified under state law."	"Provider shall provide Payer access to and shall obtain any Covered Individual's consent required in order to authorize Provider to provide Payer access to, medical, financial, and administrative records relating to the care provided to the Covered Individual, for any purpose required or permitted under this Agreement." "Upon request, Provider, at Provider's sole expense, shall forward a copy of records relating to the provision of services to Covered Individuals in a timely manner to Payer, the Covered Individual, other treating health care Providers, and/or agencies of the government."
Providers must allow Payers and certain regulatory agencies access to its records under certain circumstances. However, Providers can impose reasonable restrictions on such access.	"Provider shall permit Payer or its designees, and agencies of the government, upon reasonable notice during normal business hours, access to any books, documents, and records related to Covered Individual's medical and billing information as may be reasonably required by the Plan in carrying out the purposes of the Agreement and as required by laws and regulations."	"Upon seventy-two (72) hours advance notice, Provider shall permit Payer, its designated representatives, and/or the Comptroller General, the Secretary of the Department of Health and Human Services, the State Department of Health, and their designated representatives ("Regulatory Agencies"), access to Provider's books and records related to Covered Individuals' medical and billing information, as reasonably required to carry out their respective responsibilities and programs."	"Upon request, Provider shall: (i) provide Payer or its designees with copies of appropriate documentation related to Covered Services rendered; and (ii) permit Payer or its designees, and representatives of local, state, and federal regulatory agencies ("Regulatory Agencies"), the right to inspect, review, audit, and make copies of all records maintained by Provider related to Covered Services rendered, for any purpose related to this Agreement or as otherwise required by Payer."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
LEGAL & REGULATORY COMPLIANCE			
The agreement should contain a provision requiring both parties to adhere to applicable laws and regulations. Be alert to a provision that imposes a unilateral compliance requirement for Providers or compliance with overly broad or inapplicable requirements.	*Neutral example:* "Payer and Provider agree to comply with all requirements of the law relating to their obligations under this Agreement. From time to time, legislative bodies, boards, departments, or agencies may enact, issue, or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all said laws, rules, or regulations to the extent applicable and to cooperate with the other to carry out any responsibilities placed upon the other by said laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this Section and any other provision in this Agreement, this Section shall control."		"In the event a legislative or regulatory body, agency, board, or department enacts or issues a law, rule, or regulation pertinent to this Agreement, and upon written notice to Provider by Payer of such event, Provider agrees to immediately abide by all such laws, rules, or regulations and to cooperate with Payer to carry out any responsibilities placed upon Payer by said laws, rules, or regulations."
AMENDMENT			
Amendment of Agreement			
Providers should beware of clauses giving Payer a unilateral right to amend the terms of the Agreement, the fee schedule, or Payer's policies (including those that might adversely affect Provider's compensation) upon notice. Optimally, all amendments would require mutual written agreement. However, at minimum, Provider	"Payer may amend this Agreement, the applicable fee schedules and any attachments thereto by providing notice to Provider of not less than __ days. If Provider decides not to accept the amendment, Provider has the right to terminate this Agreement by providing written notice within __ days from Provider's receipt of the proposed	"This Agreement, including but not limited to any pricing schedules, attachments, or addenda, may be amended at any time during the term of the Agreement only by mutual written consent of the duly authorized representatives of Payer and Provider."	"Plan may amend this Agreement, the applicable fee schedules, the Provider Manual, and any attachments or addenda, upon notice to Provider."

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
should have a post-notice period in which to object to the amendment and terminate the Agreement, if necessary.	amendment from Payer. Provider's termination will take effect __ days from the date of such notice. Failure to timely provide such notice will constitute acceptance of the amendment by Provider. If Provider elects to terminate pursuant to this provision, the amendment will not go into effect as to Provider. "		
At minimum, the agreement should allow for termination or renegotiation in the event of material changes.		"In the event any material changes to this Agreement adversely affect Provider, Provider may terminate this Agreement upon 60 days' written notice if the parties are unable to renegotiate the Agreement on mutually agreeable terms within such 60-day period."	
Amendment for Regulatory Compliance			
Payers often carve out a unilateral right to amend the terms of the Agreement to ensure compliance with changing laws or regulations. However, Provider should, at minimum, be notified in writing of these changes and have an opportunity to terminate the Agreement if the amendment is unreasonable.	"This Contract may be unilaterally amended by Payer upon notice to Provider to comply with applicable regulatory requirements."	*Proposed Addition:* "Payer will provide at least __ days' written notice of any amendment to comply with regulatory requirements, unless shorter notice is necessary to accomplish regulatory compliance. Upon request by Provider, the parties and their legal counsel will discuss the basis for the regulatory amendment. In the event Provider disputes the need for the regulatory amendment and the parties are unable to reach a mutually agreeable resolution within a 60-day period, Provider may terminate the Agreement. The proposed amendment shall not take effect while the dispute resolution process is pending."	

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
Material Amendments to Provider Manual			
Payers often incorporate Payer's policies and procedures and Provider Manual into the agreement. Therefore, the Provider Manual should be reviewed before signing the Agreement. Additionally, Payers typically retain the right to amend their policies and procedures at any time and often notice is simply posted on Payer's website. These policies can materially affect the provision of and payment for Covered Services. Thus, at minimum, Providers should require written notice of any amendments that would materially affect Payer's payment for Covered Services and a post-notice period in which Provider may terminate the Agreement, if the amended policy is unacceptable.	"Provider agrees to participate in, cooperate with, and abide by the terms of the Provider Manual and other Payer policies and procedures that have been communicated to Provider by Payer."	"Provider agrees to abide by Payer's written policies and procedures as set forth in the Provider Manual and as otherwise provided to Provider by Payer (collectively, the "Policies"). Payer will provide Provider with __ days' written notice of any material changes to the Policies. In the event Provider believes that a change to the Policies would result in increased costs or decreased reimbursement to Provider, Provider shall provide written notice objecting to the change and explaining the projected financial impact to Provider from the change. In the event Provider sends such a notice, Provider and Payer agree to promptly work in good faith to resolve the issue. If the issue is not resolved to Provider's satisfaction, Provider may terminate this Agreement upon __ days' written notice to Payer."	*See Common Provision.*
NOTICE			
The Agreement should specify when written notice is required as well as how and to whom such notice will be delivered. Generally, critical notices should be by a mechanism that will provide evidence of delivery. Provisions that allow Payers to deliver notice by facsimile, email, or posting on Payer's website is not optimal.	"Any written notice required to be given pursuant to this Agreement shall be delivered by electronic mail, by facsimile, by hand, or sent postage prepaid by regular mail to the parties at the addresses set forth on the signature page, except that notice of breach of contract or termination shall be either hand delivered or sent postage prepaid by certified mail, return receipt	"Notices or communications herein required or permitted shall be given to the respective parties by registered or certified mail, return receipt requested, or by hand delivery at the following addresses unless either party provides written notice of a different address for such notices: [*Payer address and attention*] [*Provider address and attention*]."	*See Common Provision.*

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
	requested, to the parties at the addresses set forth on the signature page. Such addresses may be changed by written notice to the other party. Notwithstanding the foregoing, Payer may post updates to policies, programs, and procedures on its website."		

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
ASSIGNMENT OF AGREEMENT			
Agreements often allow Payer to assign its rights and responsibilities to another entity, at will, but prohibit Provider from doing the same, absent Payer's written consent. Providers should consider whether a unilateral restriction is acceptable in light of Provider's circumstances. It is generally preferable to have any restrictions on assignment to be reciprocal.	"Neither Payer nor Provider can assign any of its respective rights, duties, or obligations under this Agreement without prior written consent of the other party, provided, however, nothing in this Agreement shall prohibit Payer's assignment of this Agreement to any affiliate or successor in interest of Payer, nor the delegation of any administrative obligations hereunder to any other entity."	*Neutral:* "Neither Payer nor Provider can assign any of its respective rights, duties, or obligations under this Agreement without prior written consent of the other party." *Alternative:* "Neither Payer nor Provider can assign any of its respective rights, duties, or obligations under this Agreement without prior written consent of the other party, provided, however, nothing in this Agreement shall prohibit either party from assignment of this Agreement to any affiliate or successor in interest of the assigning party, nor the delegation of any administrative obligations hereunder to any other entity."	*See Common Provision.*
CHANGE OF CONTROL			
A change of control or ownership of either party's business may result in the other party entering into a relationship with an entirely unknown quantity. This risk can be controlled by including a provision that upon a change of control of one party, the other party has the right to terminate the Agreement within a specified time period.	*See Payer –Friendly Provision.*	"Payer shall provide Provider 30 days prior written notice of any proposed merger or acquisition of Payer. Provider can, at any time within __ days of receipt of such notice , terminate this Agreement upon __ days written notice to Payer. Any such termination will have no effect upon the rights and obligations of the parties arising before the effective date of termination."	"If Provider sells all or substantially all of its assets, or changes management, or materially changes its service area, business or operations, Payer may limit this Agreement to the Providers operations and business or corporate for, in existence before the occurrence of the any of the above-described events."
CHOICE OF LAW/VENUE			

GENERAL GUIDANCE	COMMON PROVISION(S)	PROVIDER-FRIENDLY PROVISION(S)	PAYER-FRIENDLY PROVISION(S)
Optimally, the Agreement should be governed by the laws of the state in which the Covered Services are provided. This is generally the state in which Provider is licensed and Provider is, thus, subject to this state's laws, regulations, and oversight. Likewise, any litigation or arbitration arising under the Agreement should be conducted in a court in the county where Covered Services are provided. Otherwise, Provider could incur considerable expense and inconvenience by having to pursue or defend an action in another state.		"This Agreement will be governed by and construed in accordance with the laws of the state of [*the state in which Provider renders services*], and any claim related to this Agreement shall be resolved in the courts located in [*the county and state in which Provider is located*.]"	"This Agreement shall be governed by, and construed in accordance with, the laws of [*the state in which Payer's principal office is located*], and any claim related to this Agreement shall be resolved in the courts located in ["*the county and state in which Payer's principal office is located*]."
WAIVER OF LEGAL PRESUMPTION			
In the event of a contract dispute, there IS A LEGAL PRESUMPTION THAT an ambiguous provision should be construed against the party who drafted it. Many Payers insert a provision that results in the waiver of this presumption. Unless Provider has had the benefit of meaningfully negotiating the terms of the Agreement, Provider should not agree to waive the presumption.	*See Payer-Friendly Provision.*		"This Agreement shall not be construed against the Party preparing it but shall be construed as if both Parties jointly prepared the Agreement, and any uncertainty and ambiguity shall not be interpreted against any one Party."