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CONTRACT REVIEW

2009 BLUE CROSS BLUE SHIELD OF MINNESOTA AWARE PROVIDER SERVICE AGREEMENT

In this document, we provide a summary of the changes made to the Blue Cross and Blue Shield of Minnesota (BCBS) 2009 Aware Provider Service Agreement (Agreement). Please note that this summary is not intended to be a comprehensive legal analysis, and it is not a substitute for legal and accounting advice. If you are interested in determining the specific application of this Agreement to your practice, or in negotiating alternate terms of the Agreement, you will need to contact your own attorney, accountant or consultant.

There are many changes in the 2009 Agreement, and some are significant. We urge our members to review all of these changes carefully as some may merit contractual negotiations.

This Agreement will become effective when accepted and signed by Blue Cross. It incorporates the provisions of your original signed agreement and all renewal amendments to date.

Either party may elect to terminate the Agreement by giving notice of termination within 30 days of the issuance of the Agreement. If you wish to give notice of termination, you must do so in writing on your corporate/partnership letterhead, appropriately addressed to Blue Cross as provided in the Agreement. The Agreement states that, "notice (must be) provided to Blue Cross within 30 days of the date Blue Cross issued the renewal or amendment." (VIII. A.) Blue Cross

has previously stated that despite this language, a Provider can terminate the contract at any time.

Changes in the 2009 Agreement are as follows:

Definitions

The definition of "Disclosing Entity" was added. (II. D.)

The definition of "Health Care Professional" or "Provider" was amended with the addition of subsection 2 which states, "an individual or entity which is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services." (II. E.)

The definition of "Managing Employee" was added. (II. G.)

The definition of "Ownership Interest" was added. (II. L.)

The definition of "Person with an Ownership or Control Interest" was added. (II. M.)

The definition of "Significant Business Transaction" was added. (II. Q.)

The definition of "Special Needs Basic Care" was added. (II. R.)

Authority and Covenants

Medical Records. The time that Providers must maintain all subscriber medical records was increased from 6 years to 11 years. (III. F.) Note: CMS requires that Providers retain medical records of Medicare enrollees for 10 years (not 11.) (See: http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr422.504.pdf.) It is unclear why Blue Cross requires an additional year.

Patient Safety Policies. Providers are required to develop and implement two new patient safety measures that are consistent with accreditation or statutory requirements: 1) "patient safety polices to systematically reduce medical errors which may include systems for reporting medical errors," and 2) "process and system analysis to discover and implement error-reducing technologies." (III. J (2) and (3).)

Minnesota Department of Human Services Disclosure Requirements. This section is new. It requires that Providers search the Medicare Exclusion Database (MED) or the Office of Inspector General List of Excluded Individuals/Entities (LEIE) databases on a **monthly basis** to ensure that no Providers or other persons managing employees are excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act or have been convicted of a criminal offense related to involvement in a Medicare, Medicaid or Title XX services program. (III. O. 1.)

To access LEIE databases, go to <http://oig.hhs.gov>, click on “Exclusions Database,” then click on either “Online Searchable Database” or “LEIE Downloadable Database.”

This section of the Agreement also requires Providers to **report the following information to Blue Cross prior to July 1, 2009:** 1) subcontractors with which Provider has had a business transaction totaling more than \$25,000 between July 1, 2008 and July 1, 2009 and 2) significant business transactions between Provider and any wholly owned supplier or between Provider and subcontractors during the five-year period ending on July 1, 2009. (III. O. 2.) This requirement stems from CMS’ Program Integrity Requirements under 42, CFR, Section 455.015(b), which were created to combat Medicaid Provider fraud and abuse.

Finally, this section requires Providers to **report the following information to Blue Cross prior to July 1, 2009:** 1) the name and address of each person with ownership or control interest in a disclosing entity or in any subcontractor in which a disclosing entity has a direct or indirect ownership of 5 percent or more and 2) a statement as to whether any person with an ownership or control interest is related to any other person with an ownership or control interest such as a spouse, parent, or sibling; and 3) the name of any other organization in which a person with an ownership or control interest in a disclosing entity also has an ownership or control interest. (III. O. 3) This section stems from CMS’ Medicare Advantage Contract Requirements, which can be viewed at: <http://www.cms.hhs.gov/manuals/downloads/mc86c11.pdf>.

Provider Reimbursement

Payment Amount. The sentence “Reimbursement may be affected by Provider certification or Blue Cross credentialing criteria, as detailed in these provisions” is new.

The 2008 Aware Provider Service Agreement stated, “When the negligence, omission or error on the part of Provider results in the Subscriber incurring additional medical expenses, no payment will be made by Blue Cross for, nor shall Provider bill either Blue Cross or the Subscriber for, said additional medical expenses.” (2008 Aware Provider Service Agreement, IV. A.) Last year, the MMA, EMMS, WMMS, and MMGMA worked with Blue Cross to clarify this language (“negligence, omission or error” were not defined, yet they would result in a denial of payment.) Although these terms are still not defined, Blue Cross added the following language to this provision: **“The National Quality Forum has defined certain events as serious preventable medical errors, and these are the situations for which no payment shall be made by Blue Cross or the Subscriber. A listing of these events can be found at <http://www.qualityforum.org>. This listing will be updated periodically by the National Quality Forum.”** (IV. A.) Note: the National Quality Forum’s list of medical events has been incorporated into Minnesota’s Adverse Events law (Minn. Stat. § 144.7067). To see the current list of preventable medical errors, go to: <http://www.qualityforum.org/pdf/reports/sre/txsrepublic.pdf>.

Minnesota Health Care Programs.

With regard to health services provided to Minnesota Health Care Programs subscribers, Blue Cross will now pay Providers for health services **“at the lesser of 90% of the Provider’s billed**

charges or 103% (as opposed to 105%, as it has done in years past) of the appropriate public program fee schedules, as published by the Department of Human Services (DHS).” (IV. B.) Note that this could be a very substantial reduction for some Providers when coupled with legislative changes that reduced the Fee-For-Service fee schedule by 5% for many physicians.

The following language was also added: “In the event that CMS or DHS has published rate or methodology changes, Blue Cross shall implement such changes within ninety (90) days of the date that the change is effective or by the first day of the following calendar quarter after the changes are released, whichever is later, unless otherwise specified by the state or federal regulatory agency. Provider shall not request adjustments and Blue Cross shall not adjust any previously paid claims affected by such changes prior to the implementation. All other rates in this Agreement shall continue to apply unless changes are mutually agreed to in writing by both parties.” (IV. B.)

Note: There is no explicit requirement in this Agreement for Blue Cross to notify Providers of any changes to rates or payment methodologies. Because Blue Cross is disclaiming any obligation to make reimbursement adjustments back to the effective date of a rate or methodology change, the impact on Providers will vary depending on whether such changes affect reimbursement positively or negatively for each Provider.

CPIU Payment Increase. Blue Cross states: “For those services that are paid at a percent of charge, Blue Cross will limit its annual payment increase to the Maximum Increase (defined as ‘the charge amount equal to the lesser of 3.5% or the percent change between the

June CPIU index level of the previous year's data and the June CPIU index level of the current year's data'). This year, Blue Cross clarified this section, stating, "CPIU means the Minneapolis/Saint Paul Average All Items Consumer Price Index for Urban Consumers as published by the U.S. Department of Labor, Bureau of Labor Statistics." It has also stated that it will use the data issued in June (as opposed to September as it has done in years past) to determine the percent change between the previous year's data and the index level of the current year. (IV. C.) A copy of the June, 2008 Consumer Price Index can be viewed at: http://www.bls.gov/news.release/archives/cpi_07162008.pdf. Note that in past years, the range of CPIU has been above 3.5% and below 0% (negative).

There were three additional reimbursement changes noted in Blue Cross's Summary of Changes to the 2009 Aware Provider Service Agreement. Providers may also refer to the fee schedule mailed to them by Blue Cross for other reimbursement information. The three reimbursement changes included:

Implementation of the 2009 Relative Value Units (RVUs): Blue Cross has stated, "Starting July 1, 2009, Blue Cross will be using the CMS transitional RVUs with site of service differential, as they were published in the Federal Register on January 13, 2009, and implemented by Blue Cross as the basis for allowance creation for professional-based services." **Providers are strongly encouraged to check their practice's billing frequencies to determine whether this change will affect their expected reimbursement.**

Unlisted Injectable Drugs: **Injectable drugs that are billed with an unlisted code, ("Unclassified," "NOC," or "NOS") must include a National Drug**

Code number and short description of the drug provided to the patient. Codes submitted with this information and an unclassified code will be priced at 82% of the average wholesale price, as determined by Blue Cross' pricing source. If the Provider wishes to appeal, the Provider must submit the actual invoice for the drug that is being appealed. An appeal does not guarantee a reimbursement adjustment.

Unlisted DME Services: Reimbursement for unlisted DME codes will default to 55% of Provider's billed charge unless the purchase invoice detailing Provider's cost is submitted with the billing. If the purchase invoice is included, reimbursement will be based on the purchase price, plus 15%.

Provider Participation Requirements

Contracted Employees. This section is new. It says, "In the case where Provider contracts with a Health Care Professional at a different rate than that Health Care Professional is paid through employment by another Provider holding and Agreement with Blue Cross, the Health Care Professional will be reimbursed at the rates of the Provider in which the Health Care Professional is employed." (VI. E..) Example: A health care professional is legally employed by Provider A. Provider A holds an Agreement with Blue Cross, and the health care professional rates are determined by the Blue Cross Agreement. The health care professional contracts with (but is not legally employed by) Provider B. Provider B also holds an Agreement with Blue Cross, and the rates of the health care professional's services are different than the rates in Provider A's Agreement. The health care professional will be compensated at Provider A's rates because Provider A is his/her legal employer.

Amendment and Termination, Arbitration

Termination. Blue Cross has indicated that Article XI.C. of the Agreement provides correct information on how Providers may provide effective notice to Blue Cross. (VIII. B. 6.)

Arbitration. When the parties of the Agreement are involved in arbitration, the expenses and fees of the sole arbitrator of the arbitration proceeding will be shared equally by each of the parties. Blue Cross has stated this year that "if the Provider prevails in the arbitration . . . Blue Cross shall pay all expenses and fees related to the arbitration." (VIII. D.)

Confidentiality; Non-Interference

Remote Access Services. This section has been removed from the Agreement. It is now located in Chapter 1, At Your Service, of the Blue Cross Provider Policy and Procedure Manual. Note that Policies contained in the Manual remain binding on Providers.

The Medicare Programs Amendments to the Agreement include:

Provider Obligations

Compliance. In this section, the Provider must comply with Blue Cross' Provider Policy Manual and all applicable federal, state, and local laws, rules and regulations including the following new requirement: "A comprehensive fraud and abuse plan to detect, correct and prevent fraud, waste and abuse (including compliance with any related CMS training requirements), in accordance with 42 C.F.R. § 423.504 (b)(4)(vi)(H)." (B.2.) To view the regulation, go to: http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr423.504.pdf.

Initial Health Assessment. This section was changed to require Providers to conduct an initial health assessment of each newly enrolled Medicare member **within one year** of the new enrollment (the former requirement was 90 days.) (B.9.)

The 90-day limit still applies for the Secure Blue/Minnesota Senior Health Options programs.

Obligations of First Tier, Downstream and Related Entities. This section is new. It defines “First Tier Entity,” “Downstream Entity” and “Related Entity.” (B. 12.)

The three defined entities must allow the Department of Health and Human Services, the Comptroller General or their designees the **right to audit, evaluate and inspect any books, contracts, records (including medical records), and documentation of the three entities involving transactions related to CMS’ contract with the Part D Plan Sponsor.** (B. 12. A.)

The Part D Plan Sponsor may delegate activities or functions to one of the three defined entities. (B.12. B.)

Services or activities performed by the three defined entities done in accordance with a contract or written agreement must be consistent and comply with the Part D Plan Sponsor’s contractual obligations. (B. 12. C.)

The following language may require clarification: “Upon request (not specified as “written request”), the three defined entities must produce books, contracts, records (including medical records) and documentation of Blue Cross, relating to the Part D program to either the Plan Sponsor (to provide to CMS) or to CMS or its designees directly.” (B. 12. D.)

The three defined entities must comply with all federal laws, regulations and CMS instructions. (B. 12. E.)

Compensation. There are two new sections under this article.

In the event that CMS or the Department of Human Services has published rate or methodology changes, **Blue Cross shall implement those changes within 90 days of the date that the change becomes effective or by the first day of the following calendar quarter, whichever is later, unless a date is specified by the state or federal regulatory agency.** No adjustments will be made to any previously paid claims affected by such changes prior to the implementation. All other rates in the Agreement will apply unless changes are mutually agreed to in writing by both parties. (C. 2.) There is no explicit requirement in this Agreement for Blue Cross to notify Providers of any changes to rates or payment methodologies. Because Blue Cross is disclaiming any obligation to make reimbursement adjustments back to the effective date of a rate or methodology change, the impact on each Provider will vary depending on whether such changes affect reimbursement positively or negatively.

The Agreement does not provide for any payment to a Provider in connection with physician-based incentive programs that may be available under Medicare, including the Physician Quality Reporting Initiative (PQRI). (C. 3.)

Protections for Medicare Members from Blue Cross’ Liabilities. This section is new.

Starting January 1, 2010, Blue Cross must adopt and maintain arrangements to protect its Medicare Members from incurring liability for payment of fees that are the legal obligation of Blue Cross.

Blue Cross must ensure that all contractual or other written arrangements with Providers prohibit Blue Cross’ network Providers from holding any Medicare Member liable for payment of any such fees. (D. 4. A.)

Blue Cross must indemnify the Medicare Member for payment of any fees that are the legal obligation of Blue Cross for services furnished by Providers that do not contract, or that have not otherwise entered into an agreement with Blue Cross, to provide services to Blue Cross’ Medicare Members. (D. 4. B.)

With regard to Medicare Members who are eligible for both Medicare and Medicaid, Blue Cross must specify in contracts with Providers that such Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Blue Cross must also inform Providers of Medicare and Medicaid benefits, and rules for Members eligible for Medicare and Medicaid. Blue Cross may not impose cost-sharing that exceeds the amount that would be permitted to the individual under Title XIX if the individual were not enrolled in such a plan. (D. 4. C.)

Given these requirements, the Agreement states that the Provider will agree to:

1. **Accept Blue Cross’ payment as payment in full, or**
2. **Bill the appropriate state source rather than the Medicare Member.** (D. 4. C.)

The parties will administer these requirements as stipulated in the Agreement.