

MMA / RMS / HMS / MMGMA: Contract Review of 2006 **BCBS Aware Provider Service Agreement**

In this document, we provide a summary of the changes made in the Blue Cross Blue Shield of Minnesota (BCBS) 2006 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.

This Agreement became effective July 1, 2006. It incorporates the provisions of your original signed agreement and all renewal amendments to date. Because many provisions of the Agreement remain unchanged, you may wish to review previously published reviews available online on the MMA Web site at:

www.MMAOnline.net/advocacynews/contractresourceslinks.cfm

Although this Agreement renewed automatically, either party may elect to terminate the Agreement by giving notice of termination within 30 days of the issuance of the contract. If you wish to give notice of termination, you must do so in writing on your corporate/partnership letterhead. The contract states, "notice (must be) provided to Blue Cross within 30 days of the date Blue Cross issued the renewal or amendment." (Article VIII, Section A). BCBS stated that despite this language, a provider can terminate the contract at any time. BCBS would however prefer to receive notice of termination by July 30, 2006 to avoid unnecessary administrative costs.

Definitions. The definition of "Average Wholesale Price" (AWP) was deleted from the Agreement because BCBS does not use this term in their Agreement. (Article I Section C.) The term "Medicare Advantage" was added to the Agreement and states that Blue Cross is the payor for Health Services provided to Medicare Subscribers. "Medicare Advantage Special Needs Plan" was also added and is a program whereby Blue Cross is the payor for Health Services provided to Medicare Subscribers with special needs. (Article II section G). Finally, the term, "Minnesota Senior Health Options (MSHO)" was added to the Agreement. This is a demonstration project used to create an alternative delivery system for acute and long-term care services. It integrates Medicare and Medicaid funding for persons age 65 and over who are dually eligible for Medicare and Medicaid as well as those who are eligible for Medicaid only. (Article II Section I).

Authority and Covenants. Requires that Provider provide services to Subscribers and deletes existing provision allowing Provider to determine whether to accept a Subscriber as a patient. BCBS stated that this alteration was made to support NCQA requirements. While the deletion could be interpreted as an infringement on a Provider's right to determine whether to accept a particular patient or any additional patients if the service is full, BCBS stated that this interpretation was not intended by the drafters of the Agreement. Physicians who are uncomfortable with this ambiguity are encouraged to contact their contract manager to modify this language. (Article III Section A).

Quality Improvement/Managed Care Requirements: Nondiscrimination. This provision requires Providers to “comply with quality improvement and care management requirements and procedures established by Blue Cross or the Plan Sponsor and communicated to the Provider (for example, utilization of a prescription drug formulary).” This provision was modified from the 2005 Agreement which provided more examples of requirements and procedures. Note that the requirements in the 2005 Agreement still apply to the 2006 Agreement even though specific examples are no longer listed. (Article III, Section I).

Medicare Cost and Medicare Advantage Programs. In 2005, this Section was titled, “Medicare Cost Contract or Risk Contract.” Much of this Section was modified to reflect the Blue Cross / CMS relationship. The Agreement states, “When applicable for a Medicare Cost and/or Medicare Advantage program, Blue Cross shall pay Provider according to the rates specified in such amendment for Health Services provided to Medicare members, and any such amendment shall be considered an attachment to this Agreement.” (Article IV, Section E). BCBS has stated that the amendment referred to in the language above will be used to include Providers in the network for these Medicare products, and for detailing the specific provisions affecting Providers. Physicians who do not wish to be a part of the network, or who do not accept Medicare patients are encouraged to contact their BCBS contract manager to modify this language.

Termination. Language was expanded to allow for immediate termination of the Agreement if a Medicare sanction is found against a Provider. (Article VIII, Section B.3)

HIPAA Security. This is a new provision that will require additional Provider attention and reporting. It requires Providers to implement administrative, physical and technical safeguards that reasonably and appropriately (not defined) protect the confidentiality, integrity and availability of electronic Protected Health Information (e-PHI) as required by the Security Rules. Further, Providers are required to ensure that any agent, including a subcontractor to whom it provides e-PHI agrees to implement reasonable and appropriate safeguards to protect it (not specified how this must be implemented or ensured). Finally, Providers are required to report to Blue Cross *any* security incident involving e-PHI of which it becomes aware. “Security Incident” is broadly defined, and physicians are encouraged to read it carefully. The provision specifies that physicians have no more than five (5) business days after learning of a **successful** security incident to report to BCBS. (Article X, Section D).

Trademarks/Service Marks. This provision prevents each party from using the other’s names, symbols, trademarks and service marks. With respect to advertising and promotion, the language was modified so that such names, symbols, trademarks and service marks will not be used on any party’s Web site(s) without prior written consent of the other party. (Article XII, Section B).

Reimbursement Changes. Article IV of the Agreement outlines the general reimbursement policy applicable under the Agreement. The specific fee schedule and relevant conversion factor(s) for a physician clinic are defined in the clinic-specific fee

schedule included with the Agreement mailing. Physicians are encouraged to carefully review the fee schedule in order to understand the financial impact of the payment changes on their specialty/practices.

Implementation of the 2006 Relative Value Units (RVUs). On July 1, 2006, the 2006 CMS Relative Value Units were implemented.

Pricing for Non-Participating Providers. With the exception of Durable Medical Equipment (DME), reimbursement for Non-Participating Providers is to be paid in the same way that 2005 Medicare payments were paid for all procedures and services. DME, however, will be paid at 20 percent less than the 2005 BCBS Allowance.

Coding Software Recognition of Modifier -59. Effective July 1, 2006, BCBS allowed for procedures or services to be reimbursed separately with the -59 modifier. BCBS is developing a process to monitor the usage of the -59 modifier through the use of audits. BCBS has stated that if inappropriate utilization of the -59 modifier is found, action will be taken, including but not limited to, making fee schedule adjustments. On July 14, 2006, BCBS distributed a Provider Bulletin that set forth appropriate uses of the -59 modifier. Physicians are encouraged to read this Bulletin and review their prior use of this modifier. The Bulletin has been posted on-line at: www.bluecrossmn.com.