2011 CONTRACT REVIEW

MEDICA ASSOCIATE CLINIC PARTICIPATION AGREEMENT

In this document, the Minnesota Medical Association, Twin Cities Medical Society and Minnesota Medical Group Management Association provide a summary of Medica's Associate Clinic Participation Agreement[1] which was originally drafted in September, 2009, revised in January, 2010, and amended further in September, 2010 in accordance with recent changes to state law governing health plan-provider contracts. Please note that this summary is not a comprehensive legal analysis and the information provided in this document 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 the terms of the Agreement, please discuss the matter with your attorney, accountant and consultant. This Agreement will become effective on the date that it is accepted and signed by Medica, and will automatically renew on the "Termination Date" (which varies by clinic and is set forth in Article 9 of your Agreement) on each two-year anniversary of that date unless one of the parties either defaults, or the parties were unsuccessful at renegotiation after the notice requirements were met (details discussed in summary of Article 9 below).

Article 1

Sets forth definitions for terms used in the Agreement. Items of note:

- The definition of "Benefit Contract" was replaced by the term "Benefit Plan" in Addendum I to the Agreement for self-insured plans. Under a Benefit Contract, a plan of health care coverage was issued by Medica for each Medica commercial, state and federal (including Medicare) government product. A Benefit Plan however is defined as being established by a Sponsor for its employees, dependants and other eligible persons. (Section 1.1, and Addendum 1, paragraph 1(a)). This change narrows the scope of the definition and allows for more variability between contracts to occur because Benefit Plans are tailored to meet the needs of the Sponsor/employer.

- The definition for "Contingency Reserve" or "PCR" states that the amount of Contingency Reserve withheld and the conditions for earning and payout are described in the Appendices to the Agreement but that the amount of Contingency Reserve withheld will not exceed twenty-five percent of the sums otherwise payable to Participating Providers. (Section 1.1).

- The definition of "Designated Provider" includes *but is not limited to* designated participating physicians and designated participating facilities that Medica has authorized to provide certain benefits to Members. It is unclear who else would be included in this definition.

- A definition is provided for "Primary Care Physician" however it only applies for purpose of Wisconsin-referenced provisions of the Agreement (i.e., it only applies to Wisconsin providers). A secondary definition is not provided for Minnesota-referenced provisions. (Section 1.1)

- A "Referral Authorization Form" must be in a format that has been approved by the Member's Clinic Physician or Medica. (Section 1.1).

Article 2

Sets forth Eligibility Requirements for Health Services. Items of note:

- The Verification of Eligibility section was modified in Addendum I to the

1. The Associate Clinic Participation Agreement includes Medica Health Plans (HMO), Medica Insurance Company, Medica Health Plans of Wisconsin (HMO) and Medica Self-Insured d/b/a Medica Self-Insured (TPA) as contracting entities. This Agreement is used to contract with all professionals (which includes clinics or sole practitioner practices). It encompasses all fully-insured group and individual products including Medicare, Medicaid and state government program products as well as self-insured group products. It does not include Medica's PPO network products with contracted entities, Medica Self-Insured d/b/a SelectCare, or the Medica Self-Insured Patient Choice Program.

Agreement. If the individual's coverage under a benefit plan was terminated prior to the time the services were rendered, or the services were not covered under the benefit plan, then the clinic may bill the Covered Person directly for the services. (Addendum I, 4.2.2) Note that in the original version of the Agreement, clinic *and* clinic providers were allowed to bill Covered Persons directly. Medica has stated that this language difference between the Agreement and Addendum I is immaterial and that Clinic and clinic providers may both bill Covered Persons directly.

Article 3

Discusses Provision of Health Services and Administrative Requirements. Items of note:

- A Prospective Clinic Provider "who is, or becomes a partner, shareholder, employee or *otherwise associated with the clinic*" must submit an application for participation to Medica in advance of the date that the affiliation occurs. Being "associated with the clinic" is very broad terminology. Clinics with extended associations with providers are encouraged to inquire about the breadth of this term with Medica. (Section 3.2.1). Medica has stated that 60 days advance notice is sufficient.

- Once Medica has received a complete application for participation from a provider, it will review the application for participation and apply its Credentialing Plan within 60 days to determine whether the provider will be accepted for participation. (Section 3.2.1).

- The Agreement states that, "Clinics will cause each Clinic Provider to be subject to and to comply with the terms and conditions of the Agreement." This language is very broad, however Medica has clarified that it would only apply to health care professionals and physicians that have been credentialed by Medica. (Section 3.2.2). This terminology is used throughout the contract and in Addendum I.

- With regard to administrative requirements, both the clinic and each Clinic Provider (which Medica has clarified to include only credentialed clinic providers) must comply with both Medica's Credentialing Plan and its Administrative requirements. Failure to do so will result in a sanction or fine (amount not disclosed), corrective action (not defined) and/or termination of the Agreement. (Section 3.4)

- Clinic and Clinic Providers are required to participate in programs established by Medica to assess, evaluate and improve the Clinic and Clinic Provider's performance. If Medica modifies its programs following the Effective Date of the Agreement, Medica will "communicate such changes to Clinic prior to their adoption and permit Clinic 45 days to comply with the additional or revised program unless a longer period of time is agreed on by both parties." (Section 3.5) Medica has stated that it will communicate these changes to the Clinic in its monthly Connections newsletter or by sending the Clinic a paper copy. The effective date will begin 45 days after the notice is provided.

- If Medica establishes a Designated Provider Network for delivery of certain Health Services, Clinic and Clinic Providers are required to refer Members seeking those Health Services to the Designated Provider Network. (Section 3.5).

- Clinic and each Clinic Provider are required to report to Medica the Clinic's level of compliance with Medica's practice guidelines in the format and within the time frames specified by Medica. Clinics are encouraged to seek further clarification about these requirements so that the reporting and time frame obligations may be met. (Section 3.6(b)).

- Medica will release consumer data provided by Clinic and Clinic Providers to purchasers of health care coverage, Members and other consumers including Clinic-specific and Clinic Provider-specific quality, outcomes, and patient satisfaction data. Clinic may not attempt to prohibit or restrict Medica's release of such information. (Section 3.7). There is no delineated grievance procedure should a Clinic or Clinic Provider disagree with the content of the data relating to the performance of Clinic or Clinic Provider however, Medica stated that it would fall to the dispute resolution process outlined in Article 10.

- Clinics are required to follow, and are bound by the results of a "complaint resolution process" (undefined) that occurs when Clinics receive a complaint from a Member regarding Health Services provided under the Agreement. It is unclear what this process entails, and who determines its results. (Section 3.9(b)).

- All subcontracted providers must be eligible (undefined) for participation with Medica. (Section 3.11).

- Under the Agreement, Medica has the right to access and audit *all* informa-

tion and records of the Subcontracted Providers relative to the provision of Health Services to Members (Section 3.11(d)). The Clinic alone, however, is responsible for payment to all Subcontracted Providers. (Section 3.11).

- Clinics may not employ or contract with individuals or entities that are excluded from participating in government programs such as Medicare and Medicaid, or with *any entity that employs or contracts with such an excluded individual or entity*. (Section 3.12). Clinics are encouraged to (i) determine whether any entity or person directly providing services is excluded; (ii) when contracting with an entity for providers, the clinic should get a list of the providers and determine whether any are excluded; and (iii) the contract should include representations, warranties and indemnification provisions addressing excluded persons and entities. Note that in addition to the non-payment consequences related to this provision, providers may also face civil monetary penalty consequences[2] for services provided by the excluded individual or entity.

Article 4

Discusses Payment for Health Services. Items of note:

- With regard to reimbursement for health services, the Sponsor (i.e. employer or provider) is *solely responsible* for the obligation for funding payments for Health Services rendered to a Covered Person. Medica Self-Insured *may* provide or arrange for claims processing services. (Addendum I to the Agreement, Section 4.1). Medica stated that it generally does claims processing, but the circumstances under which it would provide or arrange for these services would depend on the administrative services agreement it has with individual Sponsors.

- The Clinic may bill the Sponsor or the Covered Person directly for claims denied by Medica Self-Insured when Medica determines that a Sponsor materially failed to maintain its responsibility to fund payments for services. (Addendum I to the Agreement, Section 4.2.2). Medica has stated failure to fund payments for services 10% or more of the time would constitute a material failure. Clinic or Clinic Provider must make a good faith effort to collect Copayment, Coinsurance and/or Deductible amounts in the manner prescribed by Medica. It is unclear what that manner entails. (Amendment to Medica Clinic Participation Agreement, paragraph 1).

- Clinic may not withhold treatment due to a Member's failure or inability to pay a Copayment, Deductible or Coinsurance amount at or prior to the time of service. Including copayments in this provision is an expansion on the requirements of Minnesota Statute 62Q.751 which prohibits providers from withholding a service based on a patient's failure to pay only the deductible or coinsurance at or prior to the time of services. It is unclear from the provision in the Amendment whether subsequent treatment may be withheld if an unpaid balance remains on the Member's account. (Amendment to Medica Clinic Participation Agreement, paragraph 1).

- Clinics or Clinic Providers must inform Members in writing when they have knowledge that a service is or will be ineligible for coverage under the Member's benefit contract. (Amendment to Medica Clinic Participation Agreement, paragraph 1).

- Clinic is required to submit claims for Health Services to Medica electronically and in a manner and format acceptable to Medica, and in compliance with state and federal laws. Medica will provide assistance and support to Clinic to facilitate electronic claims submission. (Amendment to Medica Clinic Participation Agreement, paragraph 2). Medica's Administrative manual provides guidance. Click on: https://provider.medica.com/C4/AM-ElectronicCommerce. Providers can also submit questions to Medica's electronic commerce team via email to: medica.electroniccommerce@medica.com.

- If Clinic fails to submit claims in accordance with Medica's requirements, it may not bill the Member for the Health Services rendered. (Amendment to Medica Clinic Participation Agreement, paragraph 2).

- Claims submitted to Medica more than 180 days from the date Health Services were rendered risk being rejected for payment. (Amendment to Medica Clinic Participation Agreement, paragraph 2).

- The Agreement states that, in addition to the right to adjust claims payments

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2. The OIG Special Advisory Bulletin addressing exclusion also notes that "Under the CMP authority, providers such as hospitals, nursing homes, hospices and group medical practices may face CMP exposure if they submit claims to a Federal health care program for health care items or services provided, ***directly or indirectly***, by excluded individuals or entities." (emphasis added). See: http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp

set forth in the Agreement, Medica may exercise a right of offset such that Medica may recover any amounts due to Medica from amounts payable to Clinic pursuant to the Agreement. (Section 4.9). Medica has stated that "offsetting" payment differs from "adjusting" claims payment in that offsetting is offered as an alternative to repayment. Offsetting is also used in cases of fraud and abuse.

Article 5

Discusses the Relationship between Parties in the Agreement. Items of note:

- Providers may not knowingly refer a Member to a non-participating provider, unless the Health Services needed can only be obtained from the non-participating provider or the referral to the non-participating provider is necessary to maintain geographic accessibility. (Section 5.5(c)).

Article 6

Discusses Liability Insurance, Hold Harmless and Indemnification. Items of note:

- Clinic, each Clinic Provider and each health care professional under contract with Clinic or any Clinic Provider is required to have general insurance (unclear) and professional liability insurance or a program of self-insurance coverage with "coverage levels satisfactory to Medica." Medica's Administrative Requirements state that Individual Providers are required to have a general and professional liability insurance policy ($1,000,000 per claim/$3,000,000 aggregate), (and) listing policy coverage dates for each participating practice site.[3] Clinics and other health care professionals are encouraged to contact Medica to determine the specific amounts of insurance they are required to have. (Section 6.1).

Article 7

Discusses Compliance and Licensure Requirements. Items of note:

- Clinics are required to provide Medica with written notice either immediately or as soon as is practical, of Clinic entering into any private contract with a Medicare beneficiary; and within ten days of Clinic transferring a substantial financial risk (defined as, "risk for referral services that exceeds the risk threshold[4]") to its physicians or employees (Section 7.1 (c)).

- Clinics must send Medica written notice when any restrictions or limitations are placed on a Clinic Provider or health care professional's license, certification, registration, accreditation, authorization, staff privileges at *any* health care facility, or participation status with *any* third-party payer or heath care network. (Section 7.2). Clinics are encouraged to review their internal policies to ensure that they can meet this requirement.

- Clinics must provide written notice to Medica within ten days of receiving a request by a state fraud control unit or Attorney General's Office to review any clinic records. (Section 7.3 (b)).

- Clinics must promptly report to Medica any suspected insurance fraud relating to Medica. (Section 7.3(c)). This language is broad and would include both internal and external investigations.

Article 8

Discusses Books and Records. Items of note:

- Clinic is required to allow Medica access to all information and records of clinic related to Health Services provided under this Agreement during the term of the Agreement and for six years following the Termination of it to the extent permitted by law and subject to proper authorization from the Member. Access to records is extended to ten years from the date of termination of the Agreement or the final audit, whichever is longer, for Heath Services provided to government program Members. (Section 8.1). Clinics are encouraged to review their record retention policies to ensure that they maintain records long enough to be able to comply with this requirement.

Article 9

Discusses the Term and Termination of the Agreement. Items of note:

- The initial term of the Agreement begins on the date that it is signed and continues through the stated Termination date under Article 9. It automatically renews on the Termination Date for an additional two years unless otherwise terminated pursuant to the provisions in Section 9.2 of the Agreement. (Section 9.1).

- The Agreement may be terminated immediately by Medica upon written

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3. https://provider.medica.com/C1/AMAppReqIndivPractitioners

4. "Risk threshold" means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk. (42 C.F.R. section 422.208).

notice of an Event of Default by Clinic (Events are listed in Section 9.2 (a)).

- Medica will send a notice to Clinic if it should fail to satisfy a material term of the Agreement listed in Section 9.2(a) that describes with specificity the nature of Clinic's breach. Medica will allow Clinic the ability to cure the breach within 30 days of receiving the notice before terminating the Agreement. (Section 9.2 (a)(vii)).

- Clinic may terminate the Agreement immediately by providing Medica written notice of an Event of Default by Medica (Events are listed in Section 9.2(b)). Note that one of the Events is listed as, "Continued failure by Medica to make payments due to Clinic within 30 days after Clinic's submission of claims for Health Services to Medica . . ." "Continued failure" is not defined in the Agreement, but Medica has verbally stated that it occurs when a pattern of behavior has been identified by Medica and conveyed to the Clinic but not remedied. (Section 9.2 (b)(i)).

- For Agreements that either automatically renew after one year or two years, Medica has replaced section 9.2.2, titled, "Without Cause Termination" with a new section titled, "Notice to Renegotiate and Notice to Terminate." Clinics looking to renegotiate the Agreement's terms, including rates, are required to provide Medica with 125 days notice in advance of their regular Termination date or the anniversary of the date the Agreement would otherwise automatically renew. *Note: Clinics must request a renegotiation of the Agreement even if their intent is to terminate the Agreement. Clinics looking to terminate the Agreement may only do so when Clinic and Medica fail to reach an agreement on the new terms and Clinic provides Medica 75 days notice of its intent to terminate* (Amendment to Medica Clinic Participation Agreement, paragraph 3(a)).

- Clinics may terminate the Agreement if it receives an amendment to the Agreement and within 45 days of receiving that amendment, it gives Medica 125 days advance written notice of its desire to terminate the contract. Amendments relating to Fee Maximums or material alterations to the Credentialing Plan or Administrative requirements will not take effect during the 125 days. All other amendments will take effect as stated in the Amendment. (Section 9.2.3).

- Medica may terminate the contract without cause by providing Clinic with notice of its intent to terminate at least 125 days in advance of the Termination date or each anniversary of the date that it would otherwise automatically renew. The termination, however, will be effective only on the Termination date or the applicable anniversary of the Termination date. (Amendment to Medica Clinic Participation Agreement, paragraph 3(b)).

- Medica may terminate the status of each Clinic Provider as a Participating Provider on the date that the Clinic Provider fails to "continuously satisfy the standards and procedures of Medica." (Section 9.3(b)). "Continuous" has been verbally defined by Medica as a pattern that has been identified by Medica and conveyed to the Clinic but not remedied.

Article 10

Discusses Dispute Resolution. There were no items in particular to note, however, Clinics and Providers are encouraged to read Medica's Administrative Requirements as they are referenced frequently throughout this section. The Administrative Requirements can be viewed by clicking on the following link: https://provider.medica.com/C6/ProviderManualAdmin.

Article 11

Discusses Miscellaneous Items. Items of note:

- Clinics may not assign any of its rights or obligations under the Agreement except with the prior written consent of Medica. (Section 11.4). This may be a difficult requirement for groups who are developing Accountable Care Organizations or groups under a single tax identification number. Medica has stated that Clinics involved with a business acquisition should contact Medica to discuss the demographic changes and their potential needs.

- Medica may, without the prior consent of Clinic, assign its rights and obligations under this Agreement to any entity in control of Medica (Section 11.4).

- All notices required under the Agreement must be in writing, signed by the party giving notice, and delivered by hand or by first class mail. Clinics and Providers are encouraged to have the notice delivered via certified mail to

ensure that timely notice requirements are met. (Section 11.7).

Other:

Clinic and Clinic Providers must refer Members only to other Participating Providers, including hospitals and other facilities unless otherwise authorized by Medica pursuant to the Member's Medica Benefit Contract. (Appendix G – Protocols).

Exhibit 1 is governed by Wisconsin law. It applies only to Wisconsin providers.

Noteworthy Timing Provisions

Provision	Timing requirements	Citation
Medica reviews applications for participation and notifies applicants of its decision	60 days from receipt of completed application	Agreement section 3.2.1
Medica programs to assess evaluate and improve clinic and provider's performance	45 days to begin compliance or longer if agreed by both parties	Agreement section 3.5
Clinics and providers must report their level of compliance with Medica's practice guidelines	"Within the time frames specified by Medica."*	Agreement section 3.6(b)
Claims must be submitted to Medica for rendered Health Services to be eligible for payment	Within 180 days from the date the Health Services were rendered	Amendment, paragraph 2
Clinics must provide written notice to Medica after entering into a private contract with a Medicare beneficiary	Immediately or as soon as practical	Agreement Section 7.1(c)
Clinics must provide written notice to Medica after transferring "substantial financial risk"* to its physicians or employees	Within 10 days of the risk transfer	Agreement Section 7.1(c)
Clinics must provide written notice to Medica when employment , licensure or various other restrictions are placed on a Clinic Provider	Within 10 days of the implementation of the restriction	Agreement Section 7.2
Clinics must provide written notice to Medica when they receive a request by a state fraud control unit or Attorney General's office to review records	Within 10 days of receiving the request	Agreement Section 7.3(b)
Clinics must report to Medica suspected insurance fraud relating to Medica (includes internal and external investigations)	Report "promptly"*	Agreement Section 7.3(c)
Clinic must allow Medica access to all information and records related to Health Services provided under the Agreement	6-10 years from the date of termination of the Agreement or final audit, whichever is longer	Agreement Section 8.1
Clinic may terminate Agreement by providing Medica written notice should Medica commit an "Event of Default" listed in Agreement Section 9.2(b)	Immediately	Agreement section 9.2(b)(i)
Clinics seeking to renegotiate the terms of their Agreement with Medica must provide advance notice to Medica.	Notice must be provided 125 days in advance of the regular termination date or the date the Agreement would otherwise automatically renew	Amendment, paragraph 3(a)
Clinics wanting to terminate the Agreement	Must provide 125 days notice to Medica to renegotiate, then within that time, 75 days notice of intent to terminate.	Amendment paragraph 3(a)
Clinics who receive an amendment to the Agreement and wish to terminate must give Medica written notice.	Notice to be provided within 45 days of receiving the amendment and providing 125 days advance written notice of intent to terminate	Agreement section 9.2.3
Medica may terminate the contract without cause by providing Clinic with advance notice	At least 125 days in advance of the termination date or each anniversary date that the Agreement would otherwise renew	Amendment paragraph 3(b)

*Clinics and providers are encouraged to contact Medica and ask for clarification.