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2013 CONTRACT REVIEW

WHAT YOU NEED TO KNOW ABOUT THE 2013 BCBS AWARE PROVIDER SERVICE AGREEMENT

The Blue Cross and Blue Shield of Minnesota 2013 Aware Provider Service Agreement is here. Whether you've already signed it or may sign it in the future, there are some new terms of significance, as well as a few old terms that still warrant a second look. The Agreement highlights ICD-10 preparedness and Affordable Care Act compliance – but the practical effects of those two imperatives are still largely unknown. We have put together a succinct summary of terms and provisions to be aware of as you consider the Agreement and manage your practice.

Key Changes to the 2013 Agreement:

1. Many **definitions or provisions previously included in the Agreement have been removed entirely or moved to the Provider Policy & Procedure Manual.** Blue Cross stated that terms were moved or removed if the terms were "industry standard" or for simplification. You should retain and reference the Provider Policy & Procedure Manual for clarification of any ambiguous terms.
2. The **deadline for provider submission of claims is now 120 days** from the date of service. The deadline was previously 6 months from the date of service. Blue Cross stated that this reflected an industry change that arises from the existence of more insurance products. (Article III (C)).
3. The option to obtain special permission to submit paper claims is removed. Blue Cross stated that this is in compliance with Minnesota State law that requires **electronic submission of all claims** between providers and payors. (Article III (C)).
4. The Agreement contains a number of references to **ICD-10 preparedness**. The Agreement specifies that all claims shall include **"all documented diagnoses" coded as "specifically as possible"**. Blue Cross stated this is a clarification of what was previously required and is important as all parties prepare for ICD-10 implementation. (Article III (C)).
5. The Agreement permits Blue Cross to "reduce payment to the provider" if ICD-10 implementation gives rise to any additional provider reimbursement. Blue Cross stated that the intent of this provision is to be "budget neutral", meaning that **under ICD-10 a provider will be paid the same as under ICD-9**, even if new coding would otherwise give rise to additional provider reimbursement. **How this will operate in practice is uncertain, and the MMA, MMGMA and TCMS are concerned that good faith attempts to maintain budget neutrality may result in underpayment.** (Article IV (I)).
6. **Providers are required to furnish to Blue Cross any information required for compliance with the Affordable Care Act**. When Blue Cross was asked what specific information would be required to achieve compliance, it declined to provide reference to any specific ACA citation. Because the ACA is broad, there are many potential information requests. You should consult an attorney with questions pertaining to specific information requests. (Article III (D)).
7. If a service or treatment requires prior authorization, it is the provider's responsibility to obtain full authorization in advance. **If prior authorization is required but not obtained by the provider, the provider will not get paid**, and the provider will be responsible for the costs of the service or treatment. Blue Cross declined to provide an explanation of this new provision. (Article III (I)).
8. Previously, payment for services provided by mid-level practitioners comprised 90% of a provider's regular billed charge (RBC) or 85% of Blue Cross' fee schedule allowance, whichever was less. The Agreement is amended to outline that in addition, **payment for the following practitioners is to be the lesser of the following :**
   CRNA: 90% of Provider's RBC or 80% of Blue Cross fee schedule
   Master's Level: 90% of Provider's RBC or 80% of Blue Cross fee schedule
   PhD: 90% of RBC or 90% of Blue Cross fee schedule
   Blue Cross did not explain why these changes were being made or what providers fell under the category of "mid-level". Blue Cross characterized these additions as "clarification". (Article IV (A)).

Important reminders about preexisting terms of note:

1. The "Quality Care Delivery" provision requires providers to cooperate with Blue Cross to assure the delivery of quality, medically necessary care to subscribers. **Providers must also *assure* that no compensation or other incentives exist for the purpose of limiting care delivery** (Article IV (J)). The MMA, MMGMA and TCMS remain concerned about the breadth of this language given the new payment models, such as Total Cost of Care Agreements, that may shift the risk to physicians and other providers. In 2011, Blue Cross acknowledged that the language in this provision may need to evolve as payment models expand. It has stated that this language was added to be NCQA (National Committee for Quality Assurance) compliant.
2. The Agreement requires that **all Provider subcontracts be in writing and made available to Blue Cross upon request for its review and approval**. Subcontracting does not alter or remove the provider's responsibilities under the Agreement, meaning Providers may not delegate away responsibility to a subcontractor. (Article III (P))
3. The Agreement **permits Blue Cross to immediately terminate the provisions of the Agreement that apply to any Minnesota Health Care Program Subscribers in the event of a government shutdown or lack of state funding** that results in DHS ceasing to make payments to Blue Cross for Health Services provided to these subscribers. (Article I (H)). Blue Cross has stated that once the shutdown is resolved, the network of providers and the benefits for the members would be automatically reinstated.

Effective date and termination:

This Agreement will become effective on July 1, 2013 for all providers. This agreement incorporate all previous agreements and amendments. It will automatically renew for one-year terms commencing on July 1 for each subsequent renewal term. Reviews of prior Blue Cross Agreements are available on the MMA website at: http://www.mnmed.org/KeyIssues/LegalAdvocacy/tabid/2205/Default.aspx

Either party may elect to terminate the Agreement without cause by providing written notice to the other party. The termination will become effective 130 days after the receipt of the written notice. (Article VIII (B)).

Disclaimer:

This summary is not intended to be a comprehensive legal analysis, and it is not a substitute for legal and accounting advice. If you wish to determine the specific application of this Agreement to your practice you will need to contact your own attorney, accountant or consultant. Blue Cross has indicated that this is a standard provider contract and it will generally not alter it based on provider negotiations.