

**October 2002 Amendment to the Medica Health Plans
Medica Insurance Company • Medica Health Plans of Wisconsin
Associate Clinic Participation Agreement**

 **New Addition**

 **Changed**



 **Not in AMA/MMA Model Contract**

This document provides a brief overview of some of the key provisions in the October 2002 Amendment to the Medica Associate Clinic Participation Agreement (Agreement). Please note that this review is not a comprehensive 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 own attorneys, accountants, and consultants.


General Information & Key Provisions

The cover letter to the October 2002 amendment indicates that the amendments are unilateral and, therefore, automatically will take effect January 1, 2003. The letter failed, however, to clarify the right of physicians to terminate the contract in response to the amendment. Termination notice in response to Medica-issued amendments must be provided not more than 30 days after notice of the amendment. In this case that date was approximately November 24, 2002. Termination is effective 125 days after written notice.

This review summarizes the changes in the October 2002 amendment and also provides a summary of many of the Agreement's key provisions.

We would draw your attention to the following changed () or new () provisions in the Agreement for 2003:

- Subcontracted Provider (see pages 1 and 2 of review)
- Fraud & Abuse Requirements (see page 3 of review)
- Services to Members after Termination (see page 5 of review)
- Mediation (see page 5 of review)
- Arbitration (see page 5 of review)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) (see pages 1, 3, and 6 of review)

We would also draw your attention to the following provisions that deviate from the provisions recommended in the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002) ():

- Administrative Requirements (see page 2 of review)
- Consumer Data (see page 2 of review)
- Access to and Release of Books and Records (see page 3 of review)
- Termination without Cause (see page 4 of review)
- Arbitration (see page 5 of review)
- Assignment (see page 6 of review)


Article 1 - Definitions


This article contains definitions for 14 common terms used throughout the Agreement. Some of the key definitions are as follows:

Benefit Contract. The Agreement applies to each Medica product listed in the appendices, including commercial and government products. Several provisions of the Agreement are required under Minnesota HMO law, but are applied to all Medica products covered by the Agreement. (Article 1, Section 1.1)

Contingency Reserve. Medica continues to utilize the physician contingency reserve or PCR as a reimbursement withholding methodology. Physicians are urged to review the appendices of their Agreement to determine the specific amount of the withholding, and the performance standards established for earning and receiving payout, by product, for their practice. The PCR is a key reimbursement element of all fully-insured commercial Medica products. In 2002, the PCR was no longer applied to Medica self-insured products, but it will continue to be applied to one of Medica's government products (Prime Solution, formerly known as PHP+Medicare). (Article 1, Section 1.1.) (Corrected 1/29/03)

Fee Maximums. The Agreement continues to use the term "fee maximums" to reflect the maximum fees payable for delivered health services as "determined from time to time" by Medica. The Agreement's appendix should identify the applicable clinic-specific fees by product. Physicians should note that Medica typically updates its fee maximums in the spring of each year to incorporate the current year's relative value units (RVUs) as published by the Centers for Medicare and Medicaid (CMS). Current Medica policy (as published in its administrative manual) limits physicians to only 30 code-specific payment rates when they request the rates by telephone (after signing a confidentiality agreement). Such limited access to fee maximums can be problematic and physicians are urged to request the complete set of applicable codes. (Article 1, Section 1.1)

HIPAA. A new term and definition is added for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its related regulations. (Article 1, Section 1.1) 

Subcontracted Provider. A new term and definition is added for "subcontracted provider" to describe licensed or certified organizations, facilities, agencies, or individuals that 



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Medica would otherwise contract with or credential, but which are providing care through an arrangement with the clinic. (Article 1, Section 1.1)

Article 2 - Provision of Health Services and Administrative Requirements

This article outlines the general care delivery, access, and administrative requirements of the Agreement. Because most administrative details are not defined in the body of the Agreement, physicians are urged to request copies of and review the referenced manuals and administrative documents to understand the impact on their practices. Some of the key provisions of this article are as follows:

Submission of Participation Applications. Medica continues to require that an application for participation be submitted to Medica in advance of the date when a new provider becomes a partner, shareholder, employee, or in any other way becomes associated with the clinic.

This requirement may not always be logistically practical. The Agreement continues to state that providers are not eligible for retroactive participation, which is a National Committee on Quality Assurance (NCQA) accreditation standard, so the rationale for the advance application requirement is not entirely clear.

The October 2002 amendment deletes the phrase, “in its sole discretion” as it applies to Medica’s role in deciding to accept or reject a provider’s application for participation. **C** Despite the elimination of this phrase, it is not clear (absent a review of Medica’s Credentialing Plan) what, if any, substantive changes the amendment is intended to reflect. (Article 2, Section 2.2.1)

Administrative Requirements. Medica continues to require full compliance with its Credentialing Plan and “Administrative Requirements,” which are articulated in Medica’s Administrative Manual, Medical Policy Manuals, training manuals “or other manuals.” The Agreement expressly states that such information will be provided to the clinic “on or prior to” the effective date of the Agreement. Although the Agreement provides that the clinic will be notified of any changes or additions to the Credentialing Plan, it continues to contain inconsistent language that indicates that “at its discretion” Medica will provide notice of any change or addition to the Administrative Requirements.

- This provision is in stark contrast to the language included in the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002). The model language requires that all administrative policies and procedures be provided with the Agreement to allow review and understanding prior to execution of the contract. Although the model language recognizes the need for health plans to issue policies, procedures, rules, and regulations, the model language would require that

providers receive a 90-day written notice of such changes in advance of implementation. Furthermore, the model language would prohibit changes in policies, procedures, rules and regulations that would have a materially adverse effect on the provider unless the provider has given prior consent. (Article 2, Section 2.4)

Consumer Data. The Agreement continues to require the clinic’s consent for the release by Medica of any clinic-specific and clinic provider-specific “administrative, clinical, health improvement, or other performance data.” Although the Agreement allows for the clinic to review but not correct such data, the content and release of the data to purchasers of health care coverage, members “and other consumers” is at Medica’s sole discretion and authority. (Article 2, Section 2.7)

Subcontracted Provider Contracts. The October 2002 Amendment eases some of the requirements on clinics that wish to engage in subcontracts. Previously, Medica precluded clinics from subcontracting with providers without Medica’s prior written approval, and such subcontracts were generally limited to current Medica participating providers. The amendment allows clinics to subcontract with providers who are otherwise eligible for participation. (Article 2, Section 2.11) **C**

Article 3 - Payment for Health Services Reimbursement for Health Services. This key provision references the Agreement’s appendices, which set forth the clinic’s payment terms by Medica product. (See, also, Fee Maximums, Article 1) (Article 3, Section 3.1)

Member Protection Provisions. For services provided under the Agreement, the clinic, and the clinic’s providers, are prohibited from billing, charging, collecting a deposit from, seeking remuneration from, or having any recourse against a subscriber in the event of, but not limited to, nonpayment or breach of the Agreement. The language in this section is mandated to be included in all HMO contracts under Minnesota HMO law. Note, however, that the Agreement is used for many Medica products, not just HMO products. A similar provision is included per Medicare regulations for Medicare products issued by Medica. It requires providers, in the event of Medica’s insolvency, to continue to provide health care services for the rest of the contract for which premiums have been paid, and to continue to provide care for patients in inpatient facilities until such patients are discharged. (Article 3, Section 3.3(b)).

Article 4 - Relationship Between Parties

Communications with Members. The Agreement continues to expressly state the right of providers to discuss details regarding diagnoses, recommended procedures, risks and benefits of treatment, and “reasonable alternatives” to rec-





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ommended treatments. Providers are also able to discuss Medica's reimbursement methodology, but are precluded under the Agreement (consistent with state law) from disclosing the "specific reimbursement rates paid" by Medica. (Article 4, Section 4.3(a, c))

Article 5 - Liability Insurance, Hold Harmless and Indemnification

Liability Insurance. The Agreement continues to require that clinics maintain general and professional liability insurance for all providers under contract with the clinic. The amounts of coverage required are set forth in Medica's Administrative Manual. This section also includes a requirement that clinics notify Medica when they change carriers or coverage and notify Medica of denials, restrictions or termination of coverage as well as certain claims and settlements. (Article 5, Section 5.1)

Hold Harmless and Indemnification. The Agreement provides for mutual hold harmless and indemnification clauses, which require that the clinic and Medica will each hold each other harmless against claims, liability, costs, damages, and judgments in the event of any claim for damages against the other party.

This section also states that if there is a medical malpractice claim against the clinic or a clinic provider, the clinic may not seek indemnification or pursue a claim for contributory negligence against Medica.

Article 6 - Compliance and Licensure Requirements

Notice of Change in Licensure. The Agreement continues to require clinics to notify Medica in writing within 10 days of any termination, restriction, suspension, corrective action plan or other disciplinary action against the provider's license, certification, staff privilege or participation status with any third party payer. This section also requires notification regarding any investigation of the provider which would affect their license, staff privileges or participation status with a third party payer. (Article 6, Section 6.2)

Fraud and Abuse Requirements. This provision outlines the clinic's obligations regarding fraud and abuse investigations and requires the clinic to allow state fraud control units and/or the attorney general's office to access the clinic's administrative, financial, medical and other records during regular business hours. The October 2002 amendment deletes a previous requirement that the clinic report to the state fraud control unit or attorney general any suspicion of fraud or abuse by providers or members. There is still a requirement that any suspicion of Medica-related insurance fraud must be reported to the company, but it is unclear what level or type of suspicious circumstances would have

to occur for the obligation to report to be in effect. (Article 6, Section 6.3)

Article 7 - Books and Records

Access to and Release of Books and Records. This provision requires that the clinic provide Medica with access to all information and records related to health services provided pursuant to the Agreement, to the extent permitted by law and without any further authorization by the health plan member. Medica must provide reasonable notice to the clinic and may not require the clinic to provide this information at a period of time beyond normal business hours. This requirement remains in effect for an additional six years following termination of the contract. (Article 7, Section 7.1)

- Clinics and physicians should keep in mind that under Minnesota law, a physician must have patient consent to release medical records to a payer. Minnesota law is more restrictive than HIPAA privacy law in this regard. Therefore, the consent requirement will remain in effect after the HIPAA privacy regulation takes effect in April 2003. Once a patient gives consent to release his/her records for payment purposes, this consent remains valid until revoked. The Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002), however, recommends the more conservative approach of suggesting that the patient renew such consent annually.
- Medica's access to records provision differs substantially from the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002) in this area. The model contract recommends a two-way access to records; that is, each contracting party should have the right to access or examine the other party's records insofar as they relate to a covered service or payment for a covered service. This Agreement provides only one-way access and does not afford the clinic or provider the right to examine Medica's records if there is a dispute regarding payment or for any legitimate business purpose.
- The October 2002 amendment contains new language to comply with HIPAA privacy requirements and requires that the clinic allow Medica members to access their protected health information, amend incorrect information and receive an accounting of certain disclosures of their health record. This language mirrors HIPAA privacy requirements scheduled to take effect in April 2003.

Privacy of Records. This provision requires Medica, clinics and providers to comply with patient medical record confidentiality requirements set forth in applicable state and federal law and regulations. (Article 7, Section 7.3)

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Article 8 - Term and Termination

Term. The Agreement has an initial term of two years, and then automatically renews on the termination date for consecutive additional terms of two years unless either party terminates. (Article 8, Section 8.1)

Termination. The Agreement continues to outline a variety of termination provisions. It is important to note that Minnesota HMO law requires that providers seeking to terminate a contract without cause must give the HMO 120 days' advance notice. (Article 8, Section 8.2)

1. Termination after Default. Also known as "termination for cause," this option allows each party to immediately terminate the Agreement upon written notice if certain conditions occur. Under the agreement, there are six conditions, referred to as an "event of default" that would be grounds for Medica to terminate the Agreement:

- The clinic's inability to perform under the Agreement due to a termination of a material number of clinic providers;
- A determination by Medica that the health, safety or welfare of Members is in immediate jeopardy;
- The clinic files for or is adjudicated as bankrupt or has bankruptcy proceedings filed against it and that proceeding is not dismissed after 60 days;
- The clinic fails to maintain the levels of insurance required in section 5.1;
- The clinic fails to meet any material term or condition of the Agreement or fails to cure an alleged breach of the Agreement after 30 days written notice by Medica to do so;
- The clinic's failure to comply with Medica's privacy practices as outlined in the Administrative Manual has been added as grounds for termination for cause.

Grounds for clinics to terminate the Agreement:

- Continued failure by Medica to make payments to the clinic as required under the Agreement within either 45 days (Medica Health Plans) after the clinic has submitted claims for health services to Medica, provided that the clinic has submitted all of the information needed to process the claims. It is important to note that the Agreement states that this provision does NOT apply to claims held by Medica for purposes of coordination of benefits;
- Medica's failure to maintain any certification or license needed for performance of the Agreement;
- Medica's failure to meet any material term or condition of the Agreement or failure to cure an alleged breach of the Agreement after 30 days written notice by the clinic to do so.

2. Termination without Cause. The Agreement may be terminated without cause as long as the terminating party

provides 125-days notice in advance of the termination date. The Agreement may also be terminated at each two-year anniversary of the termination date.

•(Physicians should note that some Medica agreements may include a provision prohibiting termination without cause by either party. Such provisions are in conflict with the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002) and should be carefully considered.)

•These provisions may be contrasted with the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002) recommendations regarding termination without cause. The model contract suggests a voluntary termination provision that would allow either party to terminate the Agreement without cause but requires the terminating party to state the reason for the termination. This model requirement reflects the recognition that the termination may have a substantial economic impact on the physician's practice and is designed to protect physicians from terminations that are illegal, discriminatory or for other reasons contrary to public policy. In addition, physicians should note that unlike some termination-without-cause provisions that allow the parties to terminate at any time during the agreement period, the Medica Agreement allows for termination without cause only at the Agreement's termination date or the two-year anniversary of that date. This means that a clinic may be forced to wait up to two years to exercise the option to terminate the Agreement without cause.

3. Termination Due to Amendment. The Agreement may be terminated by a clinic as long as the clinic provides 125 days written notice to Medica of the clinic's intent to terminate AND such notice is given no more than 30 days after the date that Medica provided notice of the amendment.

A clinic may also terminate the Agreement if there is a material change by Medica to the fee maximums, as long as the clinic provides Medica with written notice within 60 days of receipt of the proposed fee change. If the clinic chooses to terminate for this reason, the termination would be effective, under the Agreement, on the latter of either 125 days from the clinic's notice or the next one-year anniversary of the effective date. It is important to note that if the clinic chooses to terminate for this reason, the proposed fee maximum changes would be implemented until the date of the termination.

(Physicians should note that some Medica Agreements may include an alternative provision regarding termination due to amendment that provides only for a termination date of 125 days from the clinic's notice of intent to terminate, rather than the latter of either 125 days from the clinic's notice or the next one-year anniversary of the effective date.)

4. Termination Following Mediation. Termination is also permissible if the parties are unable to resolve a dispute following mediation of the matter (see section 9.2). If this is the case, either party may terminate the Agreement as long



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as 125 days prior written notice is given. It is important to note that the right to terminate under this section does not preclude either party from exercising its right to arbitrate the matter in accordance with Section 9.3.

Termination of Clinic Provider Participation. Under the Agreement, the status of each clinic provider as a participating provider will be terminated upon the earlier of (a) the Agreement's termination date (b) the date the clinic provider fails to continuously satisfy the standards and procedures of Medica, including, the standards and procedures described in Medica's Credentialing Plan, and (c) the date such clinic provider's employment or other association with the clinic terminates. (Article 8, Section 8.3)

Consequences of Termination. This section outlines provisions that apply if the Agreement is terminated under any of the four provisions outlined above, or if the participation status of any provider is terminated. Unless termination is immediate, the clinic and participating providers must comply with the terms of the Agreement until the termination effective date EXCEPT Medica, in its sole discretion, may restrict the clinic or provider's status if Medica believes that there is a negative effect on Medica's relationship with its members as a result of clinic or provider actions, or if Medica determines that such restriction is necessary to ensure that health services are provided appropriately to Medica members in accordance with the benefit contract or state or federal law.

★ **Services to Members after Termination.** This section outlines the clinic's responsibility to provide health services to members after termination of either the agreement or a provider's participation status. Subdivision (b) outlines the requirements for treatment of members under Minnesota Benefit Contracts, as follows:

Up to 120 days if the Member was undergoing a current course of treatment for which care was being received at the time of termination; or the remainder of the Member's life if a physician certifies that the Member has an expected lifetime of 180 days or less (this is in accordance with state law). (Article 8, Section 8.4.2)

Review of Communication. This section states that both parties have the right to review any written communication proposed to be delivered by the other party to Medica members or other participating providers regarding termination prior to distribution of such communication. (Article 8, Section 8.4.3)

Article 9 - Dispute Resolution

Administrative Remedies. The Agreement states that in the event of a dispute related to the Agreement between Medica and a clinic, the party seeking to pursue the dispute must proceed with the remedies and procedures as outlined in Medica's Administrative Requirements and Credentialing Plan.

If the alleged dispute remains unresolved after exhaustion of the administrative remedies and procedures available, either party may request in writing that an alleged claim be resolved through the alternative dispute resolution (mediation) process, as provided in section 9.2 (Article 9, Section 9.1)

★ **Mediation.** This provision requires mediation of any and all disputes stemming from the Agreement or a breach of the Agreement that have not been resolved after 30 days. This section is new to the Agreement and replaces a more general requirement to negotiate in good faith to resolve any dispute at the request of the other party. (Article 9, Section 9.2)

Ⓢ **Arbitration.** This section on arbitration has been amended to include very specific details of the arbitration process and the rights of each party. It is recommended that physicians familiarize themselves with the provisions of this section in case a dispute arises which may be submitted to mediation and possibly arbitration. It is important to note that this section states that the arbitration is final and binding and will be the exclusive method of dispute resolution, which in general, would preclude either party from filing a lawsuit to resolve the alleged dispute.

Under the Agreement, a party is not, however, precluded from seeking any legal action in the event of fraud or to prevent imminent and irreparable harm, such as a temporary injunction or restraining order. It is important to note that the arbitrator only has the authority to enforce the terms and conditions of the Agreement and does not have the authority to ignore or change any of the terms. It is notable that use of arbitration as the sole method of dispute resolution is not recommended by the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002). The model contract suggests that arbitration is appropriate in the event that neither party has brought forth a lawsuit in a court of competent jurisdiction to address the same matter. (Article 9, Section 9.3)

Article 10 - Miscellaneous

This article contains a number of standard or "boilerplate" provisions that are important to review and understand since they do create obligations and place certain significant limitations on the rights of the parties. Some of the provisions are highlighted below:

Amendment. Any amendment, other than a material amendment to the fee maximums, that is issued by Medica 30 days prior to the effective date will be automatically incorporated into the Agreement on the effective date, unless the amendment relates to the percentage withheld under the contingency reserve. Those amendments will only become effective at the beginning of any calendar year. If a clinic chooses to terminate the Agreement after notice of an amendment, the amendment will be in place from the effective date until the termination date.



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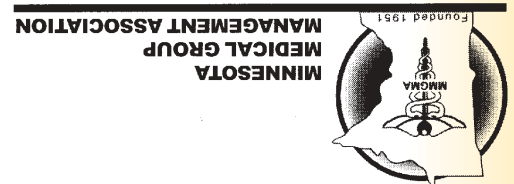
Any material change to the fee maximums is considered an amendment to the Agreement and requires 60-days-advance-written notice to the clinic. The clinic has the right to terminate the Agreement under Article 8 based upon the material change to the fee maximums. If a clinic chooses to terminate the Agreement after notice of a fee amendment, the amendment will be in place from the effective date until the termination date. (Article 10, Sections 10.1.1(a) & (b))

Confidentiality. This section states that Medica, clinics, and clinic providers must maintain the confidentiality of all member information in accordance with state and federal law including HIPAA privacy requirements. This section adds a new reference to HIPAA security standards, stating that clinics and providers must maintain the appropriate safeguards for individually identifiable health information that is stored or transmitted electronically. Additionally the Agreement states that each clinic and provider must maintain the confidentiality of the terms of the Agreement, in-

cluding the amounts paid by Medica to the clinic under the Agreement. (Article 10, Section 10.2)

Assignment. This provision first states that neither party has the right to assign or transfer any of the rights and responsibilities under the agreement; however, it then states that Medica may, without prior written consent of the clinic, assign or transfer the Agreement to another entity which controls, is controlled by, or is in common control with Medica. It is notable that the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002) recommends a mutual assignment provision, allowing either party to assign or transfer the contract without the consent of the other party. This is recommended to assist the parties administratively in the case of a change in ownership or control. (Article 10, Section 10.3)

Survival. Certain sections of the Agreement will remain in force after termination (Article 10, Section 10.9)



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