



2004 Blue Cross Blue Shield of Minnesota Aware Agreement

In this document, we provide a summary of the changes made in the Blue Cross Blue Shield of Minnesota (Blue Cross) 2004 Aware Provider Service Agreement (Agreement). Please note that this summary 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.

Summary of Changes

The changes to the 2004 Aware Agreement are modest, compared with the comprehensive update made to the Agreement in 2003. This review highlights the changes made for 2004. For a summary of the provisions that remain unchanged, please refer to the review of the 2003 Agreement published last year, which is available under "Advocacy News" and "Contracting Issues" on the MMA Web site at www.MMAOnline.net.

Physicians should note that the Agreement will renew automatically effective July 1, 2004 unless either party gives notice of termination by May 1, 2004. Blue Cross has clarified that the date for terminating the agreement identified in the cover letter ("within 30 days of the issuance of this renewal") can be interpreted to mean May 1, 2004.

- **Average Wholesale Price.** Article I of the Agreement contains definitions for fourteen terms used throughout the Agreement. One new definition has been added (Section C) for "Average Wholesale Price" or "AWP," which refers to the published wholesale price of drugs and states that Blue Cross uses the National Drug Data File and it is updated periodically. The only other change in this Article is a technical change in Section K, which simply spells out the reference to the HIPAA Privacy statute as the "Code of Federal Regulations," which was previously referenced only as "CFR." (Article I, Section C)
- **Clinical Coding Requirements.** Under Article III, Section E, Clinical Coding Requirements, there was an existing requirement that Providers submit billings based upon coding guidelines, such as

CPT, ICD-9 and HCPS. New language was added this year stating that Providers must comply with those coding guidelines "as interpreted by Blue Cross in their Coding Policies and Guidelines section of the Provider Manual" and that the Manual is amended from time to time. (Article III, Section E)

- **Patient Safety Policies.** Article III also includes a notable new section relating to patient safety. Section J begins by stating that the Provider and Blue Cross both seek to establish high standards for medical care for patients and that the Provider will at a minimum develop and implement patient safety measures that are consistent with accreditation and/or statutory requirements. Examples of high patient safety standards listed in the Agreement include monitoring for medication accuracy, peer review monitoring, non-punitive reporting and developing and implementing written policies relating to safety.

The Agreement stipulates that the Provider agrees to share information with Blue Cross regarding the Provider's efforts to measure and improve patient safety, and also stipulates that if such a request is made by Blue Cross, it will be made in writing and will not be made more than once per year. This section goes on to state that Blue Cross will be "reasonable" in their request for information, will use the information strictly for internal quality improvement purposes, will hold the information confidential and will not use the information for "punitive purposes."

- As this is a new addition to the Agreement, the manner and scope in which Blue Cross will implement it is unknown. Specifically, it is unclear what type of information and level of detail Blue Cross will seek from Providers. It is also unclear what would happen if a Provider does not produce the documentation requested by Blue Cross. It is important to keep in mind that under Minnesota law patient-specific medical information may not be shared with health plans without first obtaining patient consent. Additionally, it may be inappropriate to share certain types of information, such as peer review data. (Article III, Section J)
- **Reimbursement.** 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

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clinic are defined in the clinic-specific sample fee schedule included with the Agreement mailing. Physicians are encouraged to review this sample fee schedule in order to understand the financial impact of the specific payment changes on their specialties/practices.

- According to Blue Cross, an aggregate increase of 5.7 percent is provided for in 2004; this compares with an aggregate increase of 6 percent in 2003. The 2004 increase is exclusive of any changes made as a result of the increase in the provider tax (from 1.5 to 2 percent) effective January 1, 2004.
- **RVUs and Conversion Factors.** Effective July 1, 2004, Blue Cross will implement the 2004 Centers for Medicare & Medicaid Services (CMS) relative value units (RVUs). Physicians interested in knowing the conversion factor applicable to their practice should refer to the fee schedule provided by Blue Cross as part of the Agreement mailing. Blue Cross is maintaining its previous policy of using the higher practice expense RVUs (either facility or non-facility), which means that there is no site-of-service payment differential applied by Blue Cross. Blue Cross also continues to implement the RVUs without the geographic practice cost indices (GPCIs), which are Minnesota-specific geographic adjustment factors and which could otherwise reduce payment by approximately 3 percent.
- **Minnesota Health Care Programs Fee Schedule.** As expected, the Agreement incorporates previously amended language (September 2003) to reduce payment for services provided to patients enrolled in Minnesota Health Care Programs (i.e., Medical Assistance, General Assistance Medical Care and MinnesotaCare). This reduction, which took effect January 1, 2004, reflects, in part, state budget reductions in the amount the state pays to contracted health plans providing services to enrollees in prepaid programs such as PMAP. (Article IV, Section C & fee schedule)
- **CPIU Payment Increase.** Blue Cross reimburses some services based on a percent-of-charge methodology. For these services, Blue Cross limits the annual increase in payments to the annual change in the Consumer Price Index for Urban Consumers (CPI-U) as published by the Bureau of Labor Statistics. The CPI-U is a com-

mon inflationary index. The section was modified slightly to reflect the way Blue Cross currently calculates the CPI-U. Language was deleted that excluded the use of increases or decreases in provider tax payments in the calculations used by Blue Cross to verify the rate of the annual increase. It is possible that with the elimination of this language, the 0.5 percent increase in provider tax payments that occurred in 2004 when the provider tax rose from 1.5 percent to 2 percent may be factored into the aggregate increase paid by Blue Cross. If so, any increase in the percent-of-charge payments would be less than the CPI-U increase expected under this section. (Article IV, Section D)

- **Termination.** The Agreement continues to outline a variety of termination provisions. It is important to note that Minnesota HMO law (Minn. Stat. §62D.123, Subd. 3) requires that providers seeking to terminate a contract without cause must give the HMO 120-days advance notice.
- **Service Area Change.** A new termination option has been added to the Agreement. Blue Cross now has the right to terminate the Agreement upon 130 days' prior written notice to the provider if the provider's practice moves out of the contracting services area. This change reflects requirements imposed on Blue Cross by the Blue Cross Blue Shield Association and is intended to be used to clarify which state Blue Cross plan has jurisdiction for submitted claims. (Article VIII, Section B(6))
- **Patient/Subscriber Complaints.** Under some narrow requirements in Minnesota Rules (part 4685.1110, subp. 9), HMOs are obligated to provide "...ongoing evaluation of all enrollee complaints... including complaints filed with participating providers." The Agreement has been changed to clarify the complaint submission and resolution process (including written submission of complaints on a quarterly basis), and to state that the responsibility for resolution of complaints now lies with Blue Cross, rather than with the provider. (Article IX, Section A)