



CONTRACT REVIEW

2005 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) 2005 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.

This document highlights the changes made to the Agreement for 2005. Because many provisions in 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.

Physicians should note that the Agreement renews automatically effective July 1, 2005 unless either party gives notice of termination within 30 days of the issuance of the contract.

Advance Notice. Reduces advance notice provided by Blue Cross for such things as material amendments to the Agreement, new provider Bulletins, Rules and Regulations, fees for Remote Access Services, etc. from 90 days to 45 days. Blue Cross has stated that this

change is made in accordance with the recent health plan contracting legislation passed last year (62Q.732-62Q.75). Actually, the law says that such notice must be at least 45 days prior to the effective date. While the legislation permits Blue Cross to use a shorter period, it doesn't mandate that it be 45 days. (Article III, Section G; Article V, Section A (4); Article VIII, Section A; Article XI, Section D).

Subscriber Telephone Response. Requires that physicians provide or arrange for the provision of medical advice to Blue Cross Subscribers on a timely basis, and available "24 hours per day, 7 days per week via a telephone response." Providers are required to use a triage process to determine appropriate response time for calls from Subscribers. This could be interpreted as requiring broad 24/7 non-emergency or non-urgent telephone access for Subscribers. It isn't clear what the triage requirements entail. Blue Cross has indicated that much of this language is required by state regulators. (Article III, Section A)

Claim Submission Deadlines. Requires that physicians make best efforts to submit claims within 30 days of the date of service. This is a change from the previous 3-month requirement. The 15-month final claim submission limit remains. (Article III, Section C)

Credentialing Information. Requires that physicians submit, at their expense, any information that Blue Cross reasonably requests for credentialing. (Article III, Section D)

Patient Safety Information. Modifies the requirements for how physicians share information with Blue Cross on their efforts to measure and improve patient safety. Previously, the information only needed to be provided no more often than annually at Blue Cross' request. New language is added to minimize the administrative burden of requests to physicians – Blue Cross will, whenever possible, attempt to obtain the information from publicly reported sites. The amendment deletes language that limited the use of the reported information for internal purposes only. Also deleted is language that precluded Blue Cross from using the information for punitive purposes. The intent of these changes, however, is not clear. (Article III, Section J)

Limited Provider Networks. Modifies language to provide that Blue Cross can implement or discontinue limited provider networks for certain Health Services or for certain Subscriber networks. This change may give Blue Cross more flexibility in including and excluding providers from specific networks and appears to facilitate their tiering program. Note, however, that Blue Cross has delayed its planned physician

tiering product for January 1, 2006; a physician tiering product is likely in the future, but the timeline remains uncertain. The provision continues to require that physicians agree to make referrals to limited network providers. (Article III, Section L)

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 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 payment changes on their specialties/practices.

Increase. According to Blue Cross, an aggregate increase of 5.2 percent is provided for in 2005; this compares with an aggregate increase of 5.7 percent in 2004.

RVUs and Conversion Factors. Effective July 1, 2005, Blue Cross will implement the 2005 Centers for Medicare & Medicaid Services (CMS) relative value units (RVUs). Blue Cross is maintaining its previous policy of using the higher practice expense RVUs (either facility or non-facility), and the RVUs are implemented without the geographic practice cost indices (GPCIs) that would otherwise reduce payment by approximately 3 percent.

Other Payment Changes. Effective July 1, 2005 reimbursement will be reduced for allowable assistant-at-surgery services, as well as for services submitted with the reduced services modifier (-52).

Blue Cross will eliminate payment for surgical trays (A4550), surgical and miscellaneous supplies (A4649), and in-office surgery suites (billed with -SU or -SG modifiers).

Fee Schedule Allowances. Although not a change in practice, new language is added to clarify that Blue Cross will provide physicians with applicable fee schedule allowances upon request. Also note that the “applicable fee schedule” is now defined as part of the Agreement. (Article II, Section B; Article IV, Section A)

Preferred Provider Benefit Plans. Deletes the Preferred Provider Benefit Plans section. There will no longer be any payment differential for PPBPs. (Article IV, Section B)

Medicare Contracts. This new section provides that if Blue Cross enters into a Medicare Cost or Risk Contract, Blue Cross will use the Aware contract for the purpose of its relationship with physicians. There is a separate rate schedule and other quality assurance requirements for the Medicare products which should be reviewed. Physician inclusion in the Medicare products appears to be automatic if Blue Cross decides to enter into such an agreement with Medicare, although physicians have the right to withdraw under the terms of the separate Medicare Programs Agreement. (Article IV, Section F)

Recognizing Excellence. This new section outlines, as applicable, a performance incentive plan. Physicians involved in the program should carefully review the details outlined in the addendum. (Article IV, Section G)

Termination Notice to Subscribers.

This section requires that prior to terminating Blue Cross participation, physicians provide advance written notice to Subscribers who are in “an active course of treatment” (not defined) that they are terminating their Blue Cross Agreement. If physicians do not provide the notice, they may not collect more than the amount allowed by Blue Cross from the Subscriber. While the intent appears to be focused on active medical management, it is not clear that those who provide episodic, unscheduled or emergent care are exempted from the requirement. The provision only applies until the contract with Blue Cross is actually terminated. Note that Blue Cross already has similar requirements with respect to Excluded Providers under Article VI, Section C; those provisions survive the termination of the Agreement. Blue Cross has indicated that much of this language is required for health plan accreditation. (Article VIII, Section C)

Remote Access Services. The provisions on Remote Access Services have been revised to make more stringent the restrictions on physician use of the system and the use by any authorized users. The Amendment requires that physicians provide Blue Cross immediate written notice of their termination of employees or other individuals who have remote access to the System and that physicians warrant that information submitted to Blue Cross on User Request Forms or entered into the system is true and correct. (Article XI, Section B)

Medicare Amendment. The Medicare Programs Amendment, originally distributed to existing Aware contract holders in August 2004, modifies the

underlying Aware Provider Agreement in the event that BCBSM elects to contract to provide Medicare services. If there is a conflict between the two Agreements, the Medicare Amendment controls. The Medicare Amendment comes with additional obligations. For example, physicians are required to provide encounter data and other informational data so Blue Cross can meet its reporting obligations to Medicare. There is a separate compensation Exhibit for this Amendment. If a patient is hospitalized, physicians are required to continue to provide care (and be reimbursed per the Amendment terms) even if the Amendment is terminated. Physicians are required to cooperate with Blue Cross to conduct an initial health assessment of each newly enrolled

Medicare Member within 90 days of new enrollment, consistent with the new benefit for a “Welcome to Medicare Physical.” There are additional requirements if you use subcontractors. Physicians can terminate the Amendment and participation in the program with 130 days written notice and the Amendment is severable from the Aware contract. Blue Cross can unilaterally amend the Amendment to meet regulatory requirements, but Blue Cross must make best efforts to provide physicians with at least 45 days prior written notice of such amendments. This may be problematic as there are numerous ways to amend an agreement to meet regulatory requirements and some may be more onerous than others.

Provider and Practitioner Participation Requirements. This document, which has been available previously on the Web site (and will continue to be), includes a lengthy list of requirements that each individual provider must meet to participate under the Agreement. Physicians should review these to see if there are any reports that need to be made to Blue Cross – for example, any physician who has been subject to a Board of Medical Practice disciplinary action in the last 5 years must provide evidence they are in compliance with all stipulated practice conditions. There is an extensive protocol for physicians who have been rehabilitated from chemical substance abuse or sexual misconduct.