



Managed Care Contract Quick Reference Guide

What is the Quick Reference Guide?

As part of the Minnesota Medical Association's Physician Contracting Initiative, this Quick Reference Guide has been developed as a resource for physicians and physician clinics in their efforts to better understand and compare the major provisions of managed care contracts. The information contained in this document represents some of the significant provisions contained in the health plans' standard contracts, but physicians should note that actual provisions negotiated and agreed upon may differ. The information contained in the Quick Reference Guide is not intended to be, nor should it be, a substitute for legal advice regarding the application of a contract to an individual practice. No recommendations are included in this document and the decision to enter into a contract rests with the physician/clinic in consultation with private legal counsel. The MMA has developed, and will continue to develop, additional contracting resources to supplement the information included in this document. Contact the MMA with comments, questions, or information about other resources.



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Health Plan & Contract Name	PreferredOne Provider Agreement	UCare Minnesota Physician Services Participation Agreement	Metropolitan Health Plan (MHP) Participating Provider Agreement
Contract Date, Term & Renewal Provisions	Current provider agreement, provided to MMA July 2002. Renews automatically for 1-year terms.	Current physician agreement, provided to MMA September 2002. Contract continues until terminated.	Current provider agreement, provided to MMA September 2002. New contracts are for 1-year term, with subsequent 3-year terms. Contracts do not renew automatically.
Amendment The Quick Reference Guide describes the process used for amending or revising the contract. Note that Minnesota law (§62Q.645) prohibits plans from amending the contract without notifying the provider.	The agreement may be amended only upon the parties' written consent. For amendments required by regulatory authorities, the agreement may be amended unilaterally by PreferredOne by sending a copy of the amendment to the provider.	Any amendments (other than regulatory) must be mutually agreed to by the parties, in writing, and signed by both parties. The agreement may be amended for regulatory purposes if UCare provides written notice to provider.	Any changes to the agreement must be in writing and signed by both parties.
Physician Termination Options The Quick Reference Guide describes the mechanisms by which physicians may terminate the contract. All contracts also include termination provisions available to the health plan (e.g., breach, credentialing standards, fraud), but those provisions are not identified here. Physicians should note that Minnesota HMO law (M.S. §62D.123, Subd. 3) requires that providers seeking to terminate a contract without cause must give the HMO 120-days advance notice.	Physicians can terminate without cause, to take effect only at the end of the contract term, upon 125 days written notice; for breach of contract that is not remedied within 30 days of notice; and for changes in payment terms, if notice of termination is sent within 30 days of receiving notice of changes, with termination to be effective after 125 days.	Physicians may terminate by mutual agreement of parties; for default by UCare (e.g., loss of licensure, insolvency, continued failure to pay claims within 30 days); for breach of contract with no less than 30 days to be given to cure breach; and without cause upon at least 125-days written notice specifying termination date, but such date must be the last day of a month.	Physicians may terminate without cause, and for cause, upon 120 days written notice.
Claims Submission Deadlines The Quick Reference Guide describes the deadline(s) established by the health plan for submission of claims.	Providers must submit all clean claims within 120 days from date of service or within 60 days from the date of the primary payor's EOB when the PreferredOne payor is not primary. Appeals from a denial for untimely filing must be submitted within 60 days from date of initial claim.	Providers must submit claims no more than 1 year from the date services were provided or from the date provider knew of enrollee's coverage under UCare, whichever is later.	Provider claims must be received within 120 days of date of service. If denied, correct claims must be submitted within 90 days from date of denial.
Interest Payment on Late Claims The Quick Reference Guide describes the current health plan policy regarding payment of interest on claims. Minnesota law (§62Q.75) requires payment of interest, at a rate of 1.5% per month, on clean claims that are not paid or denied within 30 days. The law, however, allows plans to require that providers bill the plan for interest owed.	PreferredOne requires physicians to bill payors for interest owed.	UCare automatically calculates and pays interest owed (operational policy). The agreement provides that UCare will pay clean claims within 30 days, with the exception of claims pending for COB or to investigate fraud or abuse.	MHP requires physicians to bill for interest owed (operational policy).
Claims Adjustments The Quick Reference Guide describes, for the health plan and the provider, the authority and timeline for seeking payment adjustments to claims.	Payor has right to make, and provider has right to request, corrective adjustments to previous payments, but payor is not obligated to pay additional amounts after 180 days from date initial claim was paid. (The time limit on payor's ability to recoup payments is 365 days per operational policy).	UCare has right to make, and provider has right to request, corrective adjustments to any previous payment or denial provided such corrections or requests are made within 12 months from the date claim was paid or denied by UCare. This does not apply to duplicate claims payments or payment for fraudulent claims.	Provider may request claims adjustments within 6 months from the date of the explanation of benefits (EOB). Adjustments by MHP are allowed "up to the statute of limitations" (operational policy).
Payment Methodology The Quick Reference Guide describes the general physician payment methodology used by the health plan. Physicians interested in knowing the specific payment rates applicable to their practice should refer to their individual contracts and/or contact the specific health plan.	Payment is made on a fee-for-service basis according to a fee schedule based on RBRVS.	UCare pays the lesser of billed charges or its fee schedule, which is a defined percentage of the current state Medical Assistance fee schedule. Additional payments may be made, such as patient management fees for primary care clinics, and enhanced payment for completion of child and teen check-ups (C&T).	MHP pays a defined percentage of the state Medical Assistance fee schedule. For services not listed, payment is a % of billed charges. For the MN Senior Health Options product (MSHO), payment is equal to the current Medicare fee schedule.
Indemnification Provisions The Quick Reference Guide describes the indemnification provisions contained in the contract. Indemnification allocates liability in the event that the provider or the health plan is subject to a lawsuit. Although often not of concern, the provision can be important, especially if one party attempts to shift liability to the other. Under state law, if there is no indemnification provision, each party is responsible for its own acts or omissions.	The agreement provides for mutual indemnification; "each party will be responsible for any and all damages, claims, liabilities or judgments arising as a result of its own acts of negligence or intentional wrongdoing."	The agreement provides for mutual indemnification; each party will indemnify, defend and hold the other harmless from "any claims, liabilities, losses, demands and costs and expenses of any kind" due to any negligent act or omission or any intentional misconduct.	The standard MHP agreement calls for broad one-way indemnification by the provider, such that the provider "agrees to defend, indemnify, and hold harmless the County [Hennepin], its officials, officers, agents, volunteers and employees from any liability ... resulting directly or indirectly from any act or omission" of the provider. Mutual indemnification can be negotiated with approval of county attorney.
Notes	PreferredOne was founded in 1984 and is owned by Fairview Health Services, North Memorial Health Care and PreferredOne Physician Associates. It operates an HMO, a TPA, and a PPO, which is its largest line of business.	UCare was established in 1984 by the Department of Family Practice at the University of Minnesota Medical School. Its products serve patients covered by Minnesota's public health care programs (i.e., Medical Assistance, General Assistance Medical Care, MinnesotaCare), as well as Medicare enrollees.	MHP is an HMO that is operated by Hennepin County and, as such, its provider contract includes many provisions required as a result of the governmental contracting process. The Hennepin County Board of Commissioners or county administrator must approve most MHP contracts.
Provider Services Contact Information	PPO: 763-847-4400, 800-451-9597 HMO: 763-847-4488, 800-379-7727 TPA: 763-847-4477, 800-997-1750	1-888-531-1493	(612) 347-4740

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Health Plan & Contract Name	Blue Cross Blue Shield of Minnesota (BCBS) 2002 Aware Agreement	Blue Plus 2003 Primary Care Clinic (PCC) Provider Service Agreement	HealthPartners (HP) Comprehensive Health Care Provider Agreement
Contract Date, Term & Renewal Provisions The Quick Reference Guide describes the process used for amending or revising the contract. Note that Minnesota law (§62Q.645) prohibits plans from amending the contract without notifying the provider.	2002 Aware Agreement, effective July 1, 2002 - June 30, 2003. Renews automatically for 1-year terms.	2003 PCC Agreement, effective January 1, 2003 - December 31, 2003. Renews automatically for 1-year terms.	Current primary care clinic agreement provided to MMA August 2002. Term and renewal provisions vary by provider group as negotiated.
Amendment The Quick Reference Guide describes the process used for amending or revising the contract. Note that Minnesota law (§62Q.645) prohibits plans from amending the contract without notifying the provider.	BCBS may amend or modify the agreement unilaterally with at least 90-days written notice to the provider. (If a provider chooses to terminate the agreement in response to an amendment, BCBS will maintain the "old" policies for the 40-day gap between the 90-day notice and the 130-day termination period).	Blue Plus may amend or modify the agreement unilaterally with at least 90-days written notice to the provider. Material changes to the fee schedule may be made on January 1 of each year or after at least a 90 day prior written notice to provider. (If a provider chooses to terminate the agreement in response to an amendment, Blue Plus will maintain the "old" policies for the 40-day gap between the 90-day notice and the 130-day termination notice).	The agreement may only be amended by mutual, written agreement of the parties. However, the agreement may be amended unilaterally by HP as required due to changes in state or federal law or upon demand by a state or federal agency.
Physician Termination Options The Quick Reference Guide describes the mechanisms by which physicians may terminate the contract. All contracts also include termination provisions available to the health plan (e.g., breach, credentialing standards, fraud), but those provisions are not identified here. Physicians should note that Minnesota HMO law (M.S. §62D.123, Subd. 3) requires that providers seeking to terminate a contract without cause must give the HMO 120-days advance notice.	Physicians can terminate without cause upon 130-days prior written notice; for breach of contract upon 130-days prior written notice; and in response to "Rules & Regulations" that "materially affect the responsibility or rights of the provider" upon 130-days prior written notice.	Primary care clinics (PCC) can terminate without cause upon 130-days prior written notice, but Blue Plus may defer the termination for up to 12 months for some enrollees being served by the PCC; and for breach of contract upon 130-days prior written notice.	Physicians can terminate without cause at the end of the current contract term upon at least 130-days written notice; for breach of contract if HP fails to remedy default within 60 days after receipt of written notice (subject to HP's arbitration policy); and for financial instability of HP (after trying to resolve the issue) upon 130 days notice that there is reasonable belief that HP's financial condition is such that it will not be able to meet its obligations under the agreement.
Claims Submission Deadlines The Quick Reference Guide describes the deadline(s) established by the health plan for submission of claims.	Providers must submit claims within three months of the date of service, but in no event later than 15 months from the date of service.	Providers must submit claims within three months of the date of service, but in no event later than 15 months from the date of service.	Providers must submit all claims for payment (other than those pending for COB) within 90 days of the date of service. Claims pending for COB shall be submitted within 60 days of determining HP's responsibility. HP has a late claims submission appeals process.
Interest Payment on Late Claims The Quick Reference Guide describes the current health plan policy regarding payment of interest on claims. Minnesota law (§62Q.75) requires payment of interest, at a rate of 1.5% per month, on clean claims that are not paid or denied within 30 days. The law, however, allows plans to require that providers bill the plan for interest owed.	BCBS requires physicians to bill for interest owed (operational policy).	Blue Plus requires physicians to bill for interest owed (operational policy).	HP requires physicians to bill for interest owed (operational policy). The contract does provide that HP "... shall issue payment ... within 30 days of receipt of all required payment information."
Claims Adjustments The Quick Reference Guide describes, for the health plan and the provider, the authority and timeline for seeking payment adjustments to claims.	Blue Cross has very broad authority to deduct overpayments "of any type" from future provider payments. (The agreement is silent as to the process or time limit available to physicians seeking an adjustment).	Blue Plus may recover overpayments "of any type," including risk-sharing amounts. PCC must bring payment disputes to the attention of Blue Plus within 3 months of payment or denial.	HP has a policy for providers to submit adjustments for payments. There is no time limit for providers to request adjustments. Similarly, there is no time limit for adjustments made by HP.
Payment Methodology The Quick Reference Guide describes the general physician payment methodology used by the health plan. Physicians interested in knowing the specific payment rates applicable to their practice should refer to their individual contracts and/or contact the specific health plan.	Payment is the lesser of billed charges or the BCBS fee schedule, which is based on the Centers for Medicare & Medicaid Services (CMS) Relative Value Units (RVUs). The 2002 RVUs were implemented July 1, 2002, with no site-of-service differential and without application of the MN geographic practice cost indices (GPCIs).	Payment is the lesser of billed charges or the Blue Plus fee schedule, which is based on the Centers for Medicare & Medicaid Services (CMS) Relative Value Units (RVUs). The 2002 RVUs were implemented July 1, 2002, with no site-of-service differential and without application of the MN geographic practice cost indices (GPCIs). Blue Plus may also apply a withhold to a portion of the payment, the return of which is linked to defined utilization targets. PCCs will not be at risk for any amounts in excess of the withhold amount. For 2003, most PCCs will be at a 0% withhold, but will continue to be eligible for bonus payments.	HP utilizes a variety of payment methods, including capitation, fee-for-service with a withhold, fee-for-service, and case rates.
Indemnification Provisions The Quick Reference Guide describes the indemnification provisions contained in the contract. Indemnification allocates liability in the event that the provider or the health plan is subject to a lawsuit. Although often not of concern, the provision can be important, especially if one party attempts to shift liability to the other. Under state law, if there is no indemnification provision, each party is responsible for its own acts or omissions.	Under the agreement, the provider indemnifies (or holds harmless) BCBS broadly, including for "any act or omission caused by, or alleged to have been caused by" the provider or its agent or employee. Conversely, the agreement provides that BCBS will only indemnify the provider for acts or omissions by BCBS related to a "denial of coverage for Subscribers."	Under the agreement, the provider indemnifies (or holds harmless) Blue Plus broadly, including for "any act or omission caused by, or alleged to have been caused by" the provider or its agent or employee. Conversely, the agreement provides that Blue Plus will only indemnify the provider for acts or omissions by BCBS related to a "denial of coverage for Enrollees."	The agreement provides for mutual indemnification; the provider will hold HP harmless from liability against any and all claims for alleged negligence, malpractice or intentional misconduct of provider. The agreement similarly provides that HP will hold provider harmless from liability against any and all claims against provider for alleged negligence, malpractice or intentional misconduct.
Notes	BCBS has undertaken a comprehensive analysis and rewrite of the Aware agreement. Changes planned will be incorporated in the 2003 agreement.	BCBS has undertaken a comprehensive analysis and rewrite of the Aware agreement and the relevant changes are planned for incorporation in the 2004 Blue Plus PCC agreement.	HealthPartners is a family of nonprofit Minnesota health care organizations focused on improving the health of its members, its patients and the community. HealthPartners is consumer-governed. The HealthPartners family includes Group Health, a staff-model health maintenance organization (HMO) founded in 1957, and the former MedCenters Health Plan, a network-model HMO founded in 1972. HealthPartners affiliated with Regions Hospital, Ramsey clinics and Regions Hospital Foundation in 1993.
Provider Services Contact Information	651-662-5200 or 800-262-0820	651-662-5200 or 800-262-0820	Each clinic is assigned a provider relations contact, or call 952-883-5589 for assistance.

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Health Plan & Contract Name	HealthPartners (HP) Referral Provider Agreement	Medica Health Plans and Medica Insurance Company Associate Clinic Participation Agreement
<p>Contract Date, Term & Renewal Provisions</p>	<p>Current referral provider agreement, provided to MMA August 2002. Commonly, 1-year initial term with automatic renewal terms of 1-year. Renewal provisions can vary as negotiated.</p>	<p>Current clinic agreement, provided to MMA May 2002. Renews automatically for 2-year terms.</p>
<p>Amendment</p> <p>The Quick Reference Guide describes the process used for amending or revising the contract. Note that Minnesota law (§62Q.645) prohibits plans from amending the contract without notifying the provider.</p>	<p>The agreement may be amended unilaterally by HP upon giving 60 days written notice. If referral provider objects, a written objection must be postmarked within 30 days of the date the amendment was postmarked. Such amendments will not go into effect until mutually agreed-to by HP and provider. HP may amend the agreement unilaterally as required due to changes in state or federal law or upon demand by a state or federal agency.</p>	<p>Medica may unilaterally amend the agreement (with the exception of changes to the Fee Maximums and the Physician Contingency Reserve [PCR]) by providing notice 30 days prior to the effective date of the amendment. Amendments related to the PCR may only be effective at the beginning of a calendar year. Amendments that change the Fee Maximums require 60 days advance written notice. The agreement may be amended without the 30 day notification period if both parties mutually agree. Medica may amend the agreement to comply with laws and regulations and such amendments are effective on the date the law or regulation becomes effective.</p>
<p>Physician Termination Options</p> <p>The Quick Reference Guide describes the mechanisms by which physicians may terminate the contract. All contracts also include termination provisions available to the health plan (e.g., breach, credentialing standards, fraud), but those provisions are not identified here. Physicians should note that Minnesota HMO law (M.S. §62D.123, Subd. 3) requires that providers seeking to terminate a contract without cause must give the HMO 120-days advance notice.</p>	<p>Physicians can terminate by mutual agreement with HP, but only after the initial 120 days of the contract; without cause at the end of the contract term upon 120 days written notice; and for breach of contract if HP fails to remedy default within 60 days of written notice.</p>	<p>Physician clinics can terminate for breach of contract/default immediately upon written notice if Medica fails to remedy breach within 30 days of notice; without cause upon 125 days notice in advance of the termination date or each 2-year anniversary of such date; and for amendment changes, upon 125 days written notice to Medica, if such notice is given no more than 30 days after the date notice of the amendment was provided.</p>
<p>Claims Submission Deadlines</p> <p>The Quick Reference Guide describes the deadline(s) established by the health plan for submission of claims.</p>	<p>Providers must submit all claims for payment (other than those pending for COB) within 90 days of the date of service. Claims pending for COB shall be submitted within 60 days of determining HP's responsibility. HP has a late claims submission appeals process.</p>	<p>Providers must submit all claims within 180 days of the date of service. For COB claims, claims must be submitted within 18 months of the date of service (operational policy).</p>
<p>Interest Payment on Late Claims</p> <p>The Quick Reference Guide describes the current health plan policy regarding payment of interest on claims. Minnesota law (§62Q.75) requires payment of interest, at a rate of 1.5% per month, on clean claims that are not paid or denied within 30 days. The law, however, allows plans to require that providers bill the plan for interest owed.</p>	<p>HP requires physicians to bill for interest owed (operational policy).</p>	<p>Medica automatically calculates and pays interest owed (operational policy).</p>
<p>Claims Adjustments</p> <p>The Quick Reference Guide describes, for the health plan and the provider, the authority and timeline for seeking payment adjustments to claims.</p>	<p>HP has a policy for providers to submit adjustments for payments. There is no time limit for providers to request adjustments. Similarly, there is no time limit for adjustments made by HP.</p>	<p>Requests for adjustments to underpayments and any overpayments on claims must be made within 180 days from the date of payment or denial. This applies to Medica and the provider. The 180-day timeline excludes claims subject to fraud and abuse investigations, in which case Medica may make adjustments within 6 years of the date the claim was paid. Provider may use Medica's dispute resolution process to challenge any findings of overpayment (operational policy).</p>
<p>Payment Methodology</p> <p>The Quick Reference Guide describes the general physician payment methodology used by the health plan. Physicians interested in knowing the specific payment rates applicable to their practice should refer to their individual contracts and/or contact the specific health plan.</p>	<p>HP utilizes a variety of payment methods, including capitation, fee-for-service with a withhold, fee-for-service, and case rates.</p>	<p>Payment to physicians is generally based on the Resource-Based Relative Value Scale (RBRVS). The most current year Relative Value Units (RVUs), as published by the Centers for Medicare & Medicaid Services (CMS), are used upon contract renewal.</p>
<p>Indemnification Provisions</p> <p>The Quick Reference Guide describes the indemnification provisions contained in the contract. Indemnification allocates liability in the event that the provider or the health plan is subject to a lawsuit. Although often not of concern, the provision can be important, especially if one party attempts to shift liability to the other. Under state law, if there is no indemnification provision, each party is responsible for its own acts or omissions.</p>	<p>The agreement provides for mutual indemnification; the provider will hold HP harmless from liability against any and all claims for alleged negligence, malpractice or intentional misconduct of provider. The agreement similarly provides that HP will hold provider harmless from liability against any and all claims against provider for alleged negligence, malpractice or intentional misconduct.</p>	<p>The agreement provides that the provider will indemnify Medica against any and all claims, including the malpractice, negligence or breach by provider. Similarly, Medica will indemnify provider against any and all claims, including negligence or breach by Medica.</p>
<p>Notes</p>	<p>HealthPartners is a family of nonprofit Minnesota health care organizations focused on improving the health of its members, its patients and the community. HealthPartners is consumer-governed. The HealthPartners family includes Group Health, a staff-model health maintenance organization (HMO) founded in 1957, and the former MedCenters Health Plan, a network-model HMO founded in 1972. HealthPartners affiliated with Regions Hospital, Ramsey clinics and Regions Hospital Foundation in 1993.</p>	<p>The Medica Self-Insured Association Clinic Agreement was not included in this analysis. Many of the provisions listed here are the same across the two agreements. Medica is undertaking an assessment of its contracting process and is considering increasing the advance notification period given to providers for both initial contracts and amendments.</p>
<p>Provider Services Contact Information</p>	<p>Each clinic is assigned a provider relations contact, or call 952-883-5657 for assistance.</p>	<p>952-992-2232 or 800-458-5512 (SelectCare: 952-992-2500 or 800-858-9060)</p>