# MINNESOTA PROVIDER REQUIREMENTS

## 1. Liability Insurance Requirements.

### A. Providers/Practitioners/Facility.

All Providers must have a professional liability policy with a minimum limit of $1,000,000 per occurrence/$3,000,000 aggregate, except for practitioner types like Minnesota state-and/or county-run clinics and Public Health Service as discussed below;

i. **Public Health Service**: Federally supported health centers are deemed employees of the federal government and as such, are protected under the Federal Tort Claims Act (FTCA). These may include specified community health centers and Indian reservations. There are no liability limits specified, but FTCA meets any malpractice insurance coverage limits that may be required.

ii. **Minnesota state- and/or county-run clinics**: Protected under the State Tort Claims Act, which limits liability to $500,000 per claim/$1,500,000 for more than one claimant in a single occurrence for claims arising on or after July 1, 2009. (Minn. Stat. § 466.04)

## 2. Continued Provision of Health Services for Certain Members after Termination of the Agreement or Termination of Facility Provider or Clinic Provider Participation.

A. Unless otherwise provided in the Administrative Requirements, in the event the Provider Participation Agreement is terminated by Provider for any reason, the Provider Participation Agreement is terminated by Medica without cause, or, notwithstanding anything herein to the contrary, in any the event of any removal of Provider, a Clinic Provider, a Facility Provider, or a Provider location from Medica's networks that gives rise to a legal continuity of care obligation with regard to the services of a Provider, a Clinic Provider, a Facility Provider, or a Provider location, Provider will, and will cause Facility Providers and Clinic Providers to, continue to provide Health Services according to the terms of the Agreement to Members covered under a Benefit Contract after such termination. Such continuation of care will apply when requested by a Member and Medica determines that such Member meets the statutory criteria for in network benefits or continuity of care. Health Services provided in accordance with subsection 9.4.3 of the Provider Participation Agreement will be provided for:

i. Up to one hundred twenty (120) days if the Member was undergoing a current course of treatment for one or more of the following conditions at the time of termination:

**Individual & Family Business (IFB) Members:**

a. A life-threatening physical or mental illness;
b. An ongoing course of treatment for an acute condition, such as chemotherapy for the treatment of cancer;
c. Scheduled non-elective surgery, including postoperative care;
d. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the postpartum period;
e. An ongoing course of treatment for a health condition for which a treating physician or Provider attests that discontinuing care by that physician or Provider would worsen the condition or interfere with anticipated outcomes;
f. Undergoing a course of institutional or inpatient care from the Provider or facility;
g. A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death;
h. A disabling or chronic condition that is in an acute phase; or
i. An ongoing course of treatment for a chronic condition.

**Commercial Members:**

a. Continuity of care is available if Member is in an active course of treatment with a treating Provider, and:
    1. The contract between Medica and the treating Provider terminates without cause; or
    2. Medica Member's employer terminates its health plan, and their current treating Provider is not a network provider.
b. Up to one hundred twenty (120) days if the Member was undergoing a current course of treatment for one or more of the following conditions at the time of termination:
    1. An ongoing course of treatment for an acute condition;
    2. A life-threatening mental or physical illness;
    3. Undergoing a course of institutional or inpatient care from the Provider or facility;
    4. Scheduled non-elective surgery, including postoperative care;
    5. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care;
    6. A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability

has lasted or can be expected to last for at least one year or can be expected to result in death;
7. A disabling or chronic condition that is in an acute phase; or
8. An ongoing course of treatment for a chronic condition.

ii. The remainder of the Member's life if a physician certifies that the Member has an expected lifetime of one hundred eighty (180) days or less.

iii. The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees who request continuity of care with their former Provider, if the enrollee:
   a. is receiving culturally appropriate services and the health plan company does not have a Provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1 of the Minnesota Statutes; or
   b. does not speak English and the health plan company does not have a Provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1 of the Minnesota Statutes.

iv. The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

B. Health Services provided in accordance with Subsections 9.4.3 of the Provider Participation Agreement will be reimbursed by Medica in accordance with the terms of the Appendices to the Agreement.

C. As stated in your Provider Participation Agreement, Provider will accept as payment in full Medica's reimbursement to Provider for such Health Services at the contracted rates applicable prior to termination, as set forth in the Appendices to the Agreement.

**3. Member Protection Provisions**

A. The following provisions are incorporated into the Provider Participation Agreement:

PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST ANY MEMBER OR PERSONS ACTING ON HIS OR HER BEHALF FOR SERVICES PROVIDED UNDER THE PROVIDER PARTICIPATION AGREEMENT. THIS PROVISION APPLIES TO, BUT IS NOT LIMITED TO, THE FOLLOWING EVENTS: (1) NONPAYMENT BY MEDICA OR (2) BREACH OF THE PROVIDER PARTICIPATION AGREEMENT. THIS PROVISION DOES NOT PROHIBIT PROVIDER FROM COLLECTING COPAYMENTS, COINSURANCE, DEDUCTIBLES OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THE PROVIDER PARTICIPATION AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THE AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF MEMBERS. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THE AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN PROVIDER AND MEMBER OR PERSONS ACTING ON HIS OR HER BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THE AGREEMENT.

FOR PURPOSES OF THIS PROVISION, NONPAYMENT BY MEDICA WILL INCLUDE NONPAYMENT BY MEDICA IN THE EVENT OF ITS INSOLVENCY.

B. The following provision is incorporated into the Provider Participation Agreement as required by the federal regulations promulgated by the Secretary of Health and Human Services pursuant to authority granted to the Secretary under the Health Insurance for the Aged Act, 42 U.S.C. § 1395hh, which regulations are codified at 42 C.F.R. § 417.122(b):

    a. Provider agrees that in the event of Medica's insolvency, Provider will continue to provide any Member with Health Services from the date of Medica's insolvency for the duration of the contract period for which premium payment has been made by such Member. Furthermore, Provider will continue to provide Health Services to those Members who are confined in an inpatient facility until such Members are discharged.

**4. Prompt Pay.**

Medica will pay claims that are clean within 30 calendar days after the date upon which Medica or its Affiliate received the claim.

If a clean claim is not paid timely (within 30 calendar days), the rate of interest paid by Medica or Affiliate shall be 18% per annum.

"Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim.

## 5. Medical Records.

Medica does not reimburse participating Providers for the cost of collecting, copying or delivering requested medical records, except when required by law. Participating Providers, and any subcontractors or third parties who may collect, copy and/or deliver records for such Providers, may not bill Medica or any Medica Member for expenses related to a records request from Medica.

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