American Hospital Association

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Medicare Advantage

A Primer for America's Hospitals

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Session 4: Medicare Advantage Issues for Small and Rural Providers

I. Introduction

In this session, we will review topics discussed in previous sessions with an eye towards understanding how such topics impact small and rural hospitals.[1] Historically, few such providers have had the opportunity (or challenge) of participating in Medicare managed care. Now, as a consequence of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"), Medicare Advantage ("MA") plans will be offered to Medicare beneficiaries in most parts of the country. As a result, it is anticipated that small and rural hospitals, which were previously largely unaffected by Medicare managed care, will be asked to furnish services to MA enrollees with significantly greater frequency. While in many instances this will be done "by design" (i.e., as a network provider), in others it will be done "by circumstance" (e.g., as a non-network provider furnishing urgent care or emergency services). Moreover, as detailed more fully below, small and rural hospitals will be "deemed" to be contract providers of private fee-for-service ("PFFS") plans, subject to the terms and conditions of payment offered by such plans, where certain modest criteria are met. As a result, it is important for all small and rural providers to have a basic understanding of how the MA program operates — including the regulatory requirements affecting providers and the core payment rules — even if they do not intend to formally participate in an MA plan provider network.

II. Projected MA Growth in Rural Areas

A. Historical Perspective

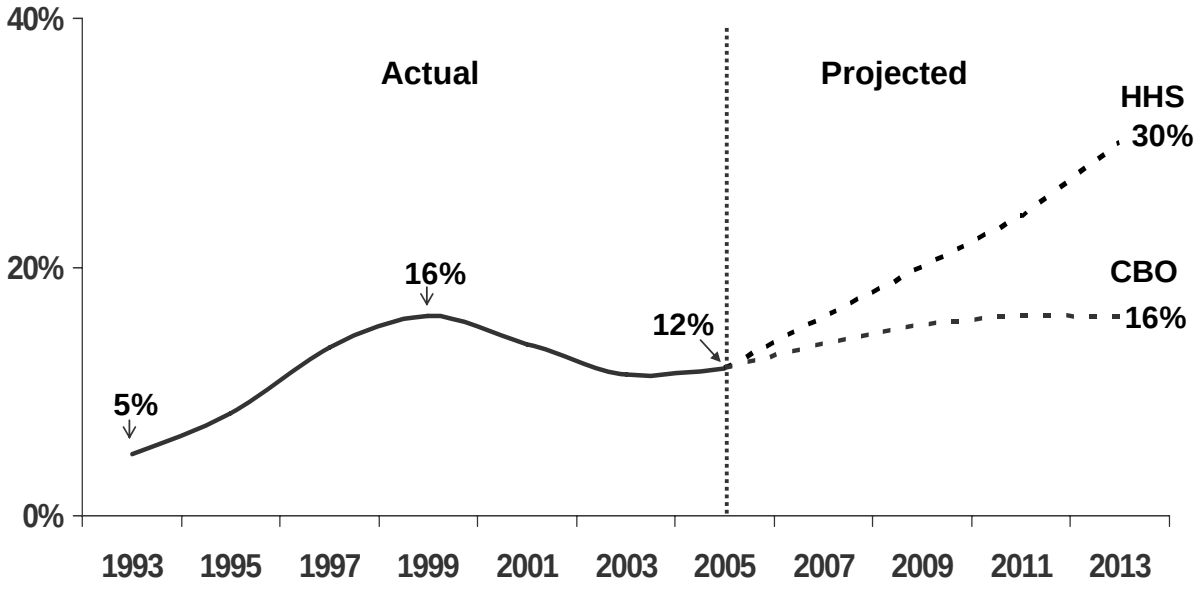
Health plan participation in Medicare Part C (formerly known as "Medicare+Choice," and now referred to as "Medicare Advantage") nearly quadrupled between 1992 and 1998, and

[1] We encourage you to review the Primers for Sessions 1 through 3, each of which is available at www.aha.org/aha/re/Medicare.

then steadily declined through 2004. In 2005, however, there was a significant resurgence in the number of Medicare managed care enrollees and plans. As of August 1, 2005, for instance, 5.1 million Medicare beneficiaries (or approximately 13% of all Medicare beneficiaries) had chosen to receive health care benefits through one of 290 MA plans.[2] By September 1, 2005, just one month later, 5.9 million beneficiaries (or approximately 14% of the Medicare population) had elected to obtain Medicare benefits through 319 MA plans.[3]

While there is much debate among government and other prognosticators concerning the likely number of plans (and Medicare beneficiaries) that will participate in the MA program in the coming years, there is general agreement (as illustrated in the chart below) that the trend will be upward on both fronts in 2005 and will further accelerate in 2006. For rural markets without any current Medicare managed care, even limited growth will have significant practical consequences, since such growth will require providers to invest time, energy and resources in learning about (and adjusting to) the unique requirements of Medicare managed care.

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans



Note: All actual data are from December of the given year, except 2005 data are from July.
SOURCE: Actual: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report. Projections: President's FY 2006 Budget, Office of Management and Budget, February 7, 2005; CBO from CBO Medicare Baseline, March 2005.

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Source: Kaiser Family Foundation, Medicare Chart Book, Summer 2005

[2] Centers for Medicare & Medicaid Services ("CMS") Medicare Managed Care Contract Report as of August 1, 2005.

[3] CMS Medicare Managed Care Contract Report as of September 1, 2005.

B. Information Available on the CMS Website

CMS recently posted information on the agency website listing MA plans that will be offered in each of the 50 states and certain jurisdictions (e.g., the District of Columbia, Puerto Rico, and the Virgin Islands). The MA plan options available to Medicare beneficiaries in 2006 will vary greatly by region. Thus, for instance, only PFFS plans will be available in Alaska, while health maintenance organization ("HMO"), local and regional preferred provider organization ("PPO"), and PFFS plans will be offered in Alabama.[4]

A review of the MA plans that will be available in largely rural states suggests significant progress towards Congress' goal of creating alternatives to original fee-for-service Medicare for beneficiaries residing in rural communities. Thus, Medicare managed care plans will be offered for the first time in many rural counties, and will be offered in significantly greater number in still others. By way of example, beginning in 2006, Montana will be served by one Regional PPO, one local PPO, and two PFFS plans.[5] Similarly, South Carolina will be served by two Regional PPOs, one local PPO, one HMO, and one PFFS plan.[6] In some states, however, MA plans will be available in only part of the state.

C. Reasons for MA Growth in Rural Areas, Particularly with Respect to PFFS and Regional PPO Plans

As discussed in earlier sessions, the growth of MA plans in rural areas can be traced directly to changes in the MMA. First, in an effort to encourage the expansion of MA plans into parts of the country not previously served by M+C organizations, Congress created Regional PPOs covering geographic areas consisting of at least an entire state (and in many instances, multiple states). Regional PPO Plans will be required to offer uniform covered benefits (and identical out-of-pocket costs) to all enrollees residing within the region. To encourage the offering and retention of Regional PPOs, Congress modified the payment methodology for such plans, offered additional economic incentives, and established risk sharing mechanisms designed to protect against significant loss.[7] All this has resulted in a proliferation of MA Regional PPOs.

Second, the MMA amended the Social Security Act to prohibit the issuance of new Medicare supplemental insurance policies (commonly known as "Medigap" policies) with prescription drug coverage after January 1, 2006.[8] It is generally thought that this will accelerate growth in MA plan enrollment because MA plans with prescription drug coverage ("MA-PDs") offer "one stop shopping" for those Medicare beneficiaries seeking fairly comprehensive medical and drug coverage. By contrast, those Medicare beneficiaries not enrolled in MA plans who

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4 For a list of MA plans operating in your state, go to www.Medicare.gov/medicarereform/map.asp#ND.

5 Id.

6 Id.

7 For more information, see the discussion of Regional PPO payment issues in the Session 2 Primer.

8 42 U.S.C. § 1395ss(v).

seek a similar level of coverage will generally need to enroll in Medicare Parts A and B, sign up for a Medicare prescription drug plan ("PDP"), and purchase a Medigap policy.[9]

Finally, many companies are betting that the "consumer directed health insurance" trend evidenced in the commercial health care market will resonate with Medicare beneficiaries, and translate into substantial PFFS plan enrollment. As a result, MA organizations will be offering PFFS plans for the first time in many rural areas of the country effective January 2006. While only time will tell if beneficiaries in rural areas will find this particular type of plan attractive, many companies are betting that Medicare beneficiaries will be willing to try something new as long as they can preserve significant freedom to choose their own physicians and hospitals.[10]

III. General Recap

A. Contract Providers

As discussed previously, in instances where hospitals and other providers directly contract with MA organizations, the terms and conditions of the relationship between the parties will be largely governed by written agreement. While the parties will be generally free to structure their relationship as they like, certain contract terms must be included in all MA provider contracts (as described below).[11]

1. Payment Based on Negotiated Contract Terms

From a business perspective, the most significant terms of the MA provider contract will relate to the amount and conditions of payment. There is no statutory or regulatory requirement that the contract payment correlate, in any way, to what the provider would have received under the original Medicare program.[12] As a result, payment amounts and/or methodologies, and the frequency and promptness of payment, are all terms that are open to negotiation. In practice, MA organizations sometimes pay providers more generously than they would have been paid under original Medicare, and some times pay providers less. The negotiated payment amount will (not surprisingly) vary based on market conditions, including local competition, hospital reputation and areas of specialty.

Notably, a recent survey of critical access hospital ("CAH") administrators found that most final MA contracts specified (after negotiation) that the CAH would be paid using a cost-based methodology, at either 100% or 101% of cost.[13] However, some of the CAH administrators surveyed indicated that they had entered into contracts with payment terms based

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[9] The benefits offered under each individual MA-PD plan will vary, as will the benefits offered under the many types of Medigap plans.

[10] The open question is whether small and rural hospitals will choose to participate in PFFS networks, as either contracted or deemed contracted providers. For the most part, this will depend largely on the specific payment and other terms being offered by the PFFS plans.

[11] See, e.g., 42 C.F.R. § 422.504(i).

[12] H.R. 880, sponsored by Rep. Kind (D-WI) and supported by the AHA, would guarantee critical access hospitals at least 101 percent of Medicare allowable costs within Medicare Advantage contracts. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h880ih.txt.pdf.

[13] Rural Health Policy Brief, Contracting with Medicare Advantage Plans: A Brief for Critical Access Hospital Administrators (December 2005), available at http://www.rupri.org/healthpolicy under "policy briefs."

on a lower percentage of cost or Medicare PPS rates.[14] For each individual hospital, contract terms for reimbursement of outpatient services generally were the same as terms for in-patient services.[15] About two-thirds of signed cost-based contracts included provisions for annual cost settlement, but in some cases administrators had to negotiate to get cost settlement terms in the final contract.[16]

2. Mandated Contract Provisions

As we discussed in Session 3, and as referenced above, the MA regulations require the inclusion of specific provisions in an MA organization's contract with network providers.[17] Such contracts must provide as follows:

1. The Department of Health and Human Services, the Comptroller General, and their designees shall have the right to inspect, evaluate, and audit any of the provider's pertinent contracts, books, documents, papers, and records involving transactions related to the MA contract for a period of six years from the final date of the contract period or from the date of completion of any audit, whichever is later.[18]

2. The provider shall not hold enrollees liable for payment of any fees that are the obligation of the MA organization.[19]

3. The MA organization may only delegate activities or functions to a provider pursuant to written agreements that meet the following requirements:

   (a) specify the relevant delegated activities and/or reporting responsibilities;

   (b) either provide for revocation of the delegation activities and/or reporting requirements or specify other remedies in instances where CMS or the MA organization determines that the delegated party has not performed satisfactorily;

   (c) specify that the performance of the parties will be monitored by the MA organization on an ongoing basis;

   (d) specify that either (1) the credentials of medical professionals affiliated with the party or parties will be reviewed by the MA organization; or (2) the credentialing process will be reviewed and approved by the MA organization and the MA organization will audit the credentialing process on an ongoing basis; and

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[14] Id.

[15] Id.

[16] Id.

[17] 42 C.F.R. § 422.504(i).

[18] Id. § 422.504(i)(2)(i) and (ii).

[19] Id. § 422.504(i)(3)(i). Such provision must apply, without limitation, to instances of insolvency of the MA organization or contract breach. Medicare Managed Care Manual ("MCM"), Ch. 11, § 100.4.

(e) specify that the provider must comply with all applicable Medicare laws, regulations, and CMS instructions.[20]

4. The provider shall perform services or other activities under the contract consistent with the MA organization's contractual obligations to CMS.[21]

5. The provider shall safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records.[22]

6. The MA organization shall pay the provider pursuant to "prompt payment" terms agreed upon by the MA organization and the provider.[23]

7. The provider shall comply with the MA organization's policies and procedures.[24]

3. Contract Adoption of MA Policies & Procedures

CMS has determined that certain provisions do not need to be specifically included in the provider contract, but must be addressed in the MA organization's policies and procedures and distributed to network providers.[25] There are thirty-two items that are essentially incorporated by reference into the provider contract in this way. This approach to provider contracting reflects CMS' recognition that MA organizations need the direct cooperation and support of their network providers in order to comply with many of the MA program requirements.

The MCM contains a helpful table summarizing the various regulatory requirements that must be included in the MA organization's policies and procedures.[26] We reference a few of the relevant requirements here:

1. Providers must safeguard the privacy of patient information and maintain records in a timely and accurate fashion.[27]

2. Providers may not generally discriminate against MA plan enrollees on the basis of health status.[28]

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[20] 42 C.F.R. § 422.504(i)(4).

[21] Id. § 422.504(i)(3)(iii).

[22] Id. § 422.118; MCM, Ch. 11, § 100.4.

[23] 42 C.F.R. § 422.520(b).

[24] MCM, Ch. 11, § 100.4. As a result, it is critical that hospitals and other providers review the MA organization's Policies & Procedure Manual prior to executing a contract in order to evaluate required obligations under the contract and access likely administration and other costs associated with compliance.

[25] Id.

[26] Given the importance of these requirements, we provide a link to the MCM here: http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326. Click on Chapter 11, § 100.4.

[27] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.118.

[28] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.110(a).

3. MA plan services must be available 24 hours per day, 7 days per week, when medically necessary.[29]

4. Services must be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.[30]

5. Providers must ensure that enrollees are informed of specific health care needs that require follow-up care and receive, as appropriate, training in self-care and other measures they may take to promote their own health.[31]

6. Providers must document in a prominent place in the medical record if the MA plan enrollee has executed an Advance Directive.[32]

7. Providers must acknowledge that they are subject to laws applicable to recipients of Federal funds, including the False Claims Act and the anti-kickback statute.[33]

8. Providers must certify the completeness and truthfulness of all encounter data submitted to the MA organization.[34]

9. Providers must cooperate with quality review and improvement organizations.[35]

10. Providers must not employ or contract with individuals or entities that are excluded from participation in Medicare.[36]

4. Implications of Federal Preemption

In the MMA, Congress strengthened the federal preemption of state managed care and other laws with respect to the MA program.[37] Thus, "state laws do not apply to MA plans offered by MA organizations," with the limited exception of State licensing laws and laws relating to insurance company and HMO fiscal solvency.[38] As a result, MA providers should seek to directly address issues in their contracts that would have been governed by state law had such laws not been preempted by federal law (e.g., penalty for slow payment and the process for appealing denied claims and resolving other disputes).

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[29] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.112(a)(7).

[30] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.112(a)(8).

[31] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.112(b)(5).

[32] MCM, Ch. 11, § 100.4; see 42, C.F.R. § 422.128(b)(1)(ii)(E).

[33] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.502(h)(i).

[34] MCM, Ch 11, § 100.4; see 42 C.F.R. § 422.504(l)(3).

[35] MCM, Ch. 11, § 100.4; see 42 C.F.R. § 422.152(a).

[36] MCM, Ch 11, § 100.4; see 42 C.F.R. § 422.752(a)(8).

[37] See 42 C.F.R. § 422. 402; 70 Fed. Reg. 4588, 4663 (Jan. 28, 2005). See also MCM, Ch. 10.

[38] 42 C.F.R. § 422.402; 70 Fed. Reg. at 4663-64.

B. Non-Contract Providers

As discussed in the Session 2 Primer, providers who have not contracted with MA organizations may nevertheless be asked to provide care to MA plan enrollees. This may occur, for example, when an MA enrollee is in need of emergency or urgently needed care or when a beneficiary enrolled in a local or Regional PPO chooses to go out-of-network to receive care from a non-contract provider, usually with greater out-of-pocket cost. Moreover, beneficiaries enrolled in MA PFFS plans may seek to obtain care from any Medicare participating provider willing to accept the PFFS plan's terms and conditions of payment.

While non-contract providers across the country may encounter MA enrollees seeking care, providers in rural areas of the country may be particularly impacted by this phenomenon. This is because MA organizations in rural areas are, for the most case, developing provider networks for the first time. A new MA organization may be conservative in its network development strategy, contracting with a limited number of providers (at least initially) due to uncertainty as to the number of beneficiaries who will enroll its MA plan. Likewise, a rural provider may be reluctant to contract with an MA organization, especially given the perceived complexity of participating in an MA network as compared to the more familiar original Medicare program.

Given the important challenges that non-contracting small and rural hospitals face, we address a series of basic questions below.

1. Will the Hospital Get Paid by the MA Plan?

The MA regulations require MA organizations to make timely and reasonable payments to non-contract providers for the following:

- ambulance services dispatched by 911 or its local equivalent;[39]
- emergency and urgently needed services;[40]
- maintenance and post-stabilization care services;[41]
- renal dialysis services provided when the enrollee was temporarily outside the MA plan's service area;[42] and
- services for which coverage has been denied by the MA organization and found (upon appeal) to be services the enrollee was entitled to have furnished or paid for by the MA organization.[43]

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[39] Id. § 422.100(b)(1)(i).

[40] Id. § 422.100(b)(1)(ii).

[41] Id. § 422.100(b)(1)(iii).

[42] Id. § 422.100(b)(1)(iv).

[43] Id. § 422.100(b)(1)(v).

For other types of services, the MA organization's obligation to pay will depend on the specific type of MA plan involved. Thus, for instance, HMO plans generally do not cover services furnished by non-network providers, except in those instances listed above. By contrast, Regional PPOs are generally obliged to pay non-contract providers where enrollees go out-of-network to receive covered non-emergency/non-urgent care. Where a Medicare beneficiary is authorized to receive services "out-of-network," MA organizations are required to pay non-contracting providers who furnish such services "an amount the provider would have received under original Medicare."[44] As a practical matter, providers should check with the specific MA plan regarding coverage rules before furnishing services, except in the case of EMTALA-required services.

2. What Will the MA Organization Pay the Hospital?

As noted above, non-contract providers are to be paid what they would have received under original Medicare.[45] This means that MA organizations must pay providers consistent with the complex payment rules that apply in the "original Medicare" context for the particular services at issue. As a result, payment formulas will vary based on the type of provider (e.g., hospital vs. physician) and the type of services (e.g., in-patient vs. outpatient). Thus, for instance, hospitals paid under the in-patient prospective payment system ("PPS Hospitals") are typically paid Diagnosis Related Group ("DRG") rates plus "add-ons," if any. Certain qualifying rural hospitals receive special enhanced payment based on their status. Critical access hospitals, by contrast to PPS Hospitals, are paid on a cost basis under original Medicare. The complexity of the payment system under original Medicare presents significant challenges for an MA organization, which must determine what the non-contract provider would have been paid under original Medicare (including beneficiary cost sharing) and make an equivalent payment to the provider (after subtracting beneficiary cost-sharing amounts under the MA plan).

a) PPS Hospitals

Under original Medicare, PPS Hospitals will typically receive PPS payments plus add-ons, such as graduate medical education ("GME"), indirect medical education ("IME"), and disproportionate share payments ("DSH").[46] In many instances, rural hospitals fall into special categories, which result in adjustments to the standard PPS payment. These categories include:

(1) Sole Community Hospitals

To qualify as a Sole Community Hospital ("SCH"), a hospital must be the sole source of in-patient hospital services available to Medicare Part A beneficiaries within 35 miles or be located in a rural area and meet other specific criteria.[47] SCHs receive either the PPS payments

[44] See 42 C.F.R. § 422.100(b)(2).

[45] Id.

[46] Id.; 70 Fed. Reg. 4611. Note that non-contracting providers will not receive IME and GME payments from MA organizations as such payments will continue to be made by Medicare fiscal intermediaries (as appropriate) for all Medicare beneficiaries (including MA plan enrollees). 70 Fed. Reg. at 4611, 4629.

[47] See 42 C.F.R. § 412.92(a).

or a hospital-specific payment rate, depending on which amount yields the greatest aggregate payment for the cost reporting period.[48]

(2) Rural Referral Centers

CMS has established criteria for rural hospitals to qualify as rural referral centers ("RRCs").[49] These criteria provide special treatment to rural hospitals that have operating costs that are more similar to urban hospitals than smaller community hospitals. Such factors include bed size, a large number of complicated cases, a high number of discharges, or a large number of referrals from other hospitals.[50] RRCs are paid the PPS rate that would be used to pay hospitals in large urban areas.[51] RRCs also receive special DSH adjustments using the DSH adjustment formula for large urban hospitals.[52]

(3) Medicare-Dependant, Small Rural Hospitals

To qualify as a Medicare-Dependant, Small Rural Hospital ("MDH"), the hospital must generally 1) be located in a rural area, 2) have 100 or fewer beds during the cost reporting period, 3) not be classified as an SCH, and 4) have at least 60 percent of its in-patient days or discharges be attributable to individuals receiving Part A benefits during particular cost reporting periods.[53] For in-patient costs, MDHs are generally paid the Federal payment rate applicable to the hospital and 50 percent of the amount that the Federal rate is exceeded by the hospital specific rate.[54] An MDH may be eligible for additional payments if it is experiencing a significant volume decrease.[55]

b) Critical Access Hospitals

Many rural hospitals receive payments under the original Medicare program on a cost basis because they are designated critical access hospitals. In order to qualify as a CAH, the hospital must:

1. Be located in a rural area;

2. Provide 24-hour emergency care services;

3. Have an average length of stay of 96 hours or less;

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48 Id. § 412.92(d).

49 42 U.S.C. § 1395ww(d)(5)(C)(i).

50 Id; 62 Fed. Reg. 26317, 26321-22 (May 12, 1998).

51 Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"), Pub. L. 108-173, § 403, 117 Stat. 2066 (Dec. 8, 2003), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_public_laws&docid=f:publ173.108.pdf.

52 Id. § 402.

53 42 C.F.R. § 412.108(a).

54 Id. § 412.108(c). The Deficit Reduction Act of 2005, pending enactment, would pay MDHs 75 percent of the difference. See S. 1932, Section 5003.

55 42 C.F.R. § 412.108(d).

4. Be located more than 35 miles from a hospital or another CAH, or more than 15 miles in areas with mountainous terrain or only secondary roads, or certified by the state as being a "necessary provider" of health care services in the area.[56]

A CAH may operate up to 25 beds for acute in-patient care (which may be swing beds), subject to the 96 hour length of stay requirement.[57]

A CAH is paid for in-patient and outpatient services on the basis of 101 percent of its current Medicare-allowable costs.[58] There are two CAH payment methods: 1) the Standard Payment Method, and 2) the Optional (Elective) Payment Method.[59] Under both methods, the CAH is paid on a cost basis for facility charges.[60]

c) Practical Challenges

(1) General

In order to comply with the MA payment rule for non-contract providers, MA organizations must have the capacity to determine what Medicare would have paid for any Medicare covered services furnished by a non-contracted provider in any area in the nation.[61] Where national PPS or fee schedules exist, payment calculations under original Medicare are relatively straightforward.[62] Even here, however, as noted, payment formulas for certain rural hospitals that qualify for SCH, RRC or MDH status are more complicated. Moreover, where payments are made based on reasonable costs or reasonable charges – as in the CAH context – it can be difficult to determine payment levels consistent with Medicare.[63]

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[56] This state certification provision sunsets as of January 1, 2006, with grandfather rights for certain CAHs. More information on CAHs can be found at: http://www.cms.hhs.gov/center/cah.asp.

[57] 42 U.S.C. § 1395(i)-4.

[58] Pub. L. 108-173, § 405.

[59] The method II billing option allows CAHs to bill for professional services performed in the outpatient department in exchange for 115 percent of the physician fee schedule. 42 C.F.R. § 413.70.

[60] Pub. L. 108-173, § 405(a).

[61] 65 Fed. Reg. 42170, 40296 (June 29, 2000).

[62] CMS provides public access to fee-for-service fee schedules and reimbursement rates. 70 Fed. Reg. at 4630. It also assists MA organizations in pricing claims for out-of-network providers by making "Grouper/Pricer" software and other Medicare claims pricing tools available to such organizations. Id. That said, CMS recognizes that "with payment rates and computations varying by provider type, locality, provider ID and service, and with the potential that an MA plan enrollee might access covered services in any part of the United States, the task of correctly applying fee schedules that are generally updated on a quarterly basis can be daunting." Id. CMS notes that "when one considers the low volume of such claims that an MA organization would expect to receive and the administrative effort involved in correctly pricing them, one begins to understand that simply making such data and systems available to MA organizations does not ensure that correct payment calculations will always occur." Id.

[63] CMS has acknowledged that calculating payments to non-contracted critical access hospitals may be especially difficult and has indicated that it will engage in increased monitoring of payments to hospitals in this context. 70 Fed. Reg. at 4631.

(2) PFFS

Recognizing that "[a]cquiring the payment amounts from individual Medicare intermediaries and carriers would be a cumbersome and difficult task, and would be likely to result in unwanted payment delays," CMS permits MA organizations offering PFFS plans to establish and use proxies in paying for services for which no Medicare prospective payment system or fee schedule exists.[64] In the preamble to the Medicare+Choice Final Rule, CMS states that "[t]hese proxy amounts must be approved by [CMS] as approximating as closely as possible what providers as a whole receive for [such] services."[65] CMS has indicated that because proxy payments are only estimates, Medicare Advantage organizations must offer an appeal mechanism by which providers may request review of individual amounts paid.[66] It is our understanding that since non-network PFFS plans meet their MA access requirements by representing that they pay providers no less than the amount Medicare would have paid under original Medicare, CMS has asked MA organizations to keep track of provider complaints and correct their payment methodology when such methodology results in providers receiving less than they would have received under original Medicare.

(3) CAHs

As noted above, non-contracting hospitals, including CAHs, which provide care to MA plan enrollees are to be paid what they would have received under original Medicare. Since under original Medicare CAHs are paid on a cost basis, this approach to paying non-contracting CAHs presents certain inherent complexities. In the context of original Medicare, there is a reconciliation process that allows cost-based payments to be perfected. However, in the context of the MA program, MA organizations reimburse non-contract providers based on interim payment amounts under original Medicare, with no subsequent adjustment based on the cost reconciliation process. Acknowledging that the lack of a reconciliation process will result in payments to CAHs that are less accurate (whether positive or negative), CMS has suggested that non-contracting CAHs may want to request mid-year updates to their interim payments. MA plans will, in turn, obtain cost data from fiscal intermediaries and carriers in calculating payments to CAHs.

d) Disputes Regarding What An MA Organization Owes Non-Contracting Providers

As we discussed in the Session 1 Primer, if an MA organization denies a request for payment from a non-contracting provider, it must notify the provider of the specific reason for the denial and describe the appeals process.[67] A non-contracting provider that wishes to appeal a

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64 65 Fed. Reg. at 40296

65 Id.

66 65 Fed. Reg. at 40296; CMS PFFS Question and Answer Guidance for Providers ("PFFS Q&A") at 4 available at http://www.cms.hhs.gov/PrivateFeeforServicePlans/Downloads/Provqa.pdf; Program Transmittal AB-02-123 (Aug. 28, 2002), at 2; MCM, Ch. 4, § 150.8. It is unclear whether CMS anticipates that MA organizations will provide a dispute resolution mechanism separate and apart from that required under the MA program generally (which is described more fully below). Notably, providers may only avail themselves of the formal MA appeal process by waiving their right to seek additional payment from the beneficiary.

67 MCM, Ch. 13, § 40.2.3.

payment denial must sign a waiver of liability statement (i.e., waive any right to collect payment from the enrollee for the service at issue).[68] Hospitals may be able to avail themselves of CMS' assistance in resolving payment disputes in some instances, but any such assistance would be provided informally on a case-by-case basis (and not through an established mechanism).[69]

Non-contracting providers thinking about pursing a payment dispute with an MA organization may wish to consult with competent counsel before proceeding.

3. What Can a Non-Contract Provider Charge MA Enrollees?

Cost-sharing responsibilities of MA enrollees to hospitals generally take the form of deductibles and co-payments specified under the terms of the plan. For instance, MA coordinated care plans that provide optional supplemental benefits will typically require beneficiary cost-sharing (in the form of co-payments) which must be paid directly by the beneficiary to the provider or physician. Likewise, PPOs (whether local or regional) typically impose specific cost-sharing (in the form of co-payments to providers) when their enrollees choose to go to an out-of-network provider or physician. PFFS plans are required to inform providers concerning the amount they are permitted to collect from enrollees under the Plan.[70] Notably, special rules apply to limit enrollee cost-sharing when a beneficiary receives emergency services from an out-of-network provider.[71]

Non-contract providers furnishing services to MA plan enrollees should contact the MA plan – or otherwise determine via enrollment card, website or otherwise – the beneficiary's cost-sharing liability, if any.

a) Special Rules for Point-of-Service Option

A Point-of-Service ("POS") option may be offered as a supplemental benefit by MA coordinated care plans.[72] Where such an option is available, the enrollee may access designated services out-of-network. An MA Regional or local PPO is permitted to offer a "POS-like" benefit as a supplemental benefit where cost-sharing for out-of-network services is reduced, in a limited manner, for services obtained from out-of-network.[73] Offering a POS–like supplemental benefit does not affect the MA Regional or local PPO's responsibility to provide reimbursement for all covered benefits that are medically necessary, regardless of whether those benefits are provided within or outside the network of contracted providers.[74]

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[68] Id. at Ch. 13, §§ 40.2.3, 60.1.4 and 70.1.

[69] While CMS has not articulated specific policy on this issue, it would appear reasonable for non-contracting hospitals to contact their local regional CMS office to request assistance in connection with significant payment disputes with MA organizations. In the preamble to the MA regulations, CMS has expressed an interest in monitoring the nature and extent of such disputes.

[70] See, e.g., MCM, Ch. 4, § 150.2.

[71] 42 C.F.R. § 422.113(b)(2)(v).

[72] Id. § 422.105(b).

[73] Id. § 422.105(b)(4).

[74] Id.

b) Balance Billing

As we have discussed, an MA organization meets its obligation to non-contracting providers "if that MA plan provides payment in an amount the provider would have been entitled to collect under original Medicare (including balance billing permitted under Medicare Part A and Part B)."[75] As CMS has noted, the participation agreement between hospitals and CMS "requires the provider to accept the fee-for-service payment amount as payment in full for services provided to Medicare beneficiaries, including those enrolled in any type of MA plans."[76] In general, a non-contract provider may not collect from an enrollee more than the cost-sharing established by the MA plan, unless the provider has opted out of Medicare.[77]

IV. Private Fee-for-Service Plans

A. What are MA PFFS Plans?[78]

Although PFFS plans will be offered in significant number in rural areas, the degree to which Medicare beneficiaries will enroll in PFFS plans is unknown. Given the ease with which hospitals will be "deemed" to be contracting providers, it is important that hospitals understand the basics concerning how PFFS plans operate and take steps to identify the specific PFFS plans that will be operating in their area (and their specific terms and conditions of participation). As a practical matter, the list of MA plans operating in a given jurisdiction is available via the CMS website. In addition, PFFS plans are required to make their terms and conditions of participation (e.g., the amount of PFFS plan payment, provider billing procedures, enrollee cost-sharing, and any permitted balance billing) reasonably available to providers furnishing health care services to their enrollees.[79] This generally means that the MA organization offering the PFFS plan will post its terms and conditions on a web site and also make them available upon written or phone request. Based on this information, hospitals and physicians will need to make a business decision whether to contract with a particular MA PFFS plan, either directly or by deeming, and make such decision known to admissions staff. Hospitals are not obligated to serve Medicare beneficiaries enrolled in PFFS plans, except in emergency situations governed by EMTALA.[80]

It is important to note that, in certain instances, providers will be deemed to be contract providers even if they do not enter into contractual arrangements with a PFFS plan.[81] Thus, except in emergency situations (when care is required by EMTALA), a provider furnishing covered services to a PFFS plan enrollee will be deemed to be a contract provider (and subject to the same terms and conditions of payment as providers with written contracts) where, prior to furnishing services (1) the provider is informed of the individual's enrollment in the PFFS plan, and (2) is informed (or given the reasonable opportunity to obtain information) about the terms

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75 Id. § 422.100(b)(2).

76 70 Fed. Reg. at 4611.

77 See, e.g., 42 C.F.R. § 422.216(b)(2); 70 Fed. Reg. at 40295.

78 For detailed additional information about PFFS plans, see Primer Session 1 and http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

79 PFFS Q&A, at 1.

80 Id.

81 42 C.F.R. § 422.216(f).

and conditions of payment under the PFFS plan.[82] PFFS plans may permit balance billing by contracted (or deemed contracted providers) up to a limit, as specified under the plan. [83] Non-contracting providers may not balance bill.[84]

B. What Amounts are Paid to PFFS Providers?

1. Payments to Contracted and Deemed Contracted Providers

An MA PFFS plan must establish uniform payment rates for all contracted providers (those with written contracts and those deemed to be contracted providers).[85] The MA PFFS plan must pay both contracted and "deemed" contracted providers the fee-for-service amount specified by the plan in the terms and conditions of payment for the particular service minus any applicable enrollee cost-sharing.[86]

The PFFS plan has discretion in setting payment rates for contracted and deemed contracted providers. Where a PFFS plan establishes payment rates that are less than original Medicare for designated types of providers, the plan must demonstrate to CMS that it has a sufficient number of providers of each such type under written contract to meet Medicare access standards.[87] CMS assesses the sufficiency of a PFFS plan's contracted network on the same basis as network sufficiency for a coordinated care plan.[88] If a PFFS plan has an insufficient number of contracted hospital providers to furnish the services covered under the PFFS plan, it must pay all hospital providers (contracting, deemed and non-contracting) at least what they would have been paid under original Medicare and may not vary beneficiary cost sharing.[89] The MA PFFS plan must make information on its payment rates available to all providers furnishing covered services.[90]

2. Payments to Non-Contracted Providers

a) The Payment Rule

Given how easy it is for a hospital to become a "deemed" contracted provider, it is likely that very few providers will ultimately be considered non-contracted providers. There are, however, situations where a provider will not be considered a deemed contracted provider. This may occur, for instance, (1) in an emergency situation where care is required to be provided under EMTALA, and (2) if the enrollee fails to inform the provider of his or her PFFS plan enrollment. In such situations, the PFFS plan will be required to pay the provider an amount equal to the amount that the provider would have received under original Medicare (minus

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[82] Id.

[83] Id. § 422.216(b).

[84] MCM, Ch. 4, § 150.5.

[85] Id. § 422.216(a)(1)(i).

[86] Id. § 422.216(a)(2).

[87] MCM, Ch. 4, § 150.4. See also 65 Fed. Reg. at 40296.

[88] 42 C.F.R. § 422.214(c)

[89] Communication with CMS staff, February 27, 2006.

[90] Id. § 422.216(a)(1)(iii).

enrollee cost-sharing permitted under the plan).[91] At the same time, "the [non-contracted] provider must accept this payment as payment in full."[92] In the case of a PPS acute care hospital, the plan would typically pay the DRG payment (plus add-ons) less the enrollee's cost-sharing.[93]

b) Estimated Original Medicare Payments

In order to comply with this payment rule, MA PFFS plans must have the capacity to determine what Medicare would have paid for any Medicare covered services furnished by a non-contracted provider in any area in the nation, as explained above.[94] Where a PFFS plan bases payment on a proxy (e.g., in the CAH context), it must disclose this fact in its posted terms and conditions of participation.[95] Because proxy payments are only estimates, PFFS plans must offer an appeal mechanism by which providers may request review of individual amounts paid.[96] If a provider is able to demonstrate that the total amount it received in fee-for-service payments from the PFFS plan and in cost-sharing from the enrollee is less than it would have been paid under original Medicare, the PFFS plan must pay the provider the difference.[97]

C. What are PFFS Enrollee Payment Responsibilities?

1. Contracted and "Deemed" Contracted Providers

Contracted providers and "deemed" contracted providers may charge enrollees no more than the cost-sharing and balance billing amounts permitted by the MA PFFS plan.[98] While the PFFS plan may authorize balance billing by contract providers as part of its plan, such balance billing is limited by regulation to no more than 15 percent of the uniform fee-for-service payment rates established by the MA PFFS plan.[99] Any written provider contract must specify the amount of cost-sharing and balance billing allowed (consistent with the MA plan's terms).[100] However, where an MA PFFS plan has a sufficient network of contracted providers, there may be significant differences in the applicable enrollee co-payment provisions at "deemed" contracted providers, exposing enrollees to much higher out-of-pocket payments and the providers to higher levels of bad debt.

2. Non-contracted Providers

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91 Id. § 422.216(a)(3) and § 422.100(b)(2). This amount represents the payment "floor;" the PFFS plan may set payment rates above this level, if it so chooses. See also PFFS Q&A, at 3.

92 65 Fed. Reg. at 40295.

93 Id. CMS has indicated that certain statutory "add on" payments are considered part of the Medicare fee-for-service amount that an MA organization must make to non-contracted providers. 70 Fed. Reg. 4611. As noted previously, an MA organization is not required, however, to include IME or GME amounts in its payments to non-contracted providers to the extent that such providers receive IME or GME payments for MA plan enrollees directly from Medicare fiscal intermediaries. Id.

94 65 Fed. Reg. at 40296.

95 PFFS Q&A, at 4.

96 65 Fed. Reg. at 40296; PFFS Q&A, at 4; Program Transmittal AB-02-123 (Aug. 28, 2002), at 2.

97 PFFS Q&A, at 4. See also 65 Fed. Reg. at 40296.

98 42 C.F.R. § 422.216(b)(1)(i).

99 Id. § 422.216(b)(1)(ii).

100 Id. at § 422.216(b)(1)(iii).

A non-contracted provider may not collect from an enrollee more than the cost-sharing established by the MA PFFS plan, unless the provider has opted out of Medicare.[101] No balance billing is allowed.[102] A non-contracted provider must accept as payment in full the amount that it would have received under original Medicare for the item or service, and the PFFS plan must pay the provider that amount minus the enrollee's cost-sharing under the plan.[103]

D. Hypotheticals

Jean Smith comes into your hospital and presents a PFFS plan card. What do you do?

If your hospital has entered into a contract with Ms. Smith's PFFS plan, you should comply with the terms and conditions of the contract. This is likely to include collecting any cost-sharing payment from Ms. Smith.

If your hospital has not entered into a contract with Ms. Smith's PFFS plan, you should familiarize yourself with the plan's terms and conditions. If your hospital provides care to Ms. Smith and either knew, or had the opportunity to know, of the PFFS plan's terms and conditions, your hospital will be deemed to have a contract with the plan (unless the care was provided on an emergency basis). Payment to your hospital will be made according to the PFFS plan's terms and conditions, including limits on beneficiary cost sharing.

If your hospital finds the PFFS plan's terms and conditions to be unacceptable, it may refuse to provide care to Ms. Smith (unless she presents with an emergency medical situation for which the hospital is required to provide care under EMTALA).

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[101] Id. at § 422.216(b)(2).

[102] 65 Fed. Reg. at 40295. CMS has emphasized that the beneficiary protections from physician balance billing set forth in Section 1848(g) of the Social Security Act apply to all beneficiaries, including those enrolled in PFFS plans. 70 Fed. Reg. at 4611. This means that for a Medicare participating physician, for instance, the billed charges cannot exceed the Medicare participating physician fee schedule amount for a Medicare-covered service. Id. For a Medicare non-participating physician that does not accept Medicare assignment in a specific case, the charges cannot exceed 115 percent of the Medicare non-participating physician fee schedule amount for a Medicare-covered service. Id. Similarly, for "providers of services" (as defined in Section 1861(u) of the Social Security Act), the Medicare participation agreement requires that the provider accept the fee-for-service payment amount as payment in full for services provided to Medicare beneficiaries, including those enrolled in any type of MA plan. Id.

[103] 65 Fed. Reg. at 40295.

Suzy Jones, a PFFS enrollee, seeks emergency medical treatment from your hospital. What do you do?

Given Ms. Jones' emergency medical situation, you must treat her and stabilize her condition as required by EMTALA. You will not be deemed a PFFS contracted provider at this point, but once the services furnished in the emergency department are no longer required under EMTALA, your hospital may be deemed a contracted provider if it continues to provide care to Ms. Smith. If your hospital chooses not to be deemed, you should contact the PFFS plan immediately to inform them of this decision so that, upon stabilization, the patient may be transferred as directed by the PFFS plan to an appropriate setting within the PFFS plan's network.

E. Practical Tips

Do not wait for the first PFFS enrollee to seek care at your facility to learn about the terms and conditions of participation for PFFS plans operating in your market. If at all possible, your hospital should decide before the first PFFS enrollee arrives at your door whether your institution is willing to accept the plan's terms and conditions of payment. If the answer is "no," the hospital should notify the admitting staff and develop policies and procedures for notifying enrollees of the PFFS plan concerning this decision.

Even where a PFFS plan asserts that its contract defines the payment and beneficiary co-sharing terms for deemed providers, hospitals should determine if the number of contracting providers is sufficient to meet the plan's network adequacy test. Network sufficiency will vary depending on the size of the plan's service area, the number of beneficiaries in the service area and the number of providers. In a county with two hospitals, contracting with one hospital may constitute a sufficient network. In a service area with two counties, one hospital in each, contracting with one of them may be sufficient, or not.

V. Regional PPOs

A. General Information

MA Regional PPOs were authorized by the MMA as a means of extending the availability of the MA program to rural areas not previously served by Medicare managed care. Regional PPOs must develop networks that are available to all Medicare beneficiaries in a region. They must pay for all plan covered services, whether provided in or out-of-network.

Special rules apply to Regional PPOs that may affect providers. For instance, a hospital that chooses not to contract with an MA plan may be designated by CMS as an "essential hospital" if the following conditions are met:[104]

1. The hospital that the Regional PPO seeks to designate as an "essential hospital" is a general acute care hospital, but is not a CAH;

[104] Id. § 422.112(c).

2. The Regional PPO presents convincing evidence to CMS that it needs to contract with the hospital to meet the MA program access/network adequacy requirements (discussed below),

3. The Regional PPO establishes that it made a "good faith" effort to contract with the hospital, but the hospital refused,[105] and

4. The Regional PPO establishes that there are no competing Medicare participating hospitals in the area to which MA Regional PPO enrollees could be referred for in-patient hospital services.

A hospital that is designated as an "essential" hospital may be eligible to receive additional payments from CMS beyond what the MA plan pays. In order to do so, the hospital must provide convincing evidence to CMS that the amount normally paid under original Medicare is less than the hospital's actual cost of providing care to the MA plan's enrollee.[106] Where CMS determines that this requirements has been met, the hospital may receive payments above its cost of care for Regional PPO enrollees, to the extent funds are available.[107] More specifically, essential hospitals can seek additional funding from CMS for up to 101 percent of the in-patient costs actually incurred in treating an MA Regional PPO enrollee.[108] Congress authorized $25,000,000 in fiscal year 2006 for payments to essential hospitals.[109] The money will be distributed to hospitals on a first-come, first-serve basis, until such funds are exhausted.[110] As we have discussed in earlier sessions, a CAH may not, by definition, be an "essential hospital." [111]

It should also be noted that even where a hospital is designated as an "essential" hospital, the hospital is under no obligation to provide care (except in an emergency situation) to the Regional PPO enrollees. In this respect, the "essential" hospital designation is largely a mechanism for allowing such plans to meet network adequacy requirements.

VI. Conclusion

The new MA program may present significant challenges for small and rural providers, regardless of whether they choose to participate in the program as network providers. It is important for small and rural hospitals – which are largely unfamiliar with Medicare managed care – to closely examine the contract terms being offered, particularly with respect to payment terms and conditions and the likely costs and operational challenges associated with adhering to MA administrative obligations. Given the complexity of the program, hospitals are well-advised

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[105] Id. A good faith effort to contract will be established where the Regional PPO can demonstrate that it offered the hospital a contract providing payment amounts no less than the hospital would have received under Section 1886(d) of the Social Security Act. Id. http://www.socialsecurity.gov/OP_Home/ssact/title18/1886.htm.

[106] 42 C.F.R. § 422.112(c)(5).

[107] Id. § 422.112(c)(6).

[108] Id.; 70 Fed. Reg. at 4631.

[109] 70 Fed. Reg. at 4631.

[110] Id.

[111] Id. at 4630.

to engage in as much advance planning as possible (particularly with respect to evaluation of PFFS plans).

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