



American Hospital Association

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Medicare Advantage

A Primer for America's Hospitals

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Session 1: The Basics

The information set forth below, and in subsequent sessions, is designed as a primer on the Medicare Advantage (“MA”) program for American Hospital Association (“AHA”) members. In these materials, we provide a basic description of the MA program, and draw distinctions from the earlier Medicare+Choice (“M+C”) program, where helpful.¹ As detailed as this summary may appear, it is only an overview. Substantial additional information concerning the MA program is available through the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the “MMA”),² the MA implementing regulations,³ and guidance issued by the Centers for Medicare & Medicaid Services (“CMS”),⁴ including the Medicare managed care manual.⁵ In addition, AHA members may

¹ Medicare Part C was introduced in the Balanced Budget Act of 1997 (“BBA”), Pub. L. 105-33, 111 Stat. 25 (Aug. 5, 1997), available at http://frwebgate.access.gpo.gov/cgi-bin/useftg.cgi?IPaddress=162.140.64.21&filename=publ33.pdf&directory=/diskc/wais/data/105_cong_public_laws. The M+C program originally contained in Medicare Part C was recently replaced by the Medicare Advantage program.

² Pub. L. 108-173, 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.

³ 42 C.F.R. Part 422, available at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=42583b0a0594c4a1d5afa09f244ec267&rgn=div5&view=text&node=42:2.0.1.2.22&idno=42>. The preamble to the final MA regulation is also helpful in understanding the scope and intent of the regulation. <http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1322.pdf>.

⁴ <http://www.cms.hhs.gov/HealthPlansGenInfo/>.

⁵ <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326>.

submit proposed questions of general interest for discussion in the “Frequently Asked Questions” portion of this website.⁶

It is important to note that there is, and will continue to be, significant interplay between the MA program and original Medicare⁷ on issues ranging from basic Medicare eligibility to decisions regarding coverage of particular health care items and services. Individuals interested in additional information on Medicare generally (and the MA program in particular) are encouraged to visit the CMS websites: www.cms.hhs.gov and www.medicare.gov.

I. The Medicare Modernization Act: Implications for Beneficiaries, Providers and Health Plans

The MMA represents the greatest change to Medicare since the program was created in 1965. Signaling what some have called a paradigm shift in the Medicare program, the MMA added a new drug benefit (through Medicare Part D), and evidenced a new emphasis on Medicare managed care and other alternatives to traditional “fee for service” Medicare (through changes to Medicare Part C). The MMA also significantly modified the relationship between CMS and the fiscal intermediaries and carriers who have traditionally administered the Medicare program on the agency’s behalf. In the end, the MMA has touched (in one way or another) on virtually every aspect of the Medicare program. *Our focus in this Primer will be on the MA program enacted through the MMA.*

A. Implications for Beneficiaries

As a result of the MMA, MA plans are expected to be offered in virtually every area of the United States. For beneficiaries, the anticipated expansion of MA plans will mean greater choice in how they access their Medicare benefits. Program changes may, however, also result in greater confusion, as beneficiaries face an increased array of options and potential trade-offs. On the positive side, beneficiaries will find many MA plans offering added benefits, reduced out-of-pocket costs and a more user-friendly system for receiving Medicare prescription drug (“Part D”) and other benefits. As a trade-off, beneficiaries will in many instances confront limitations on the providers they may choose, more bureaucracy in having care approved, and the challenge of learning how to maneuver in a new type of health care system. As a result, beneficiary education concerning MA plan benefits and requirements will be an important challenge for MA plans and, to a lesser extent, those furnishing health care services to MA enrollees.

⁶ Proposed questions may be e-mailed to Ellen Pryga at epryga@aha.org.

⁷ “Original Medicare” is used in the MA rules to refer to the health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system. We use the term similarly here.

B. Implications for Providers

Many in the government and private sectors are projecting substantial growth in the number of beneficiaries choosing MA plans. It is anticipated that this growth will occur in areas that have not previously been served by Medicare Part C plans, as well as areas that have been “marginal” markets for such plans. The consequence will be that many more providers will find themselves being invited to participate in MA organization networks, or being used as “out-of-network” providers for individuals enrolled in MA preferred provider organizations (“PPOs”), private fee-for-service (“PFFS”) plans, or the like. As a result, the MMA will bring new market pressures to bear on health care delivery, as well as new mechanisms of oversight and management of care. For this reason, it will be important for all hospitals to understand how the MA program operates, including what will be expected of providers and how they will be reimbursed for their services. While the impact of the MA program on any given hospital will vary depending on MA market penetration in the particular area, all providers should be assessing (and preparing for) the impact of the MA program on their community and their institution.

C. For Health Plans

For health plans, the MMA has rejuvenated the Medicare Part C program. Substantial new revenues have been provided by Congress. New types of MA plans have been authorized, creating incentives to serve previously unserved (or underserved) regions of the country and allowing niche MA plans to focus on beneficiaries eligible for Medicare and Medicaid (so-called “dual eligibles”), the institutionalized, and those with severe and chronic illnesses. Moreover, MA plans offering Part D prescription drug coverage are likely to be an attractive option for enrollees, largely because they allow for “one stop shopping” and, due to CMS program design, may be able to provide more attractive cost-sharing arrangements for consumers than “drug only” Part D plans. But, MA plans will also face the challenge of a new rate setting methodology that breaks the connection between the historical method of fee-for-service “shadow pricing” and instead imposes a competitive process intended to use market forces to control or reduce the cost of health care. Over time, participating MA plans will be under continued competitive pressure to improve their benefits, reduce their premiums and cost-sharing, and improve their networks and services, in order to gain or retain market share. As a result, the new MA program may encourage integrated plans that offer MA and Part D coverage to apply innovative disease prevention, disease management and other coordination of care techniques in order to drive savings and improve quality of care.

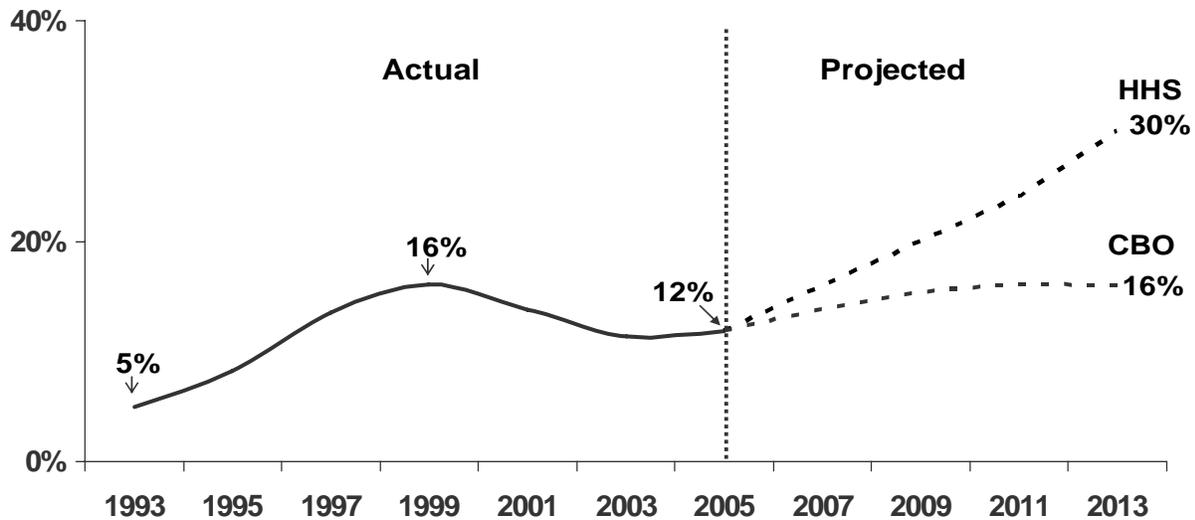
II. What’s in Store: Projections for Growth

Plan participation in Medicare Part C nearly quadrupled between 1992 and 1998, and then steadily declined through 2004. This year alone, there has been a large increase in the number of MA plans. As of August 1, 2005, 5.1 million Medicare beneficiaries (approximately 13% of all Medicare enrollees) have chosen to obtain benefits through one of

290 MA plans.⁸ While there is some debate concerning how dramatic growth will be in coming years concerning the number of MA plans, and the number of the beneficiaries enrolling in MA plans, it is widely expected that the trend will be upward on both fronts in 2005 and further accelerate in 2006. See Charts 1 and 2.

Chart 1

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.



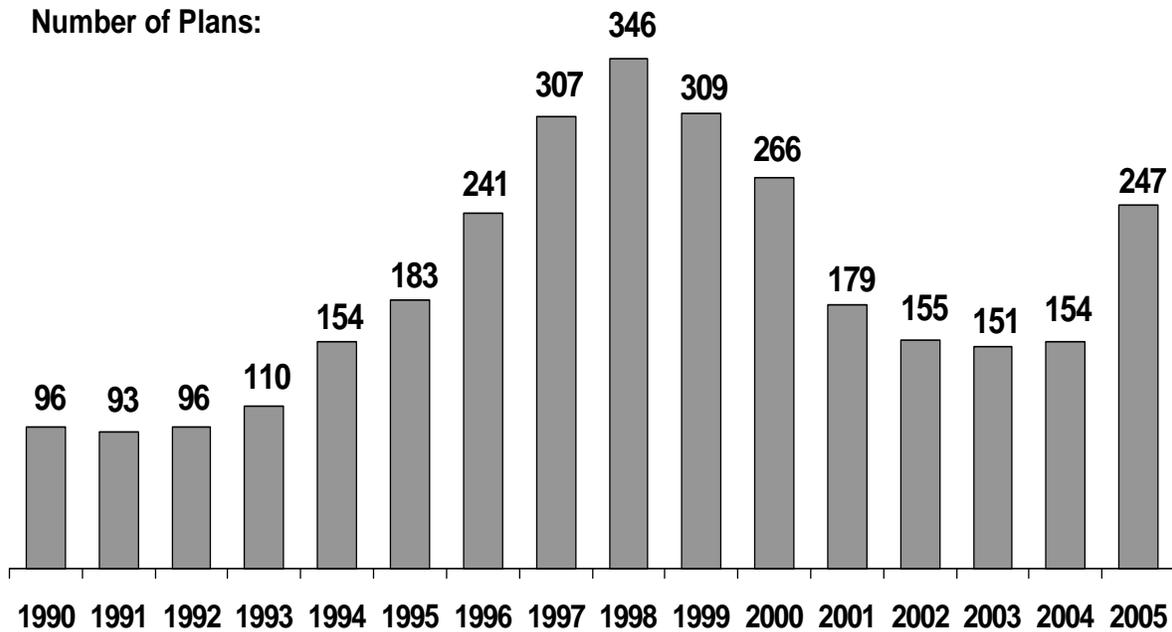
Source: Kaiser Family Foundation, Medicare Chart Book, Summer 2005

⁸ Medicare Managed Care Contract Report as of August 1, 2005 available at <http://www.cms.hhs.gov/healthplans/statistics/mmcc/mmcc082005.pdf> [This URL is no longer available as a result of CMS website changes since the initial publication of this primer].

Chart 2

Growth Of Medicare Managed Care Plans

Medicare+Choice/Medicare Advantage Plans, 1990-2005



Note: All data are from December of the given year, except 2005 data are from July. Number of plans include Medicare HMOs, PPOs (non-demonstration), and PSO contracts; excludes PFFS, demonstrations, and cost contracts.

SOURCE: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report.



III. The Evolution of Medicare Managed Care

A basic familiarity with the history of the Medicare managed care program is helpful in understanding the current Medicare Advantage program structure, policies and objectives.

A. The Tax Equity and Fiscal Responsibility Act of 1982

The Tax Equity and Fiscal Responsibility Act of 1982 (“TEFRA”)⁹ shaped the Medicare managed care market from the late 1980s to the late 1990s.¹⁰ Following the private sector model at the time, virtually all Medicare managed care plans were health maintenance organizations (“HMOs”). This period was marked by substantial growth in Medicare managed care, both in terms of the numbers of participating plans and the number of beneficiaries enrolled in them. TEFRA provided for three means of payment:

- Medicare risk plans received a monthly per enrollee capitated payment that was 95 percent of the Average Area Per Capita Cost (“AAPCC”). The AAPCC represented the cost of providing Medicare Part A and B services to Medicare beneficiaries within each county served by the MA plan. Under this payment methodology, there was little incentive for health plans to develop in counties with relatively low AAPCC payment rates and, in fact, such plans were located primarily in urban areas.
- Medicare cost plans were paid on a monthly basis based on their projected annual cost of providing Medicare Part A and B services to enrollees. At the end of each year, the actual costs of care were determined and a reconciliation took place. There remain a small number of Medicare cost plans today, mostly in rural parts of the country. While cost plans are not MA plans, they are subject to many of the same regulatory requirements.¹¹
- Health Care Prepaid Plans were reimbursed based on a hybrid payment methodology. They received a capitated payment for Medicare Part B services, but were reimbursed for Medicare Part A services under the Medicare fee-for-service system.

So called “risk adjustments” were used to fine tune payments in order to reflect the costs of particular demographic groups. These demographic-based risk adjusters were based on factors such as advanced age, sex, and institutional status.

⁹ Pub. L. 97-248, 96 Stat. 324 (Sept. 3, 1982).

¹⁰ While prepaid “managed care” health plans have been part of Medicare since the program’s inception in 1965, these early plans were little more than experiments in alternative reimbursement methodologies. TEFRA established the foundation for the Medicare managed care program as it exists today.

¹¹ Those interested in obtaining more information on Medicare cost plans may go to the CMS website at http://www.cms.hhs.gov/HealthPlansGenInfo/27_ManCarMon_01_1876CostGuide.asp#TopOfPage.

B. The Balanced Budget Act of 1997

The BBA established the M+C program.¹² As the name denotes, the program was designed to allow Medicare beneficiaries greater choice in selecting their delivery system by authorizing new types of managed care plans (similar to those proliferating at the time in the commercial market, including PPOs and HMOs with “point of service” options). The M+C program made numerous adjustments to the existing Medicare managed care program, including the manner in which health plans were reimbursed.

1. New Plan Choices

Under the M+C program, plans were segregated into two types: (1) “coordinated care plans,” including HMOs, PPOs, and provider-sponsored organizations (“PSOs”),¹³ and (2) non-coordinated plans, including Medical Savings Account (“MSA”) and PFFS plans. This distinction, which continues today, has important practical implications (as discussed below), as the regulatory requirements for coordinated and non-coordinated care plans differ in certain respects.

2. Changes in Reimbursement

The BBA changed the payment methodology for M+C plans from TEFRA’s AAPCC approach, to one in which M+C organizations were paid the greater of (1) a minimum amount set each year, (2) a blend of the national AAPCC and the county AAPCC, or (3) a rate based on a benchmark set in 1997 and updated annually (but generally limited to a 2% increase per year). The BBA also modified the risk adjustment methodology, transitioning away from the demographic model described above towards encounter-based adjustments which more directly reflected health experience.

3. Troubled Waters

While Congressional sponsors of the M+C program envisioned a substantial expansion of Medicare managed care as a result of the various program refinements, this did not in the end occur. The failure of the M+C program to flourish was due to numerous factors. Perhaps most damning was the fact that the BBA’s limitation on reimbursement growth coincided with the rapid growth of health care costs in the late 1990s and early 2000s. This, coupled with increased regulatory burdens, resulted in service area retrenchments, plan withdrawals and widespread beneficiary dislocation.

¹² Pub. L. 105-33, 111 Stat. 251 (Aug. 5, 1997).

¹³ PSOs are essentially managed care plans organized and controlled by a provider or affiliated group of providers. First authorized by the BBA, PSOs were intended to permit providers to organize health plans which could compete directly with HMOs. They had an initial advantage in how they were licensed, but over time that advantage has been lost. Few PSOs serve as MA organizations today.

C. The MMA

The MMA is the latest Congressional effort to offer (and expand) alternatives to original fee-for-service Medicare. Beyond re-labeling the Medicare managed care program, the MMA sets in motion a host of program modifications that may have significant implications for how Medicare beneficiaries receive their health care (both now and in the future), the relationship between providers and Medicare, and the roles of government and the private sector in financing and organizing the delivery of Medicare services.

1. New Types of Plans

The MMA authorizes two additional types of MA plans – Regional PPOs and MA - Special Needs Plans (“MA-SNPs”), both of which are discussed below. The incorporation of Regional PPOs in the new MA program was an acknowledgement that previous program configurations had done little to make Medicare managed care a realistic option for beneficiaries living in rural areas, and that added financial incentives were necessary to make MA plan participation in such areas more attractive. The MA-SNP option grew out of demonstration projects indicating the benefit of Medicare managed care plans tailored to serving individuals with complex and disabling diseases and conditions.

2. Change in Economics: Move from Defined Benefit to Defined Contribution

Importantly, the MMA moves away from the previous administrative pricing system based on capitation rates to a “competitive bidding” scheme.¹⁴ All MA plans must submit annual aggregated bids for each plan based on what they project it will cost them to provide the national average Medicare beneficiary with Medicare Part A and Part B services, Part D basic prescription drug benefits (if applicable), and any mandatory supplemental benefits (including reductions in beneficiary cost-sharing).¹⁵ CMS will set a “benchmark” based on the bids received.¹⁶ Plans with bids equal to or above the benchmark will be paid the benchmark, adjusted by the individual’s risk factor, and will be required to charge enrollees a premium that is the difference between the bid and the benchmark.¹⁷ Plans with bids below the benchmark will be paid their basic A/B bid amount, adjusted by the individual’s risk factor, plus a rebate amount.¹⁸ The rebate is 75% of the difference between the plan bid and the benchmark and must be used to provide mandatory supplemental benefits or reduce Part B or Part D premium costs.¹⁹

¹⁴ 42 U.S.C. § 1395w-23.

¹⁵ 42 C.F.R. § 422.254; Medicare Managed Care Manual, Ch. 1, § 10.

¹⁶ 42 C.F.R. § 422.228.

¹⁷ 42 U.S.C. § 1395w-24(b)(1)(C); 70 Fed. Reg. 4588, 4589 (Jan. 28, 2005); Medicare Managed Care Manual, Ch. 1, § 10.

¹⁸ Medicare Managed Care Manual, Ch. 1, § 10.

¹⁹ Id.

As noted, MA plans will be impacted by the application of a risk adjustment payment process, which will vary payments based on the projected health care needs of individual enrollees.²⁰ The risk adjustment process has been in place for some time, but now relies more on the use of diagnostic factors.²¹ More information on MA and provider payment issues will be reviewed in Session Two.

IV. The MA Program

A. Types of MA Plans

The MA program generally allows for the same types of plans as are available in the commercial health care market.²² The multiplicity of plans is intended by Congress to make the MA program as attractive to beneficiaries as possible, thereby expanding the number of individuals enrolled in the MA program. As mentioned above, MA plans fall into two general categories: coordinated care plans and non-coordinated care plans.

1. Coordinated Care Plans

MA coordinated care plans include HMOs (with or without point of service (“POS”) options), PSOs, and PPOs. Coordinated care plans generally provide Medicare covered services (Part A, Part B, and supplemental benefits, if any) through a defined network of clinicians and providers. Depending on the type of plan, care may be more or less coordinated. In most instances, payment to providers by coordinated care plans is established by contract between the MA organization and the provider. In order to offer an MA coordinated care plan in a particular area, the MA organization must offer at least one such plan offering Part D prescription drug coverage.²³

a) HMOs

In Medicare HMOs, beneficiaries generally obtain services from a designated network of doctors and providers who have agreed to serve plan enrollees, usually with little or no out-of-pocket costs to enrollees. HMOs are generally the most restrictive type of plans, limiting access to network providers, except in urgent or emergent care situations.²⁴ To ease restrictions on access to out-of-network providers, however, an HMO may also offer a point of service (“POS”) benefit option. A POS option allows enrollees additional choice in obtaining specified health care services without complying with the plan's normal referral or prior authorization rules, but generally requires that enrollees incur higher cost-sharing for such POS services.²⁵ Unlike an MA PPO, an HMO offering a POS benefit option can limit

²⁰ 42 C.F.R. § 422.308.

²¹ Medicare Managed Care Manual, Ch. 7, § 91.

²² See 42 C.F.R. § 422.4.

²³ Id. at § 422.4(c).

²⁴ Medicare Managed Care Manual, Ch. 1, § 30.2.2.

²⁵ Id.

out-of-network coverage to only designated services, and can also limit the dollar amount of coverage that will be provided.²⁶ The POS option may be offered as a mandatory supplemental benefit or as an optional supplemental benefit.²⁷

b) PSOs

PSOs are health plans, much like HMOs, but they are organized and operated by a provider or affiliated group of providers. To qualify as a PSO, the provider (or affiliated group of providers) must: (1) directly deliver a substantial portion of the enrollee care, (2) bear substantial financial risk, and (3) have at least a majority of financial interest in the PSO.²⁸ There appear to be fewer than ten PSOs in operation in the United States today.

c) PPOs

In MA PPOs, beneficiaries generally obtain services from a network of health care providers. Unlike traditional HMO beneficiaries, however, PPO enrollees can choose providers outside of the health plan network.²⁹ Where this is the case, enrollees typically face greater cost-sharing.

(1) Local PPOs

Local PPOs were initially authorized by the BBA. They are available to beneficiaries residing in a “local” service area, typically a group of counties which define a market area.

(2) Regional PPOs

MA Regional PPOs were authorized by the MMA as a means of extending the availability of the MA program to areas not previously served by Medicare managed care. Congress created a number of economic and regulatory incentives for health plans to become Regional PPOs. Regional PPOs must develop networks which are available to all Medicare beneficiaries in a region. They must pay for all covered services, whether provided in or out-of-network. CMS has designated 26 regions. All regions include at least one state and many include multiple states. See Chart 3 illustrating the MA PPO and Part D Regions designated by CMS.

Special rules apply in the Regional PPO context that may effect providers. For instance, a hospital that chooses not to contract with a MA plan may be designated as an “essential hospital” and “deemed” to be a network hospital, if certain conditions are met.³⁰ In order for this to occur, the following conditions must be met: (1) the hospital that the

²⁶ Id.

²⁷ 42 C.F.R. § 422.2 (Definitions, Point of Service) and § 422.105(b).

²⁸ Id. at § 422.350; See also Medicare Managed Care Manual, Ch. 1, § 30.2.3.

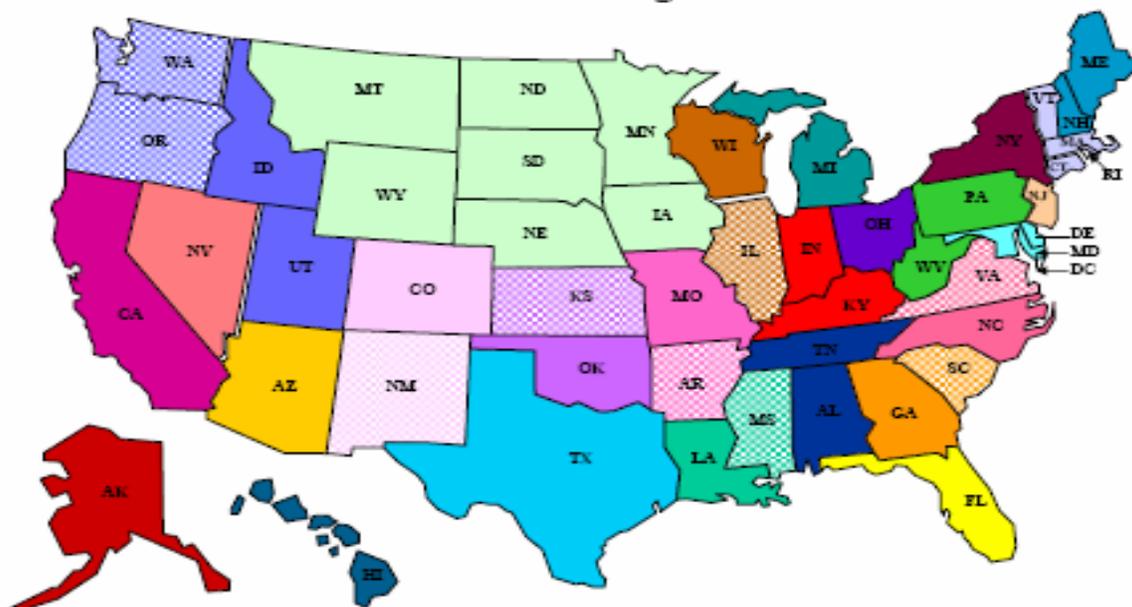
²⁹ 42 C.F.R. § 422.4(a)(1)(v).

³⁰ Id. at § 422.112(c).

Regional PPO seeks to designate as an "essential hospital" must be a general acute care hospital, (2) the Regional PPO must provide 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 must establish that it made a "good faith" offer to contract with the hospital, but the hospital refused,³¹ (4) the Regional PPO must establish that there are no competing Medicare participating hospitals in the area to which MA PPO enrollees could be referred for inpatient hospital services, and (5) the hospital must provide convincing evidence to CMS that the amounts normally paid under Section 1886 of the Social Security Act (which the MA organization agreed to pay) is less than the hospital's actual cost of providing care to the MA plan enrollees.³² Where CMS determines that the above requirements have been met, the hospital may receive payments above its costs of care for Regional PPO enrollees, to the extent funds allow.³³ This unique payment system for "essential hospitals" will be discussed more fully in Session Two.

Chart 3

MA and PDP Regions



Note: An MA region is one color. A difference in shading indicates that there are multiple PDP regions nested within the MA region. No change indicates that the MA and PDP regions are the same. For example, Wisconsin and Illinois are in one MA region; they are each a separate PDP region. Each territory is its own PDP region.

³¹ Id. at § 422.112(c). 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.

³² Id.

³³ Id.

d) SNPs

A SNP is a plan offered to Medicare beneficiaries with special needs. A SNP includes any type of Coordinate Care plan that meets CMS' SNP requirements and either exclusively enrolls special needs individuals or enrolls a greater proportion of special needs individuals than occur nationally in the Medicare population.³⁴ Special needs individuals are defined as those MA eligible individuals who:

- are also entitled to Medicaid (dual eligibles),
- are institutionalized (that is, they reside or are expect to reside in a long term care facility for at least 90 days)³⁵, or
- have severe or disabling chronic conditions.³⁶

MA-SNPs may, with CMS approval, tailor their health care delivery systems and marketing to meet the limited scope and special needs of their target population.³⁷

2. Other MA Plans

In addition to the coordinated care plans discussed above, other MA plans open to general Medicare enrollment include PFFS plans and MSA plans. These plans do not limit beneficiaries in their choice of provider and engage in little, if any, care coordination. Due to their unique nature, such plans are relieved of some of the regulatory obligations faced by coordinated care plans, such as participating in quality improvement projects.³⁸

Religious fraternal benefit ("RFBs") plans may also be offered, but these plans may limit enrollment to members of RFB societies.

a) Private Fee-for-Service Plans

PFFS plans are a growing phenomenon. Initially available largely in rural areas of the country, PFFS plans are now becoming available in more urban markets. These plans are attractive to beneficiaries who want flexibility in choosing their providers. PFFS plan enrollees are free to choose from any entity that is authorized to provide services under

³⁴ Id. § 422.4(a)(1)(iv); Medicare Managed Care Manual, Ch. 1, § 30.2.5.

³⁵ A long term care facility includes skilled nursing facilities and nursing facilities. Id.

³⁶ 42 C.F.R. § 422.2 (Definition, Institutionalized, Specialized MA Plans for Special Needs Individuals); See also Medicare Managed Care Manual, Ch. 1 § 30.2.5.

³⁷ More information is available at <http://www.cms.hhs.gov/SpecialNeedsPlans/>.

³⁸ 42 C.F.R. § 422.152(a).

Original Medicare and agrees to accept the plan's payment terms and conditions.³⁹

Like all MA plans, PFFS plans must cover at least traditional Medicare Part A and Part B benefits. PFFS plans reimburse network providers at a rate determined by the plan on a fee-for-service basis. Provider reimbursement rates may not vary based on utilization.⁴⁰ A PFFS is required to make its terms and conditions of participation (e.g., the amount of PFFS plan payment, provider billing procedures, and enrollee cost-sharing and any permitted balance billing) reasonably available to providers from whom its enrollees seek health care services.⁴¹ This generally means that the 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.

The growth of PFFS plans will present new challenges for hospitals and other providers, since these plans operate under special rules. While additional details will be provided in Session 3, it is important to note that providers will in certain instances be deemed to be contract providers even if they do not enter into contractual arrangements with a PFFS plan.⁴² Thus, except in emergency situations, 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 plan, and (2) is informed (or given the reasonable opportunity to obtain information) about the terms and conditions of payment under the plan.⁴³ PFFS plans may permit balance billing by contracted providers (up to a limit), with the beneficiary responsible for paying whatever the plan doesn't cover.⁴⁴

b) Medical Savings Accounts ("MSA")

While there are currently no MA MSA plans, it is worthwhile knowing a bit about this MA option. MSAs were initially authorized as a Medicare demonstration project as part of the BBA. MSAs were made a permanent type of MA plan by the MMA.

An MA MSA plan combines a high-deductible insurance policy and a savings account for health care expenses.⁴⁵ CMS will pay premiums for the beneficiary's insurance

³⁹ Id. at § 422.114(b). As a practical matter, to be eligible to furnish care to a PFFS enrollee (1) physicians must be State licensed and either have a Medicare billing number or be eligible to obtain one, and (2) institutional providers, such as hospitals and skilled nursing facilities, must be certified to treat Medicare beneficiaries. Medicare Managed Care Manual, Ch. 4, § 150. It is important to note that providers are not required to furnish health care services to PFFS plan enrollees, except as otherwise required under EMTALA. <http://www.cms.hhs.gov/PrivateFeeforServicePlans/>.

⁴⁰ Id.

⁴¹ <http://www.cms.hhs.gov/PrivateFeeforServicePlans/>.

⁴² 42 C.F.R. § 422.216(f).

⁴³ Id.

⁴⁴ Id. at § 422.216(b).

⁴⁵ Medicare Managed Care Manual, Ch. 1, § 30.3.

policy and make a contribution to the beneficiary's medical savings account.⁴⁶ CMS' payment for an MSA plan enrollee will be similar to CMS' payment for other types of MA plans with bids equal to the benchmark.⁴⁷ Beneficiaries will only pay premiums for supplemental benefits, if any.⁴⁸

First dollar coverage of health care costs will come from the beneficiary's medical savings account. Once the insurance policy's deductible has been met, the MA organization offering the MSA plan will be responsible for payment of 100 percent of the expenses related to covered services. Covered services include, at a minimum, those services covered under Medicare Part A and B.⁴⁹ MSA plans are not permitted to offer prescription drug coverage other than that required by Parts A and B.⁵⁰ The maximum annual MSA deductible is set by law. For 2005, an MSA plan's deductible may not exceed \$8,450.⁵¹

A provider that does not have a contract with an MSA plan is required to accept as payment in full, for covered services provided to an MSA plan enrollee, the amount the provider could have collected from fee-for-service Medicare had the individual not been enrolled in the MSA plan. MSA plans are exempt from certain MA quality improvement requirements. For instance, MSA plans are not required to have quality improvement plans.⁵²

c) Employer Sponsored MA Plans

The MA rules allow MA organizations to contract with employers and labor organizations to provide health care coverage to enrollees through MA plans.⁵³ In such cases, the employers and unions often participate in selecting the MA plan benefits offered to their members and subsidize the cost of enrollment and/or reduce the cost-sharing requirements that would otherwise apply.⁵⁴ CMS may waive MA rules that "hinder the design of, the offering of, or the enrollment in," an employer sponsored MA plan.⁵⁵ For instance, MA plans sponsored by employer groups may be authorized to restrict enrollment to group members even though MA plans must generally be open to all Medicare beneficiaries residing in a plan services area.

⁴⁶ Id.

⁴⁷ 42 C.F.R. § 422.314.

⁴⁸ Id. at § 422.262(b)(2).

⁴⁹ Id. at § 422.103.

⁵⁰ Id. at § 422.4(c)(2).

⁵¹ Medicare Managed Care Manual, Ch. 1, § 30.3.

⁵² 42 C.F.R. § 422.152(a).

⁵³ Id. at § 422.106.

⁵⁴ Id.

⁵⁵ Id. at § 422.106(c).

B. Which Law Applies?

This is a threshold question that needs to be well understood. The MMA significantly expanded the scope of Federal preemption of State law in the MA context.⁵⁶ Thus, in the MA context, MA Federal law and regulations supersede State law and regulations, with the limited exception of State licensing laws and laws relating to insurance company and HMO fiscal solvency.⁵⁷ “In other words, with those exceptions, State laws do not apply to MA plans offered by MA organizations.”⁵⁸ This has far reaching implications. Thus, for instance, state prompt payment rules do not apply to MA plans.⁵⁹ Moreover, States may not levy a tax or other fee on CMS’ payment to MA organizations or on the premium paid by MA enrollees to MA plans.⁶⁰

⁵⁶ 70 Fed. Reg. at 4663.

⁵⁷ 42 C.F.R. § 422.402; 70 Fed. Reg. at 4663-64.

⁵⁸ 70 Fed. Reg. at 4463.

⁵⁹ Id.

⁶⁰ 42 C.F.R. § 422.404.

C. Access and Availability of Services

1. For Coordinated Care Plans

MA coordinated care plans must meet certain standards of access and availability of services, generally referred to as “network adequacy.”⁶¹ An MA plan’s network of physicians and providers must be sufficient to provide access to covered benefits (Part A and Part B and supplemental benefits, if any) for all enrollees in the plan. Among the specific requirements are that plans maintain and monitor a network of appropriate providers that is supported by written arrangements and is sufficient to provide adequate access to covered services.⁶² Services must also be geographically accessible and consistent with local community patterns of care. Enrollees should not be required to travel an unreasonable distance. For instance, commonly used services must be available within 30 minutes of driving time.⁶³ Longer travel times are permissible based on the nature of the service area and the patterns of care in the area.⁶⁴ Medically necessary services must be available 24 hours a day, 7 days a week.⁶⁵

Additionally, coordinated care plans must have a panel of primary care providers (“PCP”) from which the members may select a personal PCP.⁶⁶ All services must be provided in a “culturally competent” manner and be accessible to those with limited English speaking proficiency.⁶⁷

2. For Private-Fee-For-Service Plans⁶⁸

To ensure that enrollees have adequate choice in selecting providers, a MA PFFS plan must demonstrate that it has a “sufficient number and range of providers willing to furnish services under the plan.”⁶⁹ The MA PFFS plan can meet this standard with respect to a particular category by demonstrating that it has (1) “payment rates that are not less than the rates that apply under original Medicare for the provider in question; (2) contracts or agreements with a sufficient number and range of providers to furnish the services covered under the private fee-for-service plan;” or (3) a combination of the two.⁷⁰ Where a PFFS

⁶¹ Id. at § 422.112; Medicare Managed Care Manual, Chapter 4, § 120, available at <http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf>.

⁶² 42 C.F.R. § 422.112(a)(1). MA Regional PPOs may, however, upon CMS’ approval, use methods other than written agreements to establish that access requirements are met. Id.

⁶³ Medicare Managed Care Manual, Ch. 4, § 120.2.

⁶⁴ Id.

⁶⁵ 42 C.F.R. § 422.112(a)(7).

⁶⁶ Id. at § 422.112(a)(2).

⁶⁷ Id. at § 422.112(a)(8).

⁶⁸ CMS guidance on PFFS plans can be found at <http://www.cms.hhs.gov/PrivateFeeForServicePlans/>.

⁶⁹ 42 C.F.R. § 422.114(a)(1).

⁷⁰ Id. at § 422.114(a)(2).

plan establishes payment rates for types of provider that are less than original Medicare, the plan must demonstrate to CMS that it has a sufficient number of providers of each relevant type under written contract to meet Medicare access and availability standards.⁷¹

PFFS plans typically demonstrate their network adequacy by paying providers and clinicians at least what they would be paid under the Original Medicare program (DRG rates, physicians fee schedule rates, etc.).⁷² As noted, a provider is deemed to have a contract with a PFFS if the provider knows, before furnishing services, that the beneficiary is a PFFS plan enrollee (*i.e.*, the patient presents a PFFS plan enrollment card) and either knows the terms and conditions of the PFFS plan's payment or has reasonable access to the plan's payment terms and conditions. Contracted providers (actual or deemed) who furnish services to PFFS plan enrollees are paid by the PFFS plan according to its network terms and conditions of payment.

PFFS payment terms and conditions must specify, at least (1) the amount the PFFS plan will pay for plan-covered services, (2) provider billing procedures, and (3) the amount the provider is permitted to collect from the enrollee and whether prior authorization is required from the PFFS plans before furnishing a particular service.

Non-contracting providers who furnish services to PFFS enrollee are not bound by the PFFS plan's payment terms and conditions, but are entitled to be paid what they would have been paid under fee-for-service Medicare.⁷³ The provider collects the PFFS plan allowed cost sharing from the beneficiary and the PFFS pays the provider the remainder. Claims for services provided to a PFFS enrollee are submitted to the PFFS plan, not to a fiscal intermediary or carrier. The PFFS plan must pay 95% of clean claims within 30 days of receipt if they are submitted by or on behalf of a MA PFFS enrollee.⁷⁴ If the plan does not pay such clean claims within 30 days, then it is responsible to pay interest on the claims.⁷⁵

D. Beneficiary Eligibility

1. MA Plans Generally

A beneficiary must be entitled to Medicare Part A and enrolled under Medicare Part B to be eligible for the MA program.⁷⁶ In general, beneficiaries with end-stage renal disease ("ESRD") are excluded from participation in an MA plan *unless* the beneficiary

⁷¹ Medicare Managed Care Manual, Ch. 4 § 150; 65 Fed. Reg. 40170, 40296 (Jun. 29, 2000).

⁷² 65 Fed. Reg. at 40295.

⁷³ Id.

⁷⁴ 42 C.F.R. § 422.520(a)(1); 65 Fed. Reg. at 40295.

⁷⁵ 42 C.F.R. § 422.520(a)(2).

⁷⁶ Id. at § 422.50(a)(1).

develops ESRD *while enrolled* in a Medicare Advantage plan.⁷⁷ For the most part, a beneficiary may only choose an MA plan which serves the geographic area in which the patient resides and which has capacity to accept new enrollees.⁷⁸

2. MA – Special Needs Plans

Only beneficiaries who meet one of the following criteria may enroll in an MA-SNP: individuals who (1) are dually eligible for Medicare and Medicaid, (2) reside or expect to reside continuously for at least 90 days in a long term care facility or receive an equivalent level of care in the community; or (3) are severely or chronically ill or disabled.⁷⁹ If an MA-SNP determines that the enrollee no longer meets the eligibility criteria, but can reasonably be expected to again meet the criteria within 6 months, the enrollee is deemed to remain eligible for the MA plan for a period of not less than 30 days but not to exceed 6 months.⁸⁰ This provision recognizes that, particularly with respect to “dual eligible” members, individuals can cycle between meeting the terms for MA-SNP eligibility and falling out of eligibility. A beneficiary with ESRD may enroll in an MA-SNP which has opted (with CMS permission) to enroll ESRD individuals.⁸¹

E. How Beneficiaries Enroll

The enrollment and disenrollment rules for MA beneficiaries are fairly complex.⁸² For instance, there are four types of election periods.⁸³ We provide only a partial summary here. For 2005, beneficiaries may enroll and disenroll from MA plans at anytime.⁸⁴ In 2006, however, most beneficiaries will be able to choose between MA health plans and traditional Medicare during an annual election period (“AEP”) between November 15, 2005 and May 15, 2006.⁸⁵ For 2007 and beyond, the AEP begins November 15 and ends December 31.⁸⁶

Additionally, there is an annual open enrollment period (“OEP”) during which beneficiaries may choose to change MA plans or move between traditional Medicare and

⁷⁷ Id. at § 422.50(a)(2). There are limited exceptions, however. For instance, individuals with ESRD may elect an MA special needs plan as long as that plan has opted to enroll ESRD individuals. Id.

⁷⁸ Medicare Managed Care Manual, Ch. 2, § 30.3.1.

⁷⁹ 42 C.F.R. § 422.52.

⁸⁰ Id. at § 422.52(d).

⁸¹ Id. at § 422.52(c). CMS guidance for MA-SNPs is found at <http://www.cms.hhs.gov/SpecialNeedsPlans/>.

⁸² 42 C.F.R. Subpart B, § 422.50 *et seq.* See generally, Medicare Managed Care Manual, Ch. 2, <http://www.cms.hhs.gov/manuals/downloads/mc86c02.pdf>.

⁸³ Medicare Managed Care Manual, Ch. 2, § 30.

⁸⁴ Id. at Ch. 2, § 30.3.1.

⁸⁵ Id. at Ch. 2, § 30.1 (Special Note for 2006).

⁸⁶ Id. at Ch. 2, § 30.1.

MA. Beginning in 2006, beneficiaries can only make one MA OEP election. Except for beneficiaries enrolled in a MA-SNP, once they have made their choice, they are “locked-in” until the next OEP.⁸⁷ For 2006, the OEP is the first six months of the year (January 1st through June 30th).⁸⁸ In subsequent years, the OEP will be the first three months of the year (January 1st through March 31st).⁸⁹ Special Election Periods (“SEPs”) apply in other contexts.⁹⁰ Enrollment is generally effective on the first day of the calendar year or the first day of the month following the election.⁹¹ An MA organization may not disenroll a patient from any MA plan it offers, unless (1) the enrollee does not pay the monthly premium in a timely manner (subject to a grace period), (2) the enrollee engages in disruptive behavior, or (3) the enrollee provides fraudulent information on his or her election form or permits the fraudulent use of an enrollment card.⁹²

⁸⁷ Id. at Ch. 2, §30.2-30.3.

⁸⁸ Id. at Ch. 2 § 30.3.2.

⁸⁹ Id.

⁹⁰ Id. at Ch. 2, § 30.4.

⁹¹ Id. at Ch. 2, § 30.5.

⁹² 42 C.F.R. § 422.74.

F. MA Benefits

1. Basic Benefits

MA plans must furnish, arrange for or pay for all Part A and Part B benefits (except hospice benefits) and supplemental benefits, if any.⁹³ MA plans must also provide such other benefits (vision and dental benefits, chiropractic benefits, value added benefits, etc.) as the plan has included in its bid submission, as approved by CMS.⁹⁴

While MA plans must generally provide Part A and Part B benefits, those benefits are further defined and controlled by national and local coverage decisions. This is particularly important for MA Regional PPOs in regions comprised of more than one state and where more than one Medicare contractor makes local coverage decisions. In those instances, the Regional PPO must select which contractor's local coverage decisions it will follow and those decisions must be applied uniformly across the region.⁹⁵ This may be a point of confusion and complexity for providers. Care that may be permitted under a local coverage policy by the provider's local Medicare contractor, for instance, may not be covered under the coverage policies of another Medicare contractor whose decisions the MA Regional Plan has chosen to apply to services provided to its MA enrollees.

2. Part D Prescription Drug Benefits

Describing the responsibility of MA plans to provide a Part D drug benefit requires a bit of explanation regarding the difference between MA organizations and MA plans. Essentially, an MA organization can offer one or more MA plans in its service area. Thus, Acme Health Plan could offer Acme Gold MA plan, Acme Silver MA plan, Acme Bronze MA plan, etc. Each plan can offer different benefit and cost sharing packages, subject to approval by CMS through the bidding process.

With regard to Part D benefits, an MA organization offering a coordinated care plan must offer Part D benefits through at least one of its MA plans in the area being served.⁹⁶ MA Part D plans ("MA-PDs") must meet the same requirements as "stand alone" Part D plans in terms of formulary design, benefit and cost sharing structures, pharmacy network adequacy, etc.⁹⁷

As mentioned above, the Part D program is likely to work to the advantage of MA organizations. Prior to the MMA, Medicare beneficiaries frequently purchased drug coverage through Medicare supplement insurance ("Medigap") policies. As a result of the

⁹³ 42 C.F.R. §422.101.

⁹⁴ Id.

⁹⁵ 42 C.F.R. § 422.101(b)(4).

⁹⁶ 42 U.S.C. § 1395w-131.

⁹⁷ Id.

MMA, as of January 1, 2006, Medigap carriers will be prohibited from providing drug coverage in most instances.⁹⁸ As a result, most beneficiaries wishing drug coverage will have to obtain such drug coverage from a stand-alone Part D Plan (“PDP”) or from an MA-PD.⁹⁹ The choice for many will be between obtaining health coverage from either 1) traditional Medicare *plus* a PDP *plus* a Medicare supplement insurance product (such as Medigap) or 2) an MA-PD that can provide medical benefits greater than Medicare Part A and Part B coverage and drug coverage in one package. The ease of administration in using the MA-PD, coupled with the ability of MA-PDs to provide lower premiums and cost-sharing, may well prompt many beneficiaries to choose the MA-PD option.

3. Supplemental Benefits

MA plans can offer their enrollees supplemental benefits in addition to those under Medicare Part A and B on either a mandatory and optional basis.¹⁰⁰ Such benefits might, for example, include enhanced vision or dental care, preventive benefits, or mental health or chiropractic benefits beyond what is normally covered.

"Mandatory supplemental benefits" include benefits beyond those covered by Medicare Part A and B in a plan's benefit package, and may be offered by an MA plan with CMS approval.¹⁰¹ In this context, the added benefits would be available to all enrollees, who could be required to pay an additional premium. "Optional supplemental benefits" are benefits offered beyond those covered as basic Part A and Part B benefits on an optional basis. Enrollees have complete discretion regarding purchase of optional supplemental benefits.¹⁰²

G. Beneficiary Education, Marketing, and Beneficiary Protections

CMS conducts a variety of activities to educate beneficiaries about their Medicare choices. CMS mounts a “coordinated beneficiary education campaign”¹⁰³ to coincide with the Annual Election Period. During this time, for instance, the “Medicare & You” handbook is distributed, there are local health fairs, and advertisements are posted. Typically, health plans heavily promote their MA plans during this period. The CMS website is a tremendous source of beneficiary and provider education materials concerning the MA and Part D programs.¹⁰⁴ The educational campaign is intended to inform beneficiaries of their choices in

⁹⁸ 42 U.S.C. § 1395ss(v).

⁹⁹ Many Medicare beneficiaries also have employer prescription drug coverage.

¹⁰⁰ 42 C.F.R. § 422.102(a) and (b).

¹⁰¹ *Id.* at § 422.102(a).

¹⁰² *Id.* at § 422.102(b).

¹⁰³ 42 U.S.C. § 1395w-21(d).

¹⁰⁴ <http://www.cms.hhs.gov/medicarereform/pdbma/provider.asp> [This URL is no longer available as a result of CMS website changes since the initial publication of this primer].

obtaining Medicare benefits and to help them decide their best choice. The annual education campaign is financed by user fees levied on all MA plans.¹⁰⁵

1. MA Plan Marketing

Since the earliest days of the Medicare managed care, CMS has imposed limitations on how Medicare managed care plans (and providers) may market to beneficiaries. Over time, and with experience, marketing policies and guidelines have become more detailed and more restrictive.¹⁰⁶

MA plans must submit all marketing materials and beneficiary election forms to CMS for approval at least 45 days before the date of distribution (unless the MA organization is using language pre-approved by CMS, in which case the pre-approval period is 10 days).¹⁰⁷ Plans that demonstrate consistent compliance with CMS guidelines will be allowed to distribute certain marketing materials without prior CMS approval.¹⁰⁸

MA organizations may not (1) offer cash inducements for enrollment, (2) engage in discriminatory activity (i.e., redlining), (3) conduct door-to-door solicitations, (4) act in such a way as to mislead or confuse beneficiaries, (5) misrepresent the MA organization benefits, (6) distribute marketing materials that CMS has disapproved, (7) employ MA plan names that suggest that a plan is not available to some beneficiaries, (8) use providers to distribute printed information comparing the benefits of different health plans unless the materials have the concurrence of all MA organizations involved and CMS' approval, or (9) accept applications in provider offices.¹⁰⁹

a) CMS Guidance About Provider Promotional Activities¹¹⁰

Because of the special relationship providers enjoy with their patients, CMS has issued specific guidance regarding the involvement of hospitals, physicians, and other providers in connection with to MA marketing and promotional activities.

In general, providers should only market in their capacity as a member of the MA plan's network and only in coordination with the MA organizations. Marketing by a MA plan provider is deemed to be marketing by the MA plan. Therefore, CMS has directed MA plans to stipulate in their contracts with providers that any coordinated marketing to be

¹⁰⁵ 42 U.S.C. § 1395w-27(e)(2).

¹⁰⁶ 42 C.F.R. § 422.80. Medicare Managed Care Manual, Chapter 3, available at: http://www.cms.hhs.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp#TopOfPage.

¹⁰⁷ 42 C.F.R. § 422.80(a)(i); Medicare Managed Care Manual, Ch. 3, § 20.4.

¹⁰⁸ Id. at Ch. 3, § 20.5.

¹⁰⁹ 42 C.F.R. § 422.80(e).

¹¹⁰ Medicare Managed Care Manual, Ch. 3, §50.2.

carried out by the provider must be done in accordance with all applicable CMS marketing guidelines.¹¹¹ CMS has addressed the following types of provider marketing activities:

- Health Fairs - At health fairs, provider groups and individual providers may distribute MA plan brochures, including enrollment applications.¹¹² Because they may not be fully aware of all benefits and costs of the various MA plans, providers or their representatives cannot compare benefits among MA plans in this setting.¹¹³ In addition, enrollment applications may not be accepted at health fairs.
- Provider Facility and Office Activities and Materials - In their own offices, physicians and other health care providers can distribute MA plan brochures and may display posters announcing their affiliation with MA plans.¹¹⁴ However, providers cannot distribute or accept applications in their offices.¹¹⁵ Providers cannot offer inducements to persuade beneficiaries to join MA plans or to steer beneficiaries to a specific MA plan.¹¹⁶

While providers are prohibited from giving and accepting applications in the health care setting, MA plans and provider representatives may conduct sales presentations and give and accept applications in office and facility common areas, as long as patients are not misled or pressured into participating in such activities.¹¹⁷ Common areas where marketing activities are allowed would include hospital cafeterias, community or recreational rooms, and conference rooms. Sale presentations, and the acceptance of applications, are prohibited in areas where patients primarily intend to receive health care services.¹¹⁸ These restricted areas include, but are not be limited to, waiting rooms, exam rooms, nursing resident rooms, and hospital patient rooms.¹¹⁹

Providers cannot offer anything of value to induce MA plan enrollees to select them as their provider.¹²⁰ Physicians may talk with their patients seeking

¹¹¹ Id.

¹¹² Id.

¹¹³ Id.

¹¹⁴ Id.

¹¹⁵ Id.

¹¹⁶ Id.

¹¹⁷ Id.

¹¹⁸ Id.

¹¹⁹ Id.

¹²⁰ Id.

information or advice regarding their Medicare options.¹²¹ Physicians may also refer their patient to other sources of information.

- Provider Affiliation Information - Providers can announce a new affiliation with a MA plan to their patients.¹²² An announcement to patients of a new affiliation which names only one MA plan may occur only once.¹²³ Additional contacts from providers to their patients regarding affiliation must include all the MA plans with which the provider contracts.¹²⁴ This includes, for example, annual affiliation announcements, announcements that certain affiliations have terminated, and the display of MA plan brochures or posters.¹²⁵
- Providers' Comparative/Descriptive Information - Providers may provide printed information to their patients comparing the benefits of different Medicare health plans with which they contract.¹²⁶ Providers may not target information based on health information.¹²⁷
- Provider Web Sites - Providers may provide links to MA plan enrollment applications and/or provide downloadable enrollment applications, as long as the site provides the links/downloadable formats to enrollment applications for all MA plans with which the provider participates.¹²⁸ CMS materials may be distributed by providers without further CMS approval.

H. Grievances and Appeals; Complaints

MA enrollees have significant rights to pursue grievances and to appeal MA organization determinations regarding denials or delays of care or amounts the enrollee must pay for a service.¹²⁹ MA organizations must provide enrollees a written explanation of their

¹²¹ Id.

¹²² Id.

¹²³ Id.

¹²⁴ Id.

¹²⁵ Id.

¹²⁶ Id.

¹²⁷ Id.

¹²⁸ Id.

¹²⁹ See generally, 42 C.F.R. Subpart M, (§ 422.560, *et. seq.*); see also Medicare Managed Care Manual, Chapter 13, available at http://www.cms.hhs.gov/manuals/116_mmc/mc86c13.pdf. Additional information concerning the grievance and appeal process (including answers to frequently asked questions) may be found at <http://www.cms.hhs.gov/MMCAG/>.

Under the MA rules, a "grievance" is any complaint or dispute not involving an organization determination (e.g., complaints regarding timeliness, appropriateness or access to services, or failure of the course of treatment to meet accepted standards of care). Medicare Managed Care Manual, Ch. 13, § 10.1 (Definition

rights and the grievance and appeal procedures and complaint process.¹³⁰ In some instances, providers may pursue grievances or appeals on behalf of beneficiaries. Moreover, non-contracted providers may have direct appeal rights in limited circumstances.¹³¹

1. Complaints

Complaints, which may be in writing or oral, fall into two general categories – grievances and appeals. A complaint may be either a grievance or an appeal or both, but different procedures are required for resolving grievances and appeals.¹³² Grievances are expressions of dissatisfaction with the manner in which an MA plan provides services. Typically, complaints regarding the quality of service received or the timely provision of services already provided are treated as grievances.¹³³ Organization determinations primarily include complaints concerning the benefits to which an enrollee is (or believes he/she is) entitled to receive and generally relate to the provision or payment of health care services.¹³⁴

a) Grievances

MA plans must provide procedures for timely hearing and resolution of a grievance.¹³⁵ The grievance procedure must, among other things, assure (1) timely transmission of the grievance to the appropriate level of decision-making, (2) prompt action, including a full investigation if appropriate, (3) notification of the investigation’s finding to all concerned parties, and (4) procedures for tracking and maintaining records about the receipt and disposition of grievances.¹³⁶

b) Appeals of Adverse Organization Determinations

MA plans make hosts of decisions regarding coverage, payment, timing of treatment and referrals, among other things. Such decisions are generally referred to as “organization determinations” and include (1) payment for temporarily out-of-area renal dialysis, emergency services, post-stabilization care or urgently needed care, (2) payment for any

of Terms, Grievance). By contrast, an “organization determination” is any decision made by the MA organization regarding payment or services to which an enrollee believes he or she is entitled. Id. (Definition of Terms, Organization Determination). See also 42 C.F.R. § 422.566.

¹³⁰ 42 C.F.R. § 422.562(a)(2); Medicare Managed Care Manual, Ch. 13, §§ 10.2 and 20.4.

¹³¹ Medicare Managed Care Manual, Ch. 13, § 10.

¹³² Id. at Ch. 13, § 10.1 (Definition of Terms, Complaint).

¹³³ Id. (Definition of Terms, Grievance). Note that in some instances complaints concerning the quality of medical care received under Medicare may be acted upon by the MA organization, but may also be addressed through the Quality Improvement Organization (“QIO”) process. Id. at Ch. 13, § 20.2; 42 C.F.R. § 422.564(c).

¹³⁴ Id. at Ch. 13, §§ 20.2 and 30.

¹³⁵ 42 C.F.R. § 422.564(a).

¹³⁶ Medicare Managed Care Manual, Ch. 13, § 20.3.

health service furnished by a provider that the enrollee believes is covered by Medicare or, if not Medicare covered, should be furnished by the MA plan, (3) refusal to authorize, provide or pay for care which the enrollee believes should be furnished, (4) discontinuation of a service the enrollee believes is medically necessary, or (5) failure of the MA organization to approve or pay for health care services in a timely manner or to provide the enrollee with timely notice of an adverse determination, such that further delay would adversely affect the health of the enrollee.¹³⁷

When an enrollee requests a service, the MA plan must notify the enrollee of its determination as quickly as the enrollee's health condition requires, but no later than 14 days after the request for a standard determination.¹³⁸ An enrollee or any physician (regardless of whether the physician is affiliated with an MA organization) may request an expedited organization determination where the enrollee's health condition warrants such.¹³⁹ Importantly, this does not include requests for payment of services already furnished.¹⁴⁰ The MA organization must provide for expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.¹⁴¹ Where a request for expedited determination is approved by the MA organization, the determination must be made as quickly as the enrollee's health condition requires, but typically no later than 72 hours.¹⁴²

The appeals process set forth in the MA regulation is triggered if an MA plan's organization determination is unfavorable to the enrollee.¹⁴³

2. Notices

The MA plan must provide the enrollee with a written denial notice (containing appeal rights) whenever the enrollee has requested such notice following a provider or the MA plan's denial of services.¹⁴⁴ Where an enrollee disagrees with a practitioner's decision about a request for a source or course of treatment, CMS states that a practitioner notify the enrollee of his or her right to receive, upon request, a detailed written notice from the MA

¹³⁷ 42 C.F.R. § 422.566(b).

¹³⁸ Id. at § 422.568(a).

¹³⁹ Id. at §§ 422.566(c)(2) and 423.570(a).

¹⁴⁰ Id. at § 422.570(a).

¹⁴¹ Id. at § 422.570 (c)(2)(ii).

¹⁴² Id. at § 422.590(d).

¹⁴³ Medicare Managed Care Manual, Ch. 13, § 40.1.

¹⁴⁴ Id. at Ch. 13, § 40.2.2.

organization regarding the enrollee's services.¹⁴⁵ Notices must contain specific reasons for the denial, the process for reconsideration, and time frames.¹⁴⁶

3. Notices for Denial of Payment to Non-contracted Providers

If an MA organization denies a request for payment from a non-contracting provider, it must notify the provider of the specific reasons for the denial and describe the appeals process.¹⁴⁷ *Non-contracting providers that appeal a 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).*¹⁴⁸

4. Who May Appeal Organization Determinations?

Appeals of an adverse organization determination can be requested by (1) the enrollee (or his or her representative), (2) a physician or other provider who furnished services to the enrollee and waives any right to payment from the enrollee, (3) legal representative of a deceased enrollee's estate, or (4) any other provider determined to have an appealable interest.¹⁴⁹

5. Expedited Reviews of Coverage Terminations for Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities

There are specific notice and other appeal and fast track review procedures that apply in the SNF, HHA, and CORF contexts with regard to proposed termination of services.¹⁵⁰

a) Step 1: Reconsideration by the MA Plan

The first step in appealing an adverse organization determination is to request reconsideration by the MA organization. Reconsideration consists of a review of the determination, the evidence that was considered and any additional evidence submitted. A request for reconsideration can be filed by any party to an organization determination in writing with the MA organization, a Social Security Office or, as applicable, a Railroad

¹⁴⁵ Id. at § 40.2.1.

¹⁴⁶ 42 C.F.R. § 422.568(e); see also Medicare Managed Care Manual, Ch. 13, § 40.2.2.

¹⁴⁷ Id. at Ch. 13, § 40.2.3.

¹⁴⁸ Id. at Ch. 13, §§ 40.2.3, 60.1.4 and 70.1.

¹⁴⁹ 42 C.F.R. § 422.566; Medicare Managed Care Manual, Ch. 13, § 60.1.

¹⁵⁰ For additional information, see Medicare Managed Care Manual, Ch. 13, § 90.2.

Retirement Board office within 60 days of the determination.¹⁵¹ An MA organization may accept an oral request for reconsideration.¹⁵²

A decision on reconsideration must be made as quickly as the enrollee's health condition requires, but not more than 30 days from the date the MA plan receives the request for reconsideration.¹⁵³ Special rules apply to requests for expedited reconsideration.¹⁵⁴ If the MA plan's decision on reconsideration upholds its original adverse determination, in whole or in part, it must prepare a written explanation and send the complete case file to an independent review entity contracted by CMS.¹⁵⁵ Again, this process must take place as quick as the enrollees health condition requires, but no later than 30 days from the date the MA plan received the request for standard reconsideration (or any extension).¹⁵⁶

b) Step 2: Review by the Center for Health Dispute Resolution

CMS has contracted with the Center for Health Dispute Resolution ("CHDR") (www.medicareappeal.com) to be the independent review entity responsible for reviewing MA plan reconsiderations which are unfavorable to the enrollee, in whole or in part. CHDR has a group of physicians, lawyers and other experts who review both the clinical and legal basis of a MA plan's reconsiderations. CHDR must conduct its review of the reconsideration as rapidly as the enrollee's health condition requires.¹⁵⁷

A notice of CHDR's determination must be sent to all parties. It must (1) state specific reasons for its decision, (2) inform parties (other than the MA organization) of their right to a hearing before an Administrative Law Judge ("ALJ") if CHDR's decision does not completely reverse the MA plan's adverse determination, and (3) describe the procedures that must be followed to obtain an ALJ hearing.¹⁵⁸

c) Step 3: ALJ Hearings, the Departmental Appeals Board and Judicial Review

Is it very rare that adverse MA organization determinations which are upheld by CHDR are further appealed. If the decision by CHDR upholds the MA Plan's adverse determination in any manner, the parties may seek a hearing before an Administrative Law Judge ("ALJ"), assuming certain thresholds are met.¹⁵⁹ Thus, the ALJ will first determine if

¹⁵¹ Id. at Ch. 13, §§ 70.1 and 70.2.

¹⁵² Id.

¹⁵³ 42 C.F.R. § 422.590; Medicare Managed Care Manual, Ch. 13, § 70.7.1.

¹⁵⁴ 42 C.F.R. § 422.584; Medicare Managed Care Manual, Ch. 13, § 80.

¹⁵⁵ Medicare Managed Care Manual, Ch. 13, § 70.7.2.

¹⁵⁶ Id.

¹⁵⁷ Id. at Ch. 13, § 90.

¹⁵⁸ Id.

¹⁵⁹ 42 C.F.R. §§ 422.600 and 422.602; Medicare Managed Care Manual, Ch. 13, § 100.

the amount in controversy, which may be an amount due in payment or the value of the services denied, meets appropriate thresholds. If the amount in controversy is below the threshold, the ALJ will dismiss the case. Any party dissatisfied with an ALJ's decision may seek further review by the Medicare Appeals Counsel ("MAC").¹⁶⁰ Finally, a MAC decision may be subject to review by the federal courts if certain conditions and amounts in controversy are met.¹⁶¹

6. The Notice of Discharge and Medicare Appeal Rights ("NODMAR")

When an MA Plan has authorized inpatient hospital coverage, the Plan or a hospital with delegated responsibility from the Plan to make discharge/non-coverage decisions is required to issue a written NODMAR to the enrollee when (1) the enrollee expresses dissatisfaction with his or her impending discharge, or (2) the MA organization (or the hospital if it has been delegated the responsibility) is not discharging the individual but no longer intends to continue coverage of the inpatient stay.¹⁶² The NODMAR, in turn, must specify (1) why inpatient care is no longer needed, (2) the prospective effective date of the enrollee becoming financially liable for continued inpatient care, and (3) the enrollees appeal rights.¹⁶³

An enrollee in the hospital wishing to appeal the MA Plan's discharge decision that inpatient care is no longer necessary must request immediate review from a Quality Improvement Organization ("QIO").¹⁶⁴ The submission of a timely appeal for an immediate QIO review filed by an enrollee automatically entitles the enrollee to financial protection by the MA organization. Thus, the MA organization will continue to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the enrollee of its review determination.¹⁶⁵

DISCLAIMER: These materials should not be considered as, or as a substitute for, legal advice and they are not intended to nor do they create an attorney-client relationship. Because the materials included here are general, they may not apply to your individual legal or factual circumstances. You should not take (or refrain from taking) any action based on the information you obtain from this document without first obtaining professional counsel.

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¹⁶⁰ 42 C.F.R. § 422.608; Medicare Managed Care Manual, Ch. 13, § 110.

¹⁶¹ 42 C.F.R. § 422.612; Medicare Managed Care Manual, Ch. 13, § 120.

¹⁶² Medicare Managed Care Manual, Ch. 13, § 150.2.

¹⁶³ Id. at Ch. 13, § 150.1.

¹⁶⁴ Id. at Ch. 13, § 160.

¹⁶⁵ Id. at Ch. 13, § 160.1.