



American Hospital Association

Sonnenschein
Sonnenschein Nath & Rosenthal LLP

Medicare Advantage

A Primer for America's Hospitals

By Bruce Merlin Fried, Esq.
Janice Ziegler, Esq.
Kashmira Makwana, Esq.

Session 2: Payment Issues

I. Introduction

How Medicare Advantage (“MA”) organizations are paid and how they, in turn, pay their providers, is a complex subject.¹ The monthly capitated payments that the Centers for Medicare & Medicaid Services (“CMS”) will make to MA organizations in 2006 will be the product of a largely untested payment methodology designed to bring market pressures to bear on health plans. This payment methodology, while moving toward a competitive pricing system, reflects vestiges of the old fee-for-service shadow pricing system for setting capitation rates; includes adjustments to the capitation payments intended to reflect the relative “risk” (i.e., health care costs) of each individual MA enrollee; and contains miscellaneous payment subsidies intended to induce certain MA plans to enter or remain in particular markets. In limited circumstances, the federal government and MA organizations will share risk. The degree to which MA enrollees will participate in the financing of MA plans (through premiums and cost-sharing) will vary significantly from plan to plan and market to market.

¹ American Hospital Association (“AHA”) members may submit questions of general interest concerning MA payment issues to Ellen Pryga at epryga@aha.org for possible inclusion in the “Frequently Asked Questions” portion of the MA segment of the AHA website.

A. Provider Payment – A Preview

1. Rates Established by Contract for Network Providers

How hospitals and other providers will be paid by MA organizations will vary from plan to plan. In virtually every instance, the economic relationship between an MA organization and its network providers will be determined based on negotiations and resulting contracts.²

Some providers, though substantially fewer than in earlier years of Medicare managed care, will agree to be paid on a capitated basis; that is, they will agree to receive a fixed payment per month for every MA plan enrollee assigned to them. The provider will then be obligated to meet the health care needs of the relevant MA plan enrollees in the manner specified by contract. In some instances, a provider may never see a particular MA enrollee. In other instances, a provider may need to furnish an MA enrollee with extraordinary levels of care. Regardless of the level of services furnished to an enrollee, the provider will receive the same agreed upon capitated payment amount. In recent years, providers have become increasingly unwilling to bear the risk of such arrangements.

More typically, MA organizations and their network providers negotiate fee-for-service payment arrangements.³ In the hospital context, contracts frequently build off of the Medicare Part A Diagnostic Related Group (“DRG”) payment amounts or specify a per diem payment amount.

The leverage that a particular hospital will be able to exert in negotiations with an MA organization will depend on a multitude of factors, including the institution’s reputation and prominence, the degree of competition from other providers in the MA plan’s service area, and whether the hospital is essential to establishing the MA plan’s network (in general, or with respect to particular specialty services). In some instances, a hospital may be able to negotiate payment rates greater than 100 percent of the Medicare DRG rates. Conversely, hospitals that cannot differentiate themselves in some “value-added” fashion may face difficult negotiations and be offered less than the Medicare DRG rates. In the end, the economic relationship between an MA plan and its in-network providers will generally be subject to negotiation and the give and take of the market place. As in the commercial

² In the MA private fee-for-service (“PFFS”) context, however, providers may in certain instances be “deemed” to be contract providers subject to a plan’s standard terms and conditions of payment even without the existence of a written contract. See 42 C.F.R. § 422.216(f). The unique payment features regarding PFFS plans are discussed more fully below.

In this Primer, we frequently refer to the MA regulations located at 42 C.F.R. Part 422. For ease of reference, we attach a link to the regulations here: <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>.

³ Despite the fact that only MA PFFS plans are required to pay providers on a fee-for-service basis, see 42 C.F.R. § 422.4(a)(3), many MA plans reimburse providers in this fashion.

context, providers remain free to decline to participate in an MA plan's network if the terms and conditions offered are not acceptable.⁴

2. Rates Established by MA Program for Non-contract Providers

Even providers who do not enter into agreements with MA organizations will need to understand the MA program payment rules. This is because there are any number of instances where a non-contract provider will be entitled to payment from an MA organization for care delivered to an MA plan enrollee. This may occur, for instance, where a beneficiary enrolled in a Medicare health maintenance organization ("HMO") receives urgent or emergent care out-of-network or where an enrollee has the option of obtaining covered benefits from an "out-of-network" provider (for instance, in an HMO point-of-service plan allowing out-of-network access for such services). As we explained in Session I, the latter type of situation is likely to occur with increased frequency under the MA program given the addition of regional preferred provider organizations ("Regional PPOs") as a new type of MA plan option and the anticipated rise in the number of PFFS plans (and, concomitantly, PFFS plan enrollees). As explained more fully below, the payment rate for "non-contract" providers (including payment from the MA plan and enrollee cost-sharing) is generally the amount the provider would have received under original fee-for-service Medicare.⁵

B. The Presentation Outline

In order to effectively negotiate payment arrangements with MA organizations, it is essential for providers to have a sound grounding in how the organizations themselves are paid. Among the MA organization payment topics discussed below are:

- the competitive bidding payment methodology;
- risk adjustment; and
- special risk sharing and subsidies that apply in the Regional PPO context.

After reviewing these matters, we will address issues particular to MA organization payments to providers, including:

- payments to non-contract providers;
- prompt payment requirements;
- payment for emergency, urgent and post-stabilization care;
- limitations on enrollee liability;
- the impact of national coverage decisions;

⁴ MA organizations likewise remain free to determine which providers to include in their networks. Moreover, "in order to promote competition," the MMA expressly prohibits CMS from requiring an MA organization to contract with a particular hospital, physician or other entity, or to require a particular price structure for payment in a contract between an MA organization and a provider. 42 U.S.C. § 1395w-24(a)(6)(B)(iii).

⁵ 42 C.F.R. § 422.100(b)(2).

- payments to federally qualified health centers;
- payment to “essential hospitals” in the Regional PPO context;
- special payment rules in the PFFS context; and
- Medicare Secondary Payer considerations.

II. How MA Organizations are Paid

A. The Competitive Bidding Methodology for Setting Capitation Rates

First, we start with a point of clarification. While the new methodology for setting MA organization payment rates is characterized as a “competitive bidding” process, it is not a “winner take all” bidding situation. Rather, the process allows for (and indeed encourages) multiple MA organizations to contract with CMS to offer health care services to Medicare beneficiaries within a particular service area or region. The “bidding” process is designed to move the Medicare managed care program away from the traditional system whereby capitation rates were administratively fixed based largely on average Medicare fee-for-service per capita expenditures and towards a system where rates are set based on market pressures and enrollee preferences, while at the same time maximizing enrollee choice.

1. The Bidding Process

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the “MMA”)⁶ sets forth the process for establishing MA plan payments (with the exception of MA Medical Savings Accounts).⁷ Each year, beginning in 2005, all organizations intending to contract with CMS to offer an MA plan for the subsequent year must submit a “bid” by the first Monday in June.⁸ Each bid will be based on the plan’s projected costs in its service area for providing an “average” enrollee with the following:

1. Medicare Part A and Part B benefits;
2. basic Medicare Part D prescription drug coverage; and
3. supplemental health benefits (if any).⁹

The bid must also detail the actuarial basis for determining the anticipated benefit costs submitted and the projected number of enrollees in the service area.¹⁰ Additionally, the

⁶ 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.

⁷ 42 U.S.C. § 1395w-24; 42 C.F.R. § 422.254.

⁸ 42 U.S.C. § 1395w-24(a)(1)(A).

⁹ Id. § 1395w-24(a)(6)(A).

¹⁰ Id.

MA organization must describe the out-of-pocket costs to be borne by beneficiaries in the form of deductibles, coinsurance, and co-payments.¹¹

Once an MA organization has submitted its bid, the bid will be reviewed by CMS to determine the appropriateness of the assumptions and data.¹² The bid can either be accepted by CMS or CMS can negotiate with the MA organization regarding the acceptability of the bid.¹³ Negotiations typically occur where the elements of a plan's bid vary substantially from the bid elements of other plans in the same market or if it appears that the bid is not actuarially sound.

2. Comparing the Bid to the Benchmark

Once all bids are received and accepted by CMS, they will be compared to a "benchmark" rate. For plans other than Regional PPO plans, the plan's benchmark will be based on the weighted average of the Medicare Part A and Part B components of the capitation rates for each county in the plan's service area using the plan's projected enrollment.¹⁴ For Regional PPO plans, the benchmark for the region will be based on a blend of the county rates (the statutory component) and bids of other Regional PPO plans in the region (the plan-bid component).¹⁵

3. Plan Payment and Beneficiary Premiums

The relationship of an MA plan's bid to the service area benchmark is what determines the payment that will be made to the plan and the premium that enrollees will pay. Where an MA plan's bid is equal to or greater than the benchmark, the Medicare payment to the MA plan will be the benchmark amount adjusted by the individual enrollee's risk factor.¹⁶ Additionally, the MA plan will be required to collect the difference between its bid and the benchmark from its enrollees in the form of a premium.¹⁷

Where an MA plan's bid is less than the benchmark, the plan will be paid its bid amount adjusted by the individual's risk factor.¹⁸ In such instances, there will be no

¹¹ Id.

¹² Id. § 1395w-24(a)(6)(B).

¹³ Id. § 1395w-24(a)(6)(A) and (B). Such negotiations will be in a manner similar to negotiations conducted by the Office of Personal Management with Federal Employee Health Benefit plans. See Medicare Managed Care Manual ("MCM"), Ch. 1, § 10. For ease of reference, the MCM is available at <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326>.

¹⁴ 42 U.S.C. § 1395w-23(j).

¹⁵ Id. § 1395w-27a(f).

¹⁶ MCM, Ch.1, § 10.

¹⁷ 42 C.F.R. § 422.262(a)(2).

¹⁸ MCM, Ch. 1 § 10.

beneficiary premium. Seventy five percent of the difference between the benchmark and the bid (referred to as the “average per capita savings”) will be “rebated” to beneficiaries in the form of supplemental health care benefits, Part D drug benefit premium payments, or credit toward the Part B premium.¹⁹ The remaining 25 percent of the average per capita savings will be retained by the Medicare Trust Fund.²⁰

4. The Implications of the Competitive Bidding Process

Congress’ intent in adopting this new methodology for setting MA plan capitation rates was to inject market forces into what had previously been an administratively determined payment scheme. Since MA organizations will not know in advance how their bids will compare to the benchmark, market dynamics and competition are expected to compel plans to submit bids that are as low as possible. If an MA organization’s bid is ultimately greater than the benchmark, it will be required to impose a premium on its enrollees. Conversely, if an MA organization’s bid turns out to be below the benchmark, it will not only avoid having to impose an enrollee premium, but will also likely be able to offer improved benefits and/or reduced out-of-pocket cost sharing to its enrollees. Thus, MA plans with lower bids will be more attractive to beneficiaries and will presumably capture greater market share.²¹ How this process evolves over time is anyone’s guess. But in the short term, providers should expect increased demands from MA organizations to accept lower reimbursement rates as MA organizations struggle to reduce their projected costs.

B. Risk Adjusting MA Payments

1. Background

Since the early days of the Medicare managed care program, adjustments have been made to the standard capitation payment rates to reflect the variation in health status, or “risk” (in common insurance parlance), among individual beneficiaries. Risk adjustment is important to address the perverse economic incentives inherent in a capitated payment system. If capitation payments were based solely on the cost of providing care to an “average” beneficiary, then it would make economic sense for health plans to focus their efforts on recruiting and retaining healthier than average beneficiaries (who would presumably be less costly), and avoiding those beneficiaries who were sicker than average.²²

¹⁹ Id.

²⁰ 42 U.S.C. § 1395w-24(b)(1)(C).

²¹ CMS has developed a system that allows beneficiaries to easily obtain an “apples-to-apples” comparison of the MA plans available in their area, available at: http://www.medicare.gov/MPPF/Include/DataSection/Questions/Welcome.asp?version=default&browser=IE%7C6%7CWin2000&language=English&year=2006&defaultstatus=1&pagelist=Home&user=&MPDPF_zip=. This type of system puts additional pressure on MA plans to reduce premiums and improve benefits.

²² Recognizing this incentive, the MA program expressly prohibits MA organizations from “cherry picking” healthy individuals by discriminating in marketing to, and enrolling, Medicare beneficiaries based on health status. See 42 C.F.R. § 422.110.

To the degree payments to MA organizations can accurately reflect the risk of enrolling particular members, MA organizations will have the same economic incentive to serve both low risk and high risk beneficiaries.

2. From Demographics to Diagnosis, the CMS-HCC Model

Risk adjustments were initially crude and imprecise, based only on demographic factors such as institutional status, Medicaid eligibility, working status, and advanced age.²³ In recent years, at Congress' direction,²⁴ CMS has been transitioning away from the original demographic only risk adjustment methodology to the so-called CMS Hierarchical Condition Category ("CMS-HCC") model. The CMS-HCC model develops a risk adjuster based on both diagnostic and demographic data.

The diagnostic aspect of the CMS-HCC model looks to selected significant disease types and incorporates a selected subset of ICD-9-CM diagnosis codes.²⁵ These codes are placed into approximately 70 disease groups or Hierarchical Condition Categories ("HCCs").²⁶ Each disease group includes conditions that are related clinically and have similar cost implications.²⁷ These factors will be used to calculate per person per month payments to MA organizations.²⁸ The CMS-HCC model is prospective in that it uses diagnoses from a base year to predict costs and adjust payments for the next year (with a lag for implementation delays).²⁹ The demographic aspects of the CMS-HCC model look to age, sex, Medicaid eligibility and whether the beneficiary was "originally disabled."³⁰

Describing the process for calculating beneficiary risk scores can best be accomplished through hypothetical examples. The examples set forth below are excerpted from CMS's Managed Care Manual ("MCM").³¹ In these examples, the risk adjustment process considers both demographic data and diagnosis data.

Example A - Beneficiary A is a male, aged 82 living in the community, who was originally entitled for Medicare due to disability. He is not eligible for Medicaid (no

²³ MCM, Ch. 7, at § 80.

²⁴ 42 U.S.C § 1395w-23(a)(3).

²⁵ Id., Ch. 7, § 91.

²⁶ Id. CMS is considering one of two options for 2007: (1) staying with current 70 HCC model (calibrated on 1999 diagnosis/2000 cost data); or (2) recalibrating the weights using 2002/2003 data which results in minor refinements to the current HCC categories (i.e., 69 HCCs). Medicare Advantage Risk Adjustment Method CY 2007, available at <http://cms.hhs.gov/healthplans/riskadjustment-9-27.pdf> [This URL is no longer available as a result of CMS website changes since the initial publication of this primer].

²⁷ Id.

²⁸ Id.

²⁹ Id.

³⁰ Id., Ch. 7, § 91.1.

³¹ Id., Ch. 7, § 91.5.

expenditure increment). He had several diagnoses: Diabetes with Acute Complications (HCC 17), Diabetes without Complications (HCC 19) and Pneumococcal Pneumonia (HCC 112).

Beneficiary A is placed in the appropriate sex and age group. “Male, aged 82, living in the community” carries an incremental risk factor of .657. He also is assigned “originally disabled” status, which carries an incremental risk factor of .148. For diagnoses, Beneficiary A is assigned a factor of .391 for HCC 17, and HCC 19 is dropped because both HCC 17 and HCC 19 are in the diabetes hierarchy and only the highest HCC in a hierarchy should be included in the calculation (see § 91.2.1 above for additional information on hierarchies). In addition, a factor of .202 for HCC 112 would be added. Adding the incremental risk factors produces an overall risk score of 1.398.

Example B - Beneficiary B is a female, aged 69, who was not originally disabled (no expenditure increment), is eligible for Medicaid, and living in the community. She had one diagnosis during the base year – specified heart arrhythmias (HCC 92), which is .266 and is added to the risk score. Beneficiary B is placed in the appropriate sex and age group. “Female, aged 69 living in the community” carries an incremental risk factor of .307. She also is assigned “aged with Medicaid” status, which adds an incremental risk factor of .183. The risk factor of .266 is added for HCC 92, so Beneficiary B’s overall risk score is .756, which indicates someone who is likely to incur relatively low costs in the payment year.

Example C – Beneficiary C is a female, aged 88, who is living in a long-term nursing institution. She has three diagnoses: Polyneuropathy (HCC 71), Ischemic or Unspecified Stroke (HCC 96) and Decubitus Ulcer of Skin (HCC 148). Beneficiary C is placed in the appropriate sex and age group. “Female, aged 88 living in an institution” carries an incremental risk factor of .880. The institutional risk factors of .098 (HCC 71), .151 (HCC 96), and .317 (HCC 148) are added for an overall risk score of 1.446.³²

In each instance, the risk score is then applied to the payment rate determined by the competitive bidding process for the county within the MA plan’s service area in which the individual beneficiary resides.³³

3. The Role of Hospitals and Physicians in the CMS-HCC Process

Although the risk adjustment system described above is complex, the bottom line is that MA plans will receive an increased payment for beneficiaries with higher risk scores and a lower payment for those with lower risk scores.³⁴ Providers and physicians will play a

³² Id.

³³ Id., Ch. 7 § 91.6.

³⁴ Id., Ch. 7 § 91.5.

critical role in the development and submission of data used to develop an MA plan's risk adjustment payment. Because the risk adjustment methodology will be largely based on diagnoses, MA plans must rely on the timely, accurate and complete reporting of patient diagnoses by providers in order to receive appropriate risk adjustment payments. As discussed more fully below, because the diagnosis data generated by providers will serve at least in part as the basis for federal health care payments (and thus expose the MA organization to potential fraud and abuse concerns if inaccurate), MA organizations will look for contractual and other representations from providers that the data furnished is accurate.

4. Sources of Diagnosis Data

MA plans collect diagnosis data primarily from three sources: (1) hospital inpatient data, (2) hospital outpatient data, and (3) physician data. The MCM sets forth in significant detail the guidelines for diagnosis data collection and submission.³⁵ We briefly summarize the process here.

(1) Hospital Inpatient Data

In the data submission process, hospital inpatient data is differentiated based on whether it is received from an in-network hospital or an out-of-network hospital.³⁶ Only diagnosis data from hospitals with inpatient Medicare provider numbers can be submitted by MA organizations.³⁷ Data from hospital operated skilled nursing facilities ("SNF"), or from "swing beds" when those beds are used for SNF purposes, may not be submitted by the MA organization as inpatient hospital diagnoses.³⁸

Hospital inpatient diagnosis data must be differentiated to reflect the principal diagnosis and all other inpatient diagnoses. The principal diagnosis is "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."³⁹ While MA plans should collect and report all diagnoses data, the principal diagnosis has a larger bearing in the risk adjustment methodology.⁴⁰

(2) Hospital Outpatient Data

Hospital outpatient data includes any diagnosis from any hospital outpatient department, except those diagnoses derived only from claims or encounters for laboratory services, ambulance, or durable medical equipment, prosthetics, orthotics and supplies.⁴¹

³⁵ For additional information, see generally, Ch. 7, § 111.

³⁶ Id., Ch. 7, § 111.1.

³⁷ Id.

³⁸ Id.

³⁹ Id.

⁴⁰ Id.

⁴¹ Id., Ch. 7, § 111.2

CMS has included federally qualified health centers, community mental health centers, and rural health clinics as outpatient facilities whose data MA organizations may submit.⁴² As in the inpatient hospital context, diagnoses collected from network providers are differentiated from diagnoses collected from non-network providers. A facility must have a hospital outpatient Medicare provider number in order for an MA organization to submit data from that facility.⁴³

(3) Physician Data

Physician data includes data from physicians, certain non-physician practitioners, and multi-specialty groups and clinics.⁴⁴ Physician risk adjustment data is defined as diagnoses that are noted as a result of a face-to-face visit by a patient to a physician (as broadly defined in the MCM) for medical services.⁴⁵ The face-to-face requirement does not apply to pathology or radiology services.⁴⁶ Medicare fee-for-service coverage and payment rules do not apply to risk adjustment data.⁴⁷ As a result, MA organizations may submit diagnosis data noted by a physician even when the services rendered on the visit are not Medicare covered.⁴⁸

5. Data Collection

MA organizations may collect diagnosis data from providers in several ways.⁴⁹ They can (with certain limitations) use (1) standard claim or encounter formats (including the UB-92, the National Standard Format ("NSF"), and ANSI X12 837), (2) a superbill (often used for physician claims and including ICD-9-CM codes, CPT codes and beneficiary information), and (3) the minimum data set format used to support CMS' Risk Adjustment Processing System ("RAPS").⁵⁰

⁴² Id.

⁴³ Id.

⁴⁴ Id., Ch. 7, § 111.3.

⁴⁵ Id.

⁴⁶ Id.

⁴⁷ Id.

⁴⁸ Id.

⁴⁹ Id., Ch. 7, § 111.5.

⁵⁰ Id. While CMS is trying to allow flexibility to MA organizations in how diagnosis data may be collected, the MCM contains additional detail regarding when a particular method of data collection may (or may not) be used. Thus, MA organizations may not utilize a superbill or the minimum risk adjustment data set to obtain diagnoses from providers who submit electronic claims or encounters, except in limited instances. Id. Providers may wish to inquire during contract negotiations regarding the type of data reporting that the particular MA organization would require of the provider.

6. Diagnosis Submission

The MA organization must submit each relevant diagnosis for each plan enrollee at least once during a data collection period in order for that diagnosis to be included in the risk adjustment calculation.⁵¹ A "relevant diagnosis" is one that (a) is utilized in the HCC model, (b) was received from one of the three provider types outlined above; and (c) was collected according to the risk adjustment data collection instructions set forth in the MCM.⁵² The data collection period for 2005 is from January 1 to December 31, 2004. Data must be submitted by no later than March 31, 2006.⁵³

7. Certification of Data Accuracy, Completeness and Truthfulness and CMS Data Validation

As a condition for receiving a monthly MA payment, the MA organization's chief executive officer ("CEO"), or an individual delegated the authority to sign on behalf of the CEO, must request payment under the contract on a document that certifies, based on best knowledge, information and belief, that the risk adjustment data the MA organization submits to CMS are accurate, complete and truthful.⁵⁴

CMS guidance notes that MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate data.⁵⁵ Such provisions may provide for financial penalties (including withholding of payment) for failure to submit complete data or for failure to submit data that conform to the data submission requirements.⁵⁶ In addition, the MA regulations provide that when encounter data is generated by a subcontractor (such as a contracted provider), the subcontractor must certify (based on best knowledge, information and belief), the accuracy, completeness, and truthfulness of the data.⁵⁷

CMS may validate the MA organization's diagnosis data submission against medical records to assure the accuracy of medical information. MA organizations must be able to trace the submitted diagnosis data back to the hospital or physician medical record that was the source of the diagnosis.⁵⁸

⁵¹ Id., Ch. 7, § 111.6.

⁵² Id.

⁵³ Id., Ch. 7, § 91.4, Table 3.

⁵⁴ 42 C.F.R. § 422.504(l); MCM, Ch. 7, § 111.7.

⁵⁵ MCM, Ch. 7, § 111.7.

⁵⁶ Id.

⁵⁷ 42 C.F.R. § 422.504(l).

⁵⁸ MCM, Ch. 7, § 111.8; see also 70 Fed. Reg. 4588, 4661 (Jan. 28, 2005).

C. Special Payments for Regional PPOs

In order to encourage health plans to develop and operate MA organizations in areas of the country that have not previously been served by Medicare managed care plans, Congress authorized the existence of MA Regional PPO plans.⁵⁹ As noted in Session I, MA Regional PPOs must cover an entire MA region – which may include rural areas not previously served by Medicare managed care plans – and offer a uniform benefit package across the region. Congress provided for a number of unique financial incentives designed to assist Regional PPO plans as they enter this new line of business and learn the market dynamics of serving beneficiaries across larger geographic regions.

1. Risk Sharing

Among the incentives offered by the MMA to encourage MA Regional PPO development is the establishment of “risk corridors” which serve to share risk between the MA Regional PPOs and CMS for regional MA plans during 2006 and 2007.⁶⁰ To wit, CMS will share the risk (and benefit) with MA Regional PPO plans for contract years 2006 and 2007, if plan costs are above (or below) a specific risk corridor.⁶¹ The specific formula for calculating the “risk corridors” is set forth in regulation.⁶²

2. Stabilization Fund

Beginning in 2007, an “MA Regional Plan Stabilization Fund” will be available to encourage (1) the entry of MA Regional PPOs into each MA region, and (2) the retention of MA Regional PPOs in certain MA regions with below national average MA market penetration.⁶³ The purpose of the Fund is to promote greater stability in the regional program and to provide CMS with a tool to respond to market fluctuations.⁶⁴ Congress allocated \$10 billion to the Fund to be used beginning in January 1, 2007 and through December 31, 2013.⁶⁵ While Stabilization Fund payments by CMS in a particular region may not be known at the time of contracting, providers may wish to build a contingency into their Regional PPO provider contracts that allow them to receive additional payments in the eventuality that Stabilization Funds are distributed to the particular MA plan.

⁵⁹ 42 U.S.C. § 1395w-27a.

⁶⁰ Id. § 1395w-27a(c); see also 42 C.F.R. § 422.458(b).

⁶¹ 42 C.F.R. § 422.458(c)(2).

⁶² See generally 42 C.F.R. § 422.458.

⁶³ 42 C.F.R. § 422.458(f).

⁶⁴ 70 Fed. Reg. at 4670.

⁶⁵ Id.

III. How Providers Are Paid under MA

A. An Overview

1. Contract Providers

Generally, the payment arrangements between contract providers and MA organizations are determined by the terms and conditions negotiated and agreed to in the contract between the provider and the MA organization. Often the payment terms are based on original Medicare fee-for-service or per diem rates. Some providers, however, negotiate capitated payment arrangements with MA organizations, essentially assuming risk for in-patient or out-patient care.

Given that non-contract providers offering services to MA enrollees are essentially guaranteed payment in the amount that they would have received if the beneficiary were enrolled in the original Medicare fee-for-service program (as discussed more fully below), it may be rare that a provider will agree to contract terms under which it will be paid less than 100 percent of the Medicare fee-for-service rate.⁶⁶ In some instances, providers have been successful at negotiating payment rates that exceed 100 percent of the original Medicare fee-for-service rate. Generally, these situations occur where the provider is a critical component of the MA plan's network, either because the hospital enjoys a special reputation in the community, provides unique services or is one of few such providers.

2. Non-Contract Providers

MA organizations are generally obligated to pay non-contract providers furnishing covered services to MA enrollees the amount the provider would have received if the beneficiary were enrolled in original Medicare (taking into account permitted beneficiary cost-sharing under the plan).⁶⁷ In practice, this means that the MA plan must pay the provider at least the amount that the provider would have received if the beneficiary were enrolled in original Medicare, less the enrollee's cost-sharing (e.g., coinsurance and deductibles) under the Plan.

Non-contract providers are obligated to accept as payment in full the amount the provider could collect if the beneficiary were enrolled in original Medicare.⁶⁸ As a result,

⁶⁶ That said, if Medicare managed care enrollment becomes a significant percentage of overall Medicare enrollment, providers will at some point feel pressure to consider entering into such arrangements in order to maintain their market share of Medicare patients.

⁶⁷ 42 C.F.R. § 422.100(b)(2).

⁶⁸ 42 C.F.R. § 422.214. In order to comply with this payment rule, 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. For many of the key services for which Medicare provides reimbursement, Medicare employs prospective payment systems ("PPS") or fee schedules. Where national PPS or fee schedules exist, payment calculations under original Medicare are relatively straightforward. Thus, to facilitate MA payment, CMS provides public access to fee-for-service schedules and reimbursement rates. 70 Fed. Reg. at 4630. It also assists MA organizations in pricing claims for out-or-

where a physician participates in Medicare, the plan typically pays the non-contracted physician the Medicare allowed amount less the plan's cost sharing.⁶⁹ In the case of a provider that does not participate in Medicare, the plan typically pays the non-contracted provider the Medicare limiting charge less the enrollee's cost sharing.⁷⁰ In the case of an acute care hospital, the plan typically pays the DRG payment less the enrollee's cost sharing.⁷¹ The greatest challenge comes in calculating appropriate payment rates where original Medicare payments are based on reasonable cost or reasonable charge formulas, rather than on a fee schedule or PPS system.⁷²

CMS has indicated that certain statutory "add on" payments (e.g., disproportionate share hospital ("DSH") payments) are considered to be part of the Medicare fee-for-service amount that an MA organization must make to non-contracted providers.⁷³ An MA organization is not required, however, to include indirect medical education ("IME") or GME amounts in its payment to non-contracted hospitals and other providers to the extent that such providers receive IME or GME payments for MA plan enrollees directly from Medicare fiscal intermediaries.⁷⁴ Indeed, in most instances, hospitals will receive GME and IME payments for all beneficiaries (including MA enrollees) directly from the Medicare fiscal intermediary.

B. Prompt Payment

1. Contract Providers

Contracts between MA organizations and providers must contain prompt payment provisions which are developed and agreed upon by the MA organization and the relevant provider.⁷⁵ Federal policy provides no specific mandate concerning prompt payment timeframes in this context (and thus no specific provider protection). While contracting providers are likely to be very attentive to the payment provisions in their contracts with MA

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 emergency 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" for MA organizations. Id.

⁶⁹ 65 Fed. Reg. 42170, 40295 (June 29, 2000).

⁷⁰ Id.

⁷¹ Id.

⁷² CMS has recognized, for instance, that because the amount "original" Medicare pays to critical access hospitals ("CAHs") is made on a periodic interim basis, is cost-based and is subject to cost-settlement, it will be administratively complicated for MA organizations to pay appropriate rates to non-contracting CAHs. 70 Fed. Reg. at 4630-31. Accordingly, CMS has indicated an intent to monitor payments to CAHs closely. Id.

⁷³ See 70 Fed. Reg. at 4611; see also id. at 4629.

⁷⁴ 42 C.F.R. § 422.214(b); 70 Fed. Reg. at 4611.

⁷⁵ 42 C.F.R. § 422.520(b); MCM, Ch. 11, § 100.2.

organizations, they should also pay particular attention to the “prompt payment” requirements and the means by which such requirements can be enforced (and associated penalties for slow payment).

2. Non-Contract Providers

The MA contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of “clean claims” within 30 days of receipt from non-contract providers or on behalf of MA private-fee-for-service plan enrollees.⁷⁶ Where a claim is not paid within 30 days, the MA organization must pay interest on the claim.⁷⁷ All other claims from non-contracted providers must be paid or denied within 60 days of receipt by the MA organization.⁷⁸ If CMS determines, after notice and an opportunity for a hearing, that an MA organization has failed to comply with this requirement, CMS may directly pay the non-contracting provider the amount it is owed and reduce the payment that would otherwise be made to the MA organization by the amount directly paid.⁷⁹

C. Payment for Emergency and Urgently Needed Care and Post-Stabilization Care Services

MA organizations are responsible for furnishing emergency⁸⁰ and urgently needed⁸¹ health care, regardless of whether the services are provided within the MA organization’s network and regardless of whether prior authorization has been obtained (as would normally be required).⁸² This is so regardless of the final medical diagnosis, as long as the “prudent layperson” definition of “emergency medical condition” was met.⁸³ The MA organization is

⁷⁶ 42 C.F.R. §§ 422.504(c) and 422.520.

⁷⁷ Id. § 422.520(a)(2).

⁷⁸ Id. § 422.520(a)(3).

⁷⁹ Id. § 422.520(c).

⁸⁰ An “emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a “prudent layperson,” with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Id. § 422.113(b)(1)(i).

⁸¹ “Urgently needed services” are covered services that are not emergency services, provided when an enrollee is temporarily absent from the MA plan’s service area when the services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization offering the MA plan. Id., § 422.113(b)(1)(iii).

⁸² Id. § 422.113(b)(2).

⁸³ Id. § 422.113(b)(2)(iii).

also financially responsible whenever a plan provider or other MA organization representative instructs an enrollee to seek emergency services within or outside the plan.⁸⁴

MA plan enrollees may not be charged for emergency department services more than \$50 or what the enrollee would have been charged had he or she received the emergency care through the MA organization, whichever is less.⁸⁵ However, the MA organization is not responsible for non-emergency services rendered during treatment for an emergency situation (for instance, removal of lesions).⁸⁶

MA organizations are responsible for post-stabilization care services,⁸⁷ whether provided within or outside the MA organization's network, when such services (1) are pre-approved by the plan provider or the MA organization, (2) are administered to maintain the enrollee's stabilized condition within one hour of a request to the MA organization for pre-approval of further post stabilization care; or (3) are administered to maintain, improve or resolve the enrollee's stabilized condition if the MA organization does not respond to a request for pre-approval within one hour, cannot be contacted, or the treating physician and the MA organization cannot reach agreement on the enrollee's care and a plan physician is not available for consultation.⁸⁸ The MA organization's financial responsibility for post-stabilization care services that it has not approved ends when (1) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care, (2) an MA plan physician assumes responsibility for the enrollee's care through transfer, (3) an MA organization representative and treating physician reach agreement concerning the enrollee's care, or (4) the enrollee is discharged.⁸⁹ The MA organization must limit charges to enrollees for post-stabilization care services to an amount equal to or less than what it would charge the enrollee if he or she had obtained services through the MA organization network.⁹⁰

D. Providers May Not Seek Payment from Enrollees for MA Organization Payment Obligations

Contracts between MA organizations and providers must protect MA plan enrollees from incurring liability for payment of any fees that are the legal obligation of the MA

⁸⁴ Id., § 422.113(b)(2)(iv); MCM, Ch. 4, § 130.2.

⁸⁵ 42 C.F.R. § 422.113(b)(2)(v); MCM, Ch. 4, § 130.2.

⁸⁶ MCM, Ch. 4, § 130.2.

⁸⁷ "Post-stabilization care services" means covered services that are related to an emergency medical condition, that are provided after an enrollee is stabilized in order to either maintain the stabilized condition, or under certain circumstances, to improve or resolve the enrollee's condition. 42 C.F.R. § 422.113(c)(1); MCM, Ch. 4, § 130.3.

⁸⁸ 42 C.F.R. § 422.113(c)(2).

⁸⁹ Id. § 422.113(c)(3).

⁹⁰ Id. § 422.113(c)(2)(iv). For purposes of cost-sharing, post-stabilization care begins upon inpatient admission. Id.

organization.⁹¹ Thus, providers will be required to agree not to seek payment from MA enrollees where the MA organization with which the provider contracts fails to make required payments (e.g., for insolvency or breach.)⁹²

E. Special Rules Regarding Enrollee Liability Where the Enrollee Fails to Follow Referral or Pre-Authorization Requirements

When an MA enrollee receives a health item or service that requires referral or pre-authorization, the MA plan enrollee cannot be held financially liable for more than the normal in-plan cost sharing for such item or service if the member correctly identified himself or herself as a member of an MA plan to the contracted provider before receiving the covered item or service, unless the contracted provider can show that the enrollee was notified prior to receiving the item or service that the item or service would only be covered if further action (e.g., pre-authorization request) was taken by the enrollee.⁹³ CMS has indicated that the relevant documentation may be maintained in the medical record or wherever else the provider chooses.⁹⁴ In formulating this rule, CMS explained that if a network provider furnishes a service or directs a service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization), then the beneficiary should not be penalized to the extent the provider did not follow the plan rules since "MA plan enrollees should not be held to a higher standard than plan contracting providers."⁹⁵ The MA regulations do not address how responsibility for payment shall be allocated between the MA organization and the provider in this situation, but rather focus on the lack of additional financial responsibility of the enrollee.

F. National Coverage Decisions and Clinical Trials

1. General

As mentioned in Session I, MA organizations are required to comply with Medicare National Coverage Decisions ("NCD") in administering their plans.⁹⁶ As a general matter, the costs for complying with NCDs must be assumed by MA organizations (which agree to provide Medicare Part A and Part B services as part of their benefit package). However, if an NCD is rendered subsequent to the annual setting of payment rates, and there is a determination that the cost of the NCD is "significant," the MA plan is not required to

⁹¹ Id. § 422.504(j).

⁹² Id. §§ 422.504(g)(1) and 422.504(i)(3)(i); MCM, Ch.11, § 100.4.

⁹³ 42 C.F.R. § 422.105(a).

⁹⁴ 70 Fed. Reg. 4618.

⁹⁵ Id.

⁹⁶ 42 C.F.R. § 422.101(b)(1).

assume the risk or cost of the covered benefit or service until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD.⁹⁷

In those instances where an NCD has been issued that is determined to have significant cost, and such cost has not been accounted for in setting MA organization payments, payment for the service or benefit provided the MA enrollee will be made directly by the Medicare fiscal intermediary or carrier to the provider of the service or benefit.⁹⁸ Some costs associated with NCD services will remain the responsibility of the MA plan, even in this context, such as services necessary to diagnose a condition covered by the NCD and most services furnished as follow-up care to NCD services.⁹⁹ Once MA organization payments have been adjusted to account for an NCD with significant costs, the NCD is considered to be a covered benefit under the MA organization's contract with CMS and must be furnished and paid for by the MA organization.¹⁰⁰

2. Clinical Trials

a) From September 2001 through 2005

An NCD governing clinical trials generally states that, effective for items and services furnished on or after September 19, 2000, "Medicare covers the routine costs of qualifying clinical trials, ... as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials."¹⁰¹ Since the costs of covering these benefits were not included in the 2001 Medicare+Choice ("M+C") capitation rates, and the costs were deemed to be "significant," Medicare intermediaries and carriers began paying for covered clinical trial items and services furnished to MA enrollees on a fee-for-service basis.¹⁰² This practice has continued to date since the M+C payment rates were never adjusted to include these clinical trial costs.¹⁰³ Thus, for calendar years 2002 through 2005, CMS has in the past made, and will continue to make, payments on a fee-for-service basis for covered clinical trial items and services provided to M+C (and now MA) enrollees.¹⁰⁴

⁹⁷ Id. § 422.109(a) and (b); see also MCM, Ch. 4, § 90.2 and Ch. 7, § 50.

⁹⁸ 42 C.F.R. § 422.109(c)(1); MCM, Ch. 7, § 50.2.1.

⁹⁹ 42 C.F.R. § 422.109(c)(2); MCM, Ch. 7, § 50.2.1.

¹⁰⁰ 42 C.F.R. § 422.109(d); MCM, Ch. 7, § 50.2.2.

¹⁰¹ National Coverage Determinations Manual, Ch. 1, § 310.1.

¹⁰² MCM, Ch. 7, § 55.

¹⁰³ Id.

¹⁰⁴ Id.

b) The Go-Forward Approach

Under the 2006 competitive bidding process, MA organizations were told to include the cost of furnishing services related to NCDs, including qualifying clinical trials in their bids. As a result, beginning in 2006 and on a go-forward basis, MA organizations will be responsible for covering the costs associated with NCDs, including qualifying clinical trials (as further explained in the MCM and NCD Manual), unless a new NCD is issued that could not have been accounted for in setting payment rates for the relevant contract year, and the costs associated with the new clinical trial NCD is “significant.”¹⁰⁵ As with all significant cost NCDs issued “mid-year,” the costs of such clinical trial would be paid for by the fiscal intermediary or carrier until the costs could be properly accounted for in the MA rate setting process (presumably in the next plan year).¹⁰⁶

G. MA and Local Coverage Decisions

As with the NCDs, MA organizations are required to provide plan benefits consistent with the written coverage decisions of local Medicare contractors with jurisdiction for processing claims in the geographic area in which services are furnished to MA enrollees by the MA plan.¹⁰⁷ Such decisions are commonly known as “local coverage decisions” or “LCDs.” An MA organization offering an MA plan covering a service area that encompasses more than one local coverage policy area, may elect to apply to all plan enrollees uniformly the coverage policy that is the “most beneficial” to MA enrollees.¹⁰⁸ An MA plan electing this option must provide advance notice to CMS which identifies the plan and service areas to which the uniform LCD will apply, the competing LCD, and the justification for why the selected LCD is most beneficial to plan enrollees.¹⁰⁹ CMS will review and evaluate the notice based on factors such as cost, access, geographic distribution of enrollees, and health status of enrollees, and notify the MA organization of its approval or denial of the selected uniform LCD.¹¹⁰

By contrast, MA regional PPOs are free to adopt, at their discretion (and without CMS approval), a single local coverage policy area’s LCDs to apply throughout the MA region.¹¹¹ CMS has indicated that when an MA Regional PPO does so, it must elect a single

¹⁰⁵ 70 Fed. Reg. at 4661; 42 C.F.R. § 422.308(g).

¹⁰⁶ A helpful set of questions and answers regarding coverage of clinical trials in the context of MA can be found in the MCM, Ch. 7, Exhibit 2.

¹⁰⁷ 42 C.F.R. § 422.101(b).

¹⁰⁸ 42 C.F.R. § 422.101(b)(3); see also MCM, Ch. 4, § 30.

¹⁰⁹ Id.

¹¹⁰ Id.

¹¹¹ Id.

Medicare contractor's local coverage determination policies and may not pick and choose among select local coverage policies from more than one Medicare contractor.¹¹²

Where a local MA plan adopts a particular LCD to be applied throughout its service area, or when an MA Regional PPO adopts a single area's LCDs, the MA plan is required to make information on the selected coverage policies readily available to beneficiaries and providers.¹¹³

H. Payments to Federally Qualified Health Centers

The MMA provides a new payment arrangement for federally qualified health centers ("FQHC") that contract with MA organizations. Under this methodology, the FQHCs will receive a "wrap-around payment" from CMS representing the difference (if any) between what they are paid by an MA organization, including beneficiary cost sharing, and 100 percent of their "reasonable costs" of providing care to patients served at the centers who are MA plan enrollees.¹¹⁴ MA organizations that contract with FQHCs must pay the FQHCs an amount that is not less than what they would pay for the services if they were furnished by an entity that was not an FQHC.¹¹⁵ As the preamble to the MA regulations explains, "this is designed to avoid an agreement between an MA organization and an FQHC for payment of an artificially low rate, with the knowledge that the FQHC would receive supplemental payments from [CMS] resulting in a total of 100 percent cost reimbursement."¹¹⁶

In many instances, in order to meet network adequacy and access requirements, MA organizations (most especially MA Regional PPOs) will need to contract with out-patient clinics, rural health centers, and community mental health centers. The MA program does not contain special payment rules for these types of entities, as it does for FQHCs. Accordingly, providers payments in this context will be governed by contract for in-network providers and by the general rules set forth above for non-network providers.

I. Regional PPOs – Special Payment Rules Governing Essential Hospitals

As with all other coordinated care plans, MA Regional PPOs are required to meet network adequacy and access requirements.¹¹⁷ The MMA relaxed such rules for MA Regional PPOs as they pertain to "essential hospitals," and authorized CMS to make

¹¹² 70 Fed. Reg. 4612. This will, for instance, prevent MA plans from selecting a specific coverage policy from one carrier medical director and a different coverage policy on a different medical item or service from another carrier medical director. Id.

¹¹³ 42 C.F.R. § 422.101(b)(5).

¹¹⁴ 70 Fed. Reg. at 4662; 42 C.F.R. § 422.316(a). CMS notes that there would be no "wrap around" payment for FQHCs treating PFFS patients under a "deemed" contract because the FQHC would be receiving full payment from the plan. Id.

¹¹⁵ Id.

¹¹⁶ Id.

¹¹⁷ 42 U.S.C. §1395w-28(b)(4)(A); 42 C.F.R. § 422.112(c).

additional payments to such hospitals¹¹⁸ In taking these steps, Congress attempted to address what it viewed as the potential “monopoly power” of those hospitals that are the only hospital (or the only hospital with a particular service) within a broad geographic area of a region.¹¹⁹ The “essential hospital” policy is part of an effort to “foster the growth of the MA regional plan program, a goal consistent with the Congressional intent in creating the program.”¹²⁰

1. Criteria

The “essential hospital” rule provides that an MA regional plan may request that CMS designate a non-contracting hospital as an “essential hospital” if the following conditions are met:

- The hospital is a general acute care hospital identified as a “subsection (d)” hospital as that term is defined in Section 1886(d)(1)(B) of the Social Security Act.¹²¹
- The MA regional plan provides “convincing evidence” that it needs to contract with the hospital to meet the plan’s access requirements.¹²²
- The MA regional plan made a “good faith” effort to contract with the hospital and the hospital refused.¹²³
- The MA plan demonstrated to CMS that there are no competing Medicare participating hospitals in the area to which MA regional plan enrollees could reasonably be referred for inpatient care.¹²⁴
- The hospital in question provides convincing evidence to CMS that the amount normally payable under Section 1886 of the Social Security Act (and which the MA regional plan agreed to pay) is less than the hospital’s actual costs of providing care to the plan’s enrollees.¹²⁵

¹¹⁸ 42 C.F.R. § 422.112(c).

¹¹⁹ 70 Fed. Reg. at 4625.

¹²⁰ Id. at 4626.

¹²¹ 42 C.F.R. §422.112(c)(1). A link to the relevant section of the Social Security Act is attached:
http://www.ssa.gov/OP_Home/ssact/title18/1886.htm.

¹²² Id. § 422.112(c)(2).

¹²³ Id. § 422.112(c)(3). A “good faith” effort will be deemed to have occurred to the extent that the MA regional plan can show that it has offered the hospital a contract providing for payment in an amount no less than the amount the hospital would have received had payment be made under Section 1866(d) of the Social Security Act. Id.

¹²⁴ Id. §422.112(c)(4).

¹²⁵ Id. §422.112(c)(5).

2. Implications

a) Regional PPO Network Adequacy and Enrollee Cost-sharing

If CMS determines that the first four above-referenced criteria have been met (a determination that must be renewed annually), then the hospital will be considered part of the Regional PPO's network for network adequacy purposes.¹²⁶ In this context, plan enrollees will be able to access covered services through the hospital at in-network inpatient hospital cost sharing levels.¹²⁷ The regulations do not currently require "essential hospitals" to contract with Regional PPOs or to furnish services to Regional PPO enrollees, although CMS has indicated that it will continue to evaluate its authority as a means of ensuring reasonable access at reasonable prices.¹²⁸

b) Payment

A hospital that is determined to meet all five of the above-referenced criteria will be paid the Medicare fee-for-service prospective payment amount by the MA Regional PPO.¹²⁹ After the Medicare FFS payment has been made to the "essential hospital" by the MA plan, the hospital can seek additional funding from CMS for up to 101 percent of the inpatient costs actually incurred in treating MA Regional PPO enrollees.¹³⁰ Interestingly, Congress authorized \$25,000,000 in fiscal year 2006 for payments to essential hospitals.¹³¹ The money will be distributed to hospitals on a first-come, first-serve basis, until such funds are exhausted.¹³² It should be noted that a "critical access hospital" may not, by definition, be an "essential hospital." As CMS explains in the preamble to the final MA regulation:

there was never an intent to designate or allow a CAH to become an 'essential hospital' for purposes of the MA regional plan program. The definition of 'essential hospital' in the statute prevents such an outcome. Section 1858(h)(4) of the Act is clear in defining an 'essential hospital' as a "subsection (d) hospital," as that term is defined at section 1886(d)(1)(B) of the Act. CAHs are not included in this definition and therefore can never be 'essential hospitals' for purposes of an MA regional plan offered by an MA organization.¹³³

¹²⁶ 70 Fed. Reg. at 4626.

¹²⁷ Id. § 422.112(c)(7); 70 Fed. Reg. at 4626.

¹²⁸ 70 Fed. Reg. at 4627.

¹²⁹ 70 Fed. Reg. at 4631.

¹³⁰ 42 C.F.R. § 422.112(c)(6); 70 Fed. Reg. at 4631.

¹³¹ 70 Fed. Reg. at 4631.

¹³² Id.

¹³³ 70 Fed. Reg. at 4630.

IV. Special Payment Rules for MA Private-Fee-For-Service Plans

By way of background, MA PFFS plans were described generally in the AHA MA Primer for Session I (“the Basics”).

A. The Relationship Between Providers and MA PFFS Plans

MA PFFS payment issues turn, to a substantial degree, on whether providers offering services to MA plan enrollees are contracted providers, deemed contracted providers, or non-contracted providers. It is important to keep in mind that providers may refuse to provide services to PFFS plan enrollees, except where the Emergency Medical Treatment and Active Labor Act (“EMTALA”) requires otherwise.¹³⁴

1. Contract Providers

A provider may enter into written agreement with an MA PFFS plan and thus be contractually obligated to accept the terms and conditions of the agreement. The PFFS plan must establish uniform rates of payment that apply to all contracting providers (including those with deemed contracting status).

2. Deemed Contract Providers

A provider may be “deemed” to have a contract with a PFFS plan in certain instances. Except in emergency situations, any provider furnishing covered health services to an MA PFFS plan enrollee that has not previously entered into a contract to furnish services under the plan, is “deemed” as having a contract in effect (and is subject to the same provisions as a contracted provider, including payment rates), where the following conditions are met: before furnishing the services, the provider (1) was informed of the individual’s enrollment in the PFFS plan,¹³⁵ and (2) was informed (or given a reasonable opportunity to obtain information) about the terms and conditions of payment under the plan.¹³⁶ The information must have been provided “in a manner that [is] reasonably designed to effect informed

¹³⁴ See e.g., 65 Fed. Reg. at 40297-98.

¹³⁵ This information can be provided by (1) an enrollment card, (2) notice of enrollment from CMS, a carrier or intermediary, or (3) from the MA PFFS plan. 42 C.F.R. § 422.216(g).

¹³⁶ Information on terms and conditions of payment can be provided by the PFFS plan via U.S. mail, e-mail, fax, or telephone to the provider, employee or billing agent of the provider, or other appropriate entity or the plan may establish a procedure by which a provider can receive instructions on how to request information on (a) billing procedures, (b) the payment amount for covered services, (c) the amount the provider may charge the enrollee, and (d) whether the provider must obtain advance authorization from the PFFS plan before furnishing the particular service. Id. § 422.216(h)(1) and (2). Such procedures must allow the MA organization to respond to the request before the entity furnishes the service. Id. at § 422.216(h)(2). CMS has indicated that the notice of terms and conditions can be met through a PFFS plan’s website. See CMS Private-Fee-For-Service – Provider Questions and Answers (“PFFS Q&A”) available at <http://www.cms.hhs.gov/PrivateFeeForServicePlans/Downloads/Provqa.pdf>. This CMS document is an excellent source of practical information concerning operation of the PFFS program.

agreement” on the part of the provider.¹³⁷ CMS’ view on this process is instructive: “If a provider is aware in advance of furnishing services that a person is enrolled in a PFFS plan and the provider either possesses or has access to the plan’s terms and conditions of participation the provider is automatically a deemed provider.”¹³⁸

It is important to note that the requirements regarding being informed of the beneficiary’s PFFS plan enrollment and having at least the opportunity to access the PFFS plan’s terms and conditions of payment prior to the provision of services are intended to allow the provider to be able to make an informed decision regarding whether to offer services. A provider is not required to furnish health care services to enrollees of a PFFS plan.¹³⁹ However, when a provider chooses to furnish services to a PFFS enrollee, and the deeming conditions have been met, the provider will be automatically treated as a contract provide (for that enrollee) and must follow the PFFS plan’s terms and conditions of participation.¹⁴⁰

A special exception to automatic deeming applies with respect to services provided in an emergency department of a hospital when providers are not free to refuse to see a patient. When a PFFS plan enrollee is treated in an emergency department of a hospital pursuant to EMTALA obligations, the relevant physician/hospital shall not be treated as a “deemed” contracted provider.¹⁴¹ Once the services furnished in the emergency department are no longer required under EMTALA, however, the requirements for “deemed” contracted provider status apply (and may be met).¹⁴²

3. Non-Contracted Providers

If a provider furnishes services to a PFFS enrollee but the deeming requirements are not met then the provider becomes a non-contracting provider.

- For example, a provider cannot become a deemed contracted provider in circumstances where the provider does not know in advance of furnishing

¹³⁷ 42 C.F.R. § 422.216(f)(3).

¹³⁸ PFFS Q&A, at 6. A CMS description of the deeming process is helpful: “In most cases, a PFFS enrollee will inform a provider before obtaining services that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or web address where the provider can obtain the PFFS plan’s terms and conditions of participation. Accordingly, if an enrollee informs a provider of their enrollment and the provider furnishes services the provider will become a deemed provider bound by the PFFS plan’s terms and conditions of participation. Once the provider knows an enrollee is enrolled in a PFFS plan it is up to the provider to either make the phone call or access the plan’s web site for information on the plan’s terms and conditions of participation.” Id.

¹³⁹ Id. at 3.

¹⁴⁰ Id.

¹⁴¹ 65 Fed. Reg. 40297-98.

¹⁴² Id.

services that a patient is a member of a PFFS plan. This could occur, for instance, in an emergency where a provider cannot communicate with the patient before furnishing care.

- By way of further example, a provider cannot become a deemed provider if the provider has not received or does not have reasonable access to a PFFS plan's terms and conditions of participation prior to furnishing services to a PFFS enrollee. This could happen, for instance, if the terms and conditions of payment are only available via the website and the website is not operational at the time the patient is seen.¹⁴³

B. PFFS Plan Payments to Providers

1. Payments to Contracted and Deemed 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).¹⁴⁴ The MA PFFS plan must pay both contracted and "deemed" providers the fee-for-service amount specified by the plan in the terms and conditions of payment for the particular service minus any applicable cost-sharing.¹⁴⁵

The PFFS plan has discretion in setting payment rates for network, contracted providers. Where a PFFS plan establishes payment rates that are less than original Medicare for designated types of providers, however, 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.¹⁴⁶ The MA PFFS plan must make information on its payment rates available to all providers furnishing covered services.¹⁴⁷

2. Payments to Non-Contracted Providers

a) The Payment Rule

Given the way the PFFS payment system is structured, it is reasonable to believe that very few providers will be non-contract providers, because most will either have written contracts with the PFFS plan or be deemed to be contract providers through the minimal requirements set forth above. In those situations where a provider offering services to a

¹⁴³ Id.

¹⁴⁴ Id. § 422.216(a)(1)(i).

¹⁴⁵ Id. § 422.216(a)(2).

¹⁴⁶ MCM, Ch. 4, § 150. By way of example, a PFFS plan may choose to establish hospital payments that are less than original Medicare. However, in such circumstance, to ensure member access to hospital services, the PFFS plan must establish direct contracts with a sufficient number of hospitals to meet Medicare's access and availability standards. Id. See also 65 Fed. Reg. 42170, 40296 (June 29, 2000).

¹⁴⁷ 42 C.F.R. § 422.216(a)(1)(iii).

PFFS plan enrollee is not a contracted provider, the PFFS plan will be required to pay the provider in an amount at least equal to the amount that the provider would receive under original Medicare (minus enrollee cost-sharing permitted under the plan).¹⁴⁸ Concomitantly, “the [non-contracted] provider must accept as payment in full the amount that it would be entitled to receive under original Medicare, and the [PFFS] plan must pay the provider at least the amount that the provider would collect if the beneficiary were enrolled in original Medicare, less the enrollee’s cost-sharing” under the Plan.¹⁴⁹ In the case of an acute care hospital, the plan would typically pay the DRG payment less the enrollee’s cost-sharing.¹⁵⁰

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.¹⁵¹ Medicare employs prospective payment systems or fee schedules for many of its covered services.¹⁵² Where national PPS or fee schedules exist, payment calculations under original Medicare are relatively straightforward. By contrast, where PPS and fee schedules are not available (for instance, where payments are made based on reasonable costs or reasonable charges), it can be difficult to determine payment levels consistent with Medicare.¹⁵³

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 PFFS plans to use proxies in paying for services for which no Medicare PPS or fee schedule exists.¹⁵⁴ Where a PFFS plan bases payment on a proxy, it must disclose this fact in its posted terms and conditions of participation.¹⁵⁵ Because proxy payments are only estimates, PFFS plans must offer an appeals mechanism by which providers may request review of individual amounts paid.¹⁵⁶ If

¹⁴⁸ 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.

¹⁴⁹ 65 Fed. Reg. at 40295.

¹⁵⁰ 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.

¹⁵¹ 65 Fed. Reg. at 40296.

¹⁵² Id.

¹⁵³ 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. 70 Fed. Reg. at 4631.

¹⁵⁴ 65 Fed. Reg. at 40296.

¹⁵⁵ PFFS Q&A, at 4.

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

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, then the PFFS plan must pay the provider the difference.¹⁵⁷

C. 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.¹⁵⁸ While the PFFS plan may authorize balance billing by network providers, such balanced billing is limited to no more than 15 percent of the uniform fee-for-service payment rates established by the MA PFFS plan.¹⁵⁹ Any written provider contract must specify the amount of cost-sharing and balance billing allowed (consistent with the MA plan’s terms).¹⁶⁰

2. Non-contracted Providers

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.¹⁶¹ No balance billing is allowed.¹⁶² 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.¹⁶³

V. Medicare Secondary Payer Issues in MA

It is well established that the Medicare program will not pay first (or “primary”) for health care services furnished to Medicare beneficiaries if Medicare should be the secondary

¹⁵⁷ PFFS Q&A, at 4. See also 65 Fed. Reg. at 40296.

¹⁵⁸ 42 C.F.R. § 422.216(b)(1)(i).

¹⁵⁹ Id. § 422.216(b)(1)(ii).

¹⁶⁰ Id. at § 422.216(b)(1)(iii).

¹⁶¹ Id. at § 422.216(b)(2).

¹⁶² 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.

¹⁶³ 65 Fed. Reg. at 40295.

payer to dual health care coverage under the Medicare Secondary Payer laws and regulations.¹⁶⁴ Consequently, MA organizations are required on an annual basis to identify payers that are primary to Medicare. CMS uses this MA plan survey data and information contained in the common working file to create payment adjustment factors for each MA plan.¹⁶⁵ The MA organizations are required to identify the amounts payable by other primary payers and coordinate benefits accordingly.¹⁶⁶ The MA organization, or an authorized provider, may bill other individuals or entities for covered services for which Medicare is not the primary payer.¹⁶⁷ Therefore, if an MA enrollee has received services from an MA plan that are also covered under workers compensation, any no-fault insurance, any liability insurance or plan, including a self-insured plan, the MA organization or an authorized provider can bill the insurance carrier, the employer or any other entity that is liable for payment of the services.¹⁶⁸ Similarly, to the extent the MA enrollee has been paid by the carrier, employer, or entity for the service, the MA organization or an authorized provider can bill the enrollee.¹⁶⁹ Finally, the MA organization may bill a group health plan for services it furnishes to a Medicare enrollee who is also covered under the group health plan and may bill the enrollee to the extent that he or she has been paid by the group health plan.¹⁷⁰

As we have discussed elsewhere, MA laws preempt any state law (other than those governing insurance licensure and solvency). In that vein, a state cannot take away an MA organization's right to bill, or to authorize providers to bill, for services for which Medicare is not the primary payer.¹⁷¹

25154220\V-5

¹⁶⁴ 42 U.S.C. § 1395y(b); 42 C.F.R. § 422.108(a).

¹⁶⁵ See [Medicare Advantage Risk Adjustment Method CY 2007](#) [This URL is no longer available as a result of CMS website changes since the initial publication of this primer].

¹⁶⁶ Id. § 422.108(b).

¹⁶⁷ Id. § 422.108(c).

¹⁶⁸ Id., § 422.108(d).

¹⁶⁹ Id.

¹⁷⁰ Id. § 422.108(e).

¹⁷¹ Id., § 422.108(f).