A. Fundamentals of Medicare and Medicaid Reimbursement

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Medicare & Medicaid...
just the fundamentals please

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Le Annual Pop Quiz

• To be inserted soon.... 😊
Road Map

- Structure of Medicare & Medicaid Programs
- Key Players at the State & Federal Level
- Providers & Payment Systems (A, B, C, D)
- The Medicaid Payment System(s)
- Answers to all of your excellent questions
- Leave and go to the next presentation, as long as your review of this presentation is excellent.

The Health Insurance Market

- Medicare
- Medicaid
- Private Payors
Medicare

Just a few facts.. first

What is Medicare?

• A program for only senior citizens?

• A managed care program run like the FEHB program where beneficiaries get to choose their private health insurance plan?

• An exchange-based system where plans compete for Medicare beneficiaries?

• The last true indemnity insurance plan in the United States?
Its as easy ABCD...

- **Part A** covers inpatient hospital stays, skilled nursing facility stays, home health visits (some also covered under Part B), and hospice care, and **accounted for 34% of benefit spending in 2013**. Part A benefits are subject to a deductible ($1,216 per benefit period in 2014) and coinsurance.

- **Part B** covers physician visits, outpatient hospital services, DME, some drugs, diagnostic services and accounted for **25% of benefit spending in 2013**. Part B benefits are subject to a deductible ($147 in 2014), and cost sharing for most services.

- **Part C** refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO), and receive all Medicare-covered benefits. Payments to Medicare Advantage plans accounted for 25% of benefit spending in 2012.

- **Part D** is the voluntary outpatient prescription drug benefit, with additional subsidies for beneficiaries with low incomes and modest assets. The Part D benefit is offered through private plans that contract with Medicare, both stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs). In 2013, Part D accounted for **11% of benefit spending**.
Medicare Spending 2010-2020*

*Projected after 2013 based upon the CBO Medicare Baseline Data 2010-2013.

Medicare Benefit Payments By Type of Service, 2012

NOTE: Numbers do not sum to 100% due to rounding. Total does not include administrative expenses and is net of recoveries.
Medicare – Basics

Eligibility

“Beneficiaries”:

- **Part A** – no premium payment if:
  - 65 years of age or older; paid Medicare taxes for at least 10 years; and receiving, or eligible to receive, retirement benefits from Social Security or the Railroad Retirement Board
  - Permanent kidney failure requiring dialysis or transplant (“ESRD”) – *regardless of age*
  - Entitled to Social Security or Railroad Retirement Board disability benefits for 24 months - *regardless of age*
  - Government employee, or spouse of government employee

- **Part A** – with premium payment if:
  - Did not pay Medicare taxes; age 65 or older; and a citizen or permanent resident of the United States,

- **Part B** –
  - Eligible for Part A and payment of monthly premium.

Sources: 42 C.F.R §§ 406.10, 406.20, 406.12, 406.13, 407.10, 407.17

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Medicare Enrollment, 1966-2013

NOTES: Numbers may not sum to total due to rounding. People with disabilities under age 65 were not eligible for Medicare prior to 1972.

**Medicare/Medicaid/CHIPS/Private Insurance & Uninsured*\**

*Source of data: CMS 2013 Medicare Trustee's Report

**Median Per Capita Income of the Medicare Population, Overall, and by Race/Ethnicity, 2012**

**NOTE:** Beneficiaries identified as "other" races not shown separately. Numbers do not sum, because 2.1 million are identified as "Other" races.

**SOURCE:** Urban Institute / Kaiser Family Foundation analysis, 2012.
Sources of Income among Medicare Beneficiaries in the Middle of the Income Distribution, by Race/Ethnicity, 2012

**White**
- Social Security Income: 57%
- Pension Income: 14%
- Earnings: 13%
- Other Income (e.g., Investments, IRA distributions): 16%

**Black**
- Social Security Income: 80%
- Pension Income: 9%
- Earnings: 4%
- Other Income (e.g., Investments, IRA distributions): 7%

**Hispanic**
- Social Security Income: 76%
- Pension Income: 13%
- Earnings: 5%
- Other Income (e.g., Investments, IRA distributions): 7%

Median income: $24,800
Mean income: $25,100

Median income: $15,250
Mean income: $15,150

Median income: $13,800
Mean income: $13,700

NOTE: “Middle of the Income Distribution” refers to beneficiaries in the middle 20% of the per capita income distribution, by race/ethnicity. Investment income includes interest, dividends, rental income, and IRA withdrawals. Numbers may not sum to 100 percent due to rounding. Beneficiaries identified as “other” races not shown separately.


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**Medicare – Basics**

*Program Administration*

- Centers for Medicare and Medicaid Services (“CMS”) formerly known as “Health Care Financing Administration” (“HCFA”)
  - Operational control over Medicare Program
- CMS Central Office (Baltimore, Maryland)
- CMS Regional Offices
  - Boston (Region 1), New York (Region 2), Philadelphia (Region 3), Atlanta (Region 4), Chicago (Region 5), Dallas (Region 6), Kansas City (Region 7), Denver (Region 8), San Francisco (Region 9) and Seattle (Region 10).
- DHHS Office Of Inspector General (“OIG”)
- State agencies
Medicare – Basics
*Program Administration*

- Quality Improvement Organizations ("QIOs")
- Medicare Administrative Contractors ("MACs")
- Part C Insurance Plans
- Part D Prescription Drug Plans ("PDPs")

Private insurers under contract with CMS for:
- provider/supplier enrollment
- claims payment; and
- Appeals

Medicare Administrative Contractors ("MACs”).

- Transition to MACs from “Part B Carriers,” “Fiscal Intermediaries,” and “DMERCs” began Jan. 2006 and concluded in 2011.

- MACs will cover 15 distinct regions and those replacing DMERCS will cover 4 distinct regions.

*Sources: §§ 911, 912 MMA; 70 Fed. Reg. 9358 (Feb. 25, 2004)*
Sources of Medicare Coverage

- Statutes
- Manuals
- Local Coverage Determinations (LCD)
- National Coverage Determinations (NCD)
- ALJ Decisions

Medicare – Basics
Select Sources of Medicare Law

- 42 C.F.R. § 406—Part A Eligibility
- 42 C.F.R. § 407—Part B Eligibility
- 42 C.F.R. § 412—Inpatient Hospital PPS
- 42 C.F.R. § 413—End Stage Renal Disease
- 42 C.F.R. § 416—Ambulatory Surgery Services
- 42 C.F.R. § 420—Program Integrity
- 42 C.F.R. § 424—Assignment/Reassignment
- 42 C.F.R. § 1000-1008—OIG Regulations
### Medicare – Basics

**Select Sources of Medicare Law**

- Medicare Manuals
  - Repository of operating instructions, policies, and procedures to administer CMS programs.
  - Based on interpretations of statutes and regulations
  - Drafted for CMS agencies, contractors, and State survey agencies
  - Useful for many others as source of technical and professional information about the Medicare and Medicaid

- Paper Manuals
  - Original manual system (e.g., Medicare Carrier’s Manual)

- Internet Only Manuals (“IOM”)
  - CMS has moved most of the manuals into new IOM
  - IOM is organized by functional area (i.e., program integrity, eligibility, entitlement, claims processing, etc.).
  - Once all information is moved to the IOM the paper based manuals will be discontinued


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### Medicare - Basics

**Provider/Supplier Enrollment**

- CMS Forms 855

- Health Care Providers that will bill Medicare fiscal intermediaries* (CMS 855A)

- Health Care Providers that will bill Medicare carriers* (CMS 855B)

- Individual Health Care Practitioners (CMS 855I)

- Individual Reassignment of Benefits (CMS 855R)

- DMEPOS Suppliers that bill DMERCS (CMS 855S)

*All FIs and Carriers are being switched to MACs and DMACS

Medicare – Basics
Medicare Lingo

“Provider vs. Supplier”

– “Provider” is a Part A term which includes:
  • Hospital
  • Skilled nursing facility ("SNF")
  • Comprehensive outpatient rehabilitation facility ("CORF")
  • Home health agency ("HHA")
  • Hospice
  • Critical access hospital ("CAH")
  • Outpatient physical therapy or speech pathology services
  • Community mental health center furnishing partial hospitalization services

Source: 42 C.F.R. § 400.202

Medicare – Basics
Medicare Lingo

• “Supplier” is a Part B term which includes:
  – Durable medical equipment prosthetic orthotic suppliers ("DMEPOS")
  – Ambulatory Surgery Center ("ASC")
  – Independent Diagnostic Testing Facility ("IDTF")
  – Physicians

Source: 42 C.F.R. § 400.202
Medicare – Basics

Medicare Lingo

• Advanced Beneficiary Notice (“ABN”)
  – Informs beneficiaries of items/services not covered by Medicare
  – Applies to providers and suppliers
  – Must be in writing
  – Must be provided before items/services provided
  – Must conform to certain requirements and inform beneficiary why
    coverage is not anticipated and extent of anticipated charge

• Notice of Non-Coverage
  – Specific to hospital inpatients
  – Care is not covered because (i) it is not medically necessary, (ii) it is
    not delivered in the most appropriate setting, or (iii) is custodial

Medicare – Basics

Medicare Lingo

Assignment vs. Reassignment

– Determination of who receives payment for items, services, or supplies
  furnished to beneficiaries

– Assignment requires that payment for covered items, services, or supplies go
  to the provider/supplier and not the beneficiary

– Reassignment permits provider/supplier to redirect payment to another
  person or entity

– General rule is against reassignment, unless the criteria of an exception are
  met

– Providers/suppliers accepting assignment may not charge beneficiaries more
  than the Medicare payment amount

– Physicians rejecting assignment may charge up to 115% of the fee schedule
  amount (i.e., no more than 115% of 80% of the fee schedule amount).

Sources: 42 U.S.C.A. § 1395u(b)(3)(B); 42 U.S.C.A.§§ 1395w-4(g)(2)(C); 42 C.F.R. §424,
Medicare Carriers Manual §§ 3045.1, 3060
Medicaid

A quick snapshot...

What is Medicaid?

- A program for long-term care?
- A program for Pregnant Women and Babies?
- A fee-for-service payment system?
- A capitated payment system?
- A cost-based payment system?
- A program with bundled payments for episodes of care?
- A dental and vision plan?
- A challenging program for providers?
Medicaid Basics: Overview

- **2011-12 Statistics:**
  - 20% Americans on Medicaid: ~70.4m
  - 16% Americans on Medicare: ~49m
- **Significant Expenditure for States Growth Projections & Dual Eligibles**
- **Program Integrity and State False Claims Acts**
- **Unwise to ignore Medicaid. Consider Medicaid implications in every deal.**

Medicaid Basics: Statistics

2012 CMS Office of the Actuary Medicaid Report*
- Total federal and state combined Medicaid outlays in 2011 were $432.4 billion (64% federal / 36% state)
- 55.7 million people on average were covered by Medicaid in 2011; however, 70.4 million people were enrolled at least one month during 2011.
  - 70.4 million people = 1 in 5 persons in the U.S.
- Total projected annual spending by 2021: $795 billion
  - Increase of $448b 2014-2012 (FFP: $388b or 87%)
- Medicaid expansion expected to add 8.7 million new Medicaid members by 2014 and 18.3 million by 2021

*Post NFIB: assumes 55% in 2014, 65% in 2015+
Medicaid Basics: Structure

**Health Insurance Coverage**
31 million children & 16 million adults in low-income families; 
16 million elderly and persons with disabilities

**Assistance to Medicare Beneficiaries**
9.4 million aged and disabled — 20% of Medicare beneficiaries

**Long-Term Care Assistance**
1.6 million nursing home residents; 2.8 million community-based residents

**Support for Health Care System and Safety-net**
16% of national health spending; 35% of long-term care services

**State Capacity for Health Coverage**
FY 2013 FMAP ranges: 50% to 73.4

SOURCE: Kaiser Commission on Medicaid and the Uninsured, March 2013

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Medicaid Basics: Feds & State

- Shared Federal-State Program Since 1965
  1. CM[M]S
  2. Single State Agency
- Federal Rule Compliance Required for Federal Financial Participation (FFP) or will be withheld
- States Not Required to Participate
  - Arizona last state to join in 1982
  - Currently 54 Medicaid Programs: 50 States, District of Columbia, Puerto Rico, USVI, Guam & American Samoa
- Significant Variety in the Programs
  - Eligibility
  - Services Covered,
  - Administration (e.g. reimbursement rules)
A primer on payment systems

...or, as Cuba Gooding says, "show me the money"...

Putting the pieces together...
One turn at a time
Payment Systems

Cost Basis

Fee Schedules

Prospective Payment ("Mini-bundle")
New Payment Systems

- Risk Transfer & Capitation
- Bundled Payment ("Episode of Care")
- Shared Savings
Medicare Part A

...where it all began

Four Main Areas Covered under Part A

• Inpatient hospital care
• Skilled nursing facility (SNF) care
• Home health care*
• Hospice care
Inpatient Hospital Services & Supplies

- General/acute care hospitals
  - Includes “specialty” hospitals like orthopedic hospitals, surgery hospitals, heart hospitals, etc.
  - Includes other “specialty” hospitals, such as long term acute care hospitals, critical access hospitals, psychiatric hospitals, rehabilitation hospitals, etc.
- Limited to 90 days per “spell of illness”
- Beneficiaries also get 60 lifetime reserve days
- Beneficiary responsible for deductible and coinsurance payments for days 61-90 and larger deductible and coinsurance payments for days 91-150

Skilled Nursing Facility (SNF) Services

- "Skilled" nursing care to beneficiaries (vs. “custodial”)
- Limited to 100 days per “spell of illness”
- Requires “qualifying hospital stay” (i.e., hospital inpatient for at least three consecutive calendar days) prior to SNF admission
- Admitted to SNF within 30 days after discharge from hospital

*Pop Quiz Question: Medicare is the largest payor of SNF care in the United States?*
Home Health Services

- Services and supplies furnished in a beneficiary’s “home”. Beneficiary must be:
  - Confined to the home or outpatient setting;
  - Receiving treatment from a physician, under a plan of care and needs (1) intermittent skilled nursing care, physical therapy, or speech language therapy, or (2) continuing need for occupational therapy.
- If both a Part A and Part B beneficiary:
  - Part A covers the first 100 HHA visits if the beneficiary was discharged from a 3 day or longer hospital or SNF stay and was discharged from that stay within 14 days of the first HHA visit.
  - Part B covers visits over 100 and if Part A criteria not met
  - If only Part A or only Part B, all visits covered by such Part

Hospice

- Services provided to terminally ill (e.g., pain management and palliative care). Requires:
  - Written beneficiary election (except for certain pre-election services – see 42 U.S.C.A. 1395d(a)(5))
  - Physician determination that beneficiary is terminally ill
  - Establishment of plan of care
  - Covered in “benefit periods”
    - two 90 day periods
    - unlimited 60 day periods
- Coverage includes: nursing care; medical social services; physicians' services; counseling services; home health aide; medical appliances and supplies, including drugs and biologicals; and physical and occupational therapy.
Conditions of Participation ("CoP")

- Required minimum standards for “providers” to participate in Medicare Part A. Covers such things as:
  - criteria for governing body
  - patient rights
  - medical staff
  - quality assurance
  - infection control
  - medical records
- Compliance with CoPs determined by state agencies under contract with DHHS

Certification of Providers

- Providers (e.g. hospitals) may be “deemed” to satisfy CoPs if accredited by a CMS-approved accrediting body
  - For hospitals, The Joint Commission ("TJC") and the American Osteopathic Association (“AOA”) have historically been the only ones
  - For the first time in 40 years, a new accrediting body for hospitals approved by CMS in 2008: Det Norske Veritas Healthcare, Inc. (“DNV Healthcare”)
  - Accreditation program called “National Integrated Accreditation for Healthcare Organizations” (ISO 9001)
Certification of Providers: Provider Agreement

- Written agreement with DHHS
- Agreement to abide with SSA and federal regulations
- Non-negotiable (sorry)
- Automatic annual renewal
- Provider number – linked to federal tax ID number
- Identification and billing purposes
- Since 2008, individual program provider numbers replaced by “national provider identifiers” (“NPI”) – sole provider identifier for all payors, including state, federal, and managed care companies.
- Provider Enrollment, Chain and Ownership System (PECOS)
- CMS Form 855-A
- Automatic assignment in connection with a change of ownership (CHOW) with transfer of provider liabilities.

...but is it really that simple
The slow march towards 'rationale' payment

- Prior to 1983, all Medicare reimbursement was based on the actual costs of the provider (aka the "battleship")
- Beginning in 1983, hospitals were reimbursed for inpatient services under a "prospective payment system"
- Since then, prospective payment systems have been developed for:
  - SNF (phased in over 3 years beginning July, 1998)
  - Home Health (October, 2000)
  - Inpatient rehabilitation facilities (January, 2002)
  - Long-term care hospitals (October, 2002)
  - Inpatient psychiatric hospitals (January, 2005)
  - Outpatient hospital services (January, 2005)

Hospital Inpatient Prospective Payment System (IPPS)

- Most patient care services are reimbursed based on a pre-determined flat (bundled) payment rate
  - Rate represents the average cost nationally for treating a Medicare beneficiary
  - Regardless of actual costs or length of stay
  - Hospital can “lose” or “win”
  - Since 2005, annual payment rate adjustments have been linked to the reporting of performance quality measures – current list is up to 76 measures for 2015
  - Certain costs and adjustments are still reimbursed based on actual and reasonable cost principles
Costs included vs. excluded from IPPS

<table>
<thead>
<tr>
<th>Included in IPPS rate</th>
<th>Excluded from IPPS rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient operating costs</td>
<td>Direct medical education</td>
</tr>
<tr>
<td>Routine ancillary</td>
<td>Acquisition costs of heart, kidney, liver, lung for transplants</td>
</tr>
<tr>
<td>Intensive care</td>
<td>Non-physician anesthetists and other non-physician costs</td>
</tr>
<tr>
<td>Malpractice insurance</td>
<td>Outpatient services</td>
</tr>
<tr>
<td>Preadmission services (&quot;72 hour rule&quot;)</td>
<td>Services covered under Parts B, C &amp; D</td>
</tr>
<tr>
<td>Inpatient capital–related costs*</td>
<td>Medicare-excluded services</td>
</tr>
</tbody>
</table>

Source: 42 C.F.R. § 412.2. * - Inpatient Capital-related costs has its own PPS payment system.

Introduction to the DRG Payment System

5 steps for determining payment a hospital will receive for providing inpatient services:

1. Assignment of MS-DRG and MS-DRG weight
2. Multiplying MS-DRG weight by the standardized amount
3. If applicable, percentage add-on for disproportionate share and/or teaching activities
4. If applicable, additional payments for “outliers”
5. Other special payment adjustments
Step 1: Figure out the DRG

- Diagnosis related groups ("DRGs") and Medicare-severity DRGs ("MS-DRGs")
- Organized under major diagnostic categories ("MDCs")
  - currently there are 25 MDCs
  - Resources to treat a given disease or condition
  - A significant change implemented as of 10/1/07 for DRGs => conversion to “severity-adjusted DRGs or “Medicare-severity DRGs" (MS-DRGs)
  - 538 DRGs replaced with 745 MS-DRGs
  - Each MS-DRG assigned a weight relative to mean weight of 1.0

Step 1: Figure out the DRG

- MS-DRG is selected according to the existence or absence of complications or co-morbidities
- ICD-9 codes are analyzed to determine: (i) principal diagnosis; (ii) up to 8 additional diagnoses; and (iii) 6 procedures performed during the stay
- In a small number of cases, MS-DRG may be based on age, sex and discharge status of patient.
- Note: ICD-10 = new coding system scheduled to be effective 10/1/13 – delayed; under it, CMS may be able to analyze up to 25 diagnoses codes
Examples of MS-DRGs and Weighting Factors

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>DRG Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>343</td>
<td>Appendectomy without complicated principal diagnosis and without complications/comorbidities (CC) (geometric mean length of stay = 1.7)</td>
<td>0.9587</td>
</tr>
<tr>
<td>342</td>
<td>Appendectomy without complicated principal diagnosis and with complication or co-morbidity (length of stay = 2.9)</td>
<td>1.3477</td>
</tr>
<tr>
<td>340</td>
<td>Appendectomy with complicated principal diagnosis and without CCs (geometric mean length of stay = 3.2)</td>
<td>1.2308</td>
</tr>
<tr>
<td>341</td>
<td>Appendectomy without complicated principal diagnosis and with a Major CC (geometric mean length of stay = 5.0)</td>
<td>2.3570</td>
</tr>
<tr>
<td>339</td>
<td>Appendectomy with complicated principal diagnosis and with CCs (geometric mean length of stay = 5.4)</td>
<td>1.8484</td>
</tr>
<tr>
<td>338</td>
<td>Appendectomy with complicated diagnoses &amp; MCCs (8.3)</td>
<td>3.2639</td>
</tr>
</tbody>
</table>


Step 2: Standardized Amount

- DRG weight is multiplied by the “standardized amount” which is the average Medicare allowable operating cost per discharge for that year.
- The standardized amount is divided into two components, each of which is adjusted by:
  - Wage index (the “labor-related share”)
  - 68.8% for wage index > 1; 62% if < 1
  - Cost of living factor (the “non-labor share”)
Step 3: Percentage "add-ons" for DSH and Teach Hospitals

- DSH - A percentage add-on is applied to the DRG-adjusted base payment rate for hospitals that serve a “disproportionate share” of low-income patients
- Formulas determine eligibility for DSH
- IME - A percentage add-on is applied to the base payment rate for hospitals that train interns and residents under “approved residency programs”
- IME adjustment is calculated based on the ratio of interns and residents to the number of beds
- These add-on payments are significant enough to generate a lot of administrative appeals and litigation

Step 4: Outliers

- For certain cases that involve extraordinarily high costs compared to most discharges in the same DRG
- Determined based on published outlier thresholds = fixed dollar amount by which hospital’s actual costs exceed DRG payment
- If a hospital's actual costs exceeds the threshold on a given case, it qualifies for the additional payment
Step 5: Other Possible Payment Adjustments

• New technologies and medical services – more costly than applicable DRG rate with a “substantial clinical improvement” over existing technologies/services

• Transfers versus discharge
  – Transfer = admitted to another IPPS hospital, to a PPS-exempt hospital, to a SNF, or home for home health care
  – Transfers paid on per diem share of DRG payment; discharges paid full DRG payment

• High volume of ESRD discharges – 10% or more of total Medicare discharges

• Low-volume hospitals – located more than 25 road miles from a similar hospital and less than 200** total discharges per year (15 mi./1600 disch. for ’11-’12)

...easy!
Vestiges of Battleship Reimbursement

- Cost reimbursement of hospitals under Part A
  - Rural-area hospitals
  - Sole community hospitals
  - Critical access hospitals
  - Rural referral centers
  - Medicare-dependent hospitals
  - Hospitals excluded from PPS – children’s and cancer
  - Direct graduate medical education (“GME”)
- Blood clotting factor to hemophiliac patients
- Bad debts for hospitals
- Nursing education programs
- Organ acquisition costs

Other PPS Providers under Part A

- Inpatient Rehabilitation
- Long Term Care Hospitals
- Psychiatric Facility or Unit
- SNF
- Hospice
- Home Health
Skilled Nursing Facility--PPS

• Per day payments cover all costs (including, routine, ancillary and capital)
• Case mix adjusted by a resident classification system ("Resource Utilization Groups" or "RUGs"), with adjustment for geographic variation in wages
• Consolidated billing requirement - a SNF must submit all Medicare claims for all services a resident receives (unless otherwise excluded), even if provided by others. For example:
  – Professional services of physicians and non-physician practitioners
  – Dialysis services, supplies and equipment
  – Epoetin Alfa ("EPO") and darbepoetin Alfa ("DPA");
  – Hospice care; and
  – Ambulance services at admission and discharge

Hospice---PPS

• Pre-election benefit for hospice consultation services
• Prospective per diem payments for each day a beneficiary is under a hospice election
• Payments depend upon type of care provided:
  – Routine home care
  – Continuous home care
  – Inpatient respite care, and
  – General inpatient care
• Hospice payments are subject to adjustments for geographic wage variation, cost cap and inflation update
Hospice--PPS

• Hospice Cost Cap
  – After payment of daily per-diem hospice providers are subject to a cap on total aggregate payments received.
  – Cap period runs from November 1st of each year through October 31 of the next year.
• Payments in excess of the cap must be refunded to CMS
• “Cap amount” is calculated by multiplying the number of beneficiaries electing hospice care during the period by an annual Cap adjustment each year
• Cap applied in the aggregate across entire Hospice provider

Home Health Agency--PPS

• Paid a prospective rate for each 60-day “episode of care”
  – Case mix adjusted by “Home Health Related Groups” (or “HHRGs”)
• Adjustments:
  – Geographic wage variations
  – High cost outliers
• Consolidated billing requirement
  – DME excepted and paid under fee schedule
  – Eliminates double billing
  – Prohibits “unbundling” of services
  – Forces HHA to provide services directly or “under arrangements” with outside supplier
Other PPS Part A Providers

- Long-term care hospitals PPS
  - Hospitals with an average length of stay greater than 25 days (sometimes referred to as “LTCHs” or “LTAC”)
  - PPS system phased in over 5 years beginning October, 2002
  - Similar to DRGs

- Psychiatric Facility/Unit PPS
  - Per day payments based on average daily costs
  - Some adjustment for excessive resource needs, wage levels, rural facilities and teaching facilities

..what about quality?

“...The distribution of performance-based payments may widen sociodemographic disparities in health care resources as well as disparities in the quality of care.”
### Quality Enters Part A

- Quality was not originally a factor in Medicare reimbursement
  - From 1966 to 2005, Medicare paid solely based on the *cost of the services* rendered
- Dec. 2002 – CMS announces joint collaborative with AHA, AMA, JCAHO, etc. on public reporting of hospital quality information
  - *Voluntary* initiative around 10 measures – Heart attacks and pneumonia
  - Nursing Home Compare – CMS website

### Quality Incentives

- With 2003 passage of the Medicare Modernization Act, Congress adopted the same “voluntary” quality reporting program on a limited basis AND *temporarily* linked payment updates to participation in the reporting program
  - Established “Reporting Hospital Quality Data for the Annual Payment Update” (RHQDAPU) program
  - Effective 10/1/04 (FFY 2005), hospitals received a 0.4% market basket update if they participated; 0.4% reduction if they did not participate
  - Same 10 measures used for the first year
Quality Incentives

- Each year since, the number of reporting measures has increased – note that only the reporting of the data required, regardless of performance ...
- Deficit Reduction Act of 2005 made the link to payment updates permanent and increased to 2.0% factor
- CMS has added similar “voluntary” quality reporting systems for hospital outpatient services (HOP QDRP) and for physician services (PQRI)
- Leading to Hospital Compare web cite:
  http://www.medicare.gov/hospitalcompare/search.html

Quality Incentives

- Hospital Inpatient Quality Reporting Program (successor name to RHQDAPU)
  - Quality measures have been expanded from “starter set” of 10 to 76 for FY 2015
  - Hospital Readmissions Reduction Program
- Hospital “Value-Based Purchasing” Program.
Health Care Reform Impact: Part A

• Value-based purchasing
  – Hospitals (starting 10/1/2012)
  – SNFs (report due 10/1/2011)
  – Home health agencies (report due 10/1/2011)
  – Hospital acquired conditions (FFY 2015) and readmission (FFY 2013) penalties
• DSH payment changes (FFY 2014)
• Market basket reductions – hospitals, SNFs, IRFs, LTCHs, HHAs, Hospice
• Quality reporting – IRFs, LTCHs, Hospice
• Re-based Home Health Agency payments (FFY 2014)

..and now for something completely different

• Accountable Care Organizations and Medicare shared savings program
  – Part A and B payments continue; supplemented by shared savings
• Center for Medicare and Medicaid Innovation – www.innovations.cms.gov
• “Bundled Payments for Improvement” Initiative – Aug. 23, 2011
• Independent Payment Advisory Board – to be or not to be …
Part B

...expanding the benefit design

Medicare – *Part B*

*Eligibility*

- Persons eligible for Part A
- Disabled (including those under 65) who have received disability benefits for at least 24 months
- ESRD patients
- “Dual eligibles”
- Beneficiaries “elect” Part B

Sources: 42 C.F.R. §§ 406.12, 406.13, 407.17
Medicare – *Part B*

*Eligibility*

- Beneficiary responsibility for deductibles and coinsurance
  - Medicare pays 80% of the fee schedule amount and the beneficiary pays the remaining 20% after the beneficiary has satisfied the annual deductible ($147 in 2014)

- Services not subject to deductible:
  - Home health services
  - Clinical diagnostic laboratory services
  - Fecal occult blood tests
  - Pneumonia and flu vaccines
  - Kidney donation
  - FQHC services
  - Covered screening services

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**Key Part B Services**

- Physicians Services & Incident To Physicians Services
- Hospital Outpatient Department Items & Services
- Durable Medical Equipment Prosthetics, Orthotics & Supplies (DMEPOS)
- Ambulance Services
- Diagnostic Services (Laboratory & Diagnostic Imaging)
- Ambulatory Surgery Centers (ASC)
- Some drugs.
Medicare – Part B
Coverage

Selected non-covered services:
- Services “Not Reasonable And Necessary”
- Diagnostic Screening Services
- Investigational Drugs And Devices
- Services Paid For By The Government
- Services Provided Outside Of The U.S.
- Personal Comfort Items
- Routine Physical Exams (except for “Welcome to Medicare” exam)
- Custodial Care
- Cosmetic Surgery
- Dental Services
- Surgical Assistants
- Eyeglasses And Contact Lenses
- Hearing Aids And Exams
- Services Furnished Under Private Contract
- Self-Administered Drugs

A framework for payment
Professional Services

Professional services personally performed by a:

- Physician (M.D., D.O.) (including those provided “incident to”* the physician’s services), including physician practices and physician directed clinics;
- Dentist (very limited)
- optometrist
- podiatrist
- Chiropractor (very limited)

* Integral, although incidental, part of the physician's professional services, furnished (1) in a non-institutional setting to non-institutional patient in a physician's office (2) without charge, or included in the physician's bill; (3) under the physician's direct supervision (4) by employees, leased employees, or independent contractors

Sources: 42 U.S.C.A §§ 1395d(a)(3), 1395k(a)(2)(A), 1395x(r)

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Professional Services

- Therapists (PT, OT, SLP)
- Clinical psychologists
- Licensed clinical social workers (“LCSW”)
- Certified nurse midwives
- Certified registered nurse anesthetists (“CRNA”)
- Physician’s Assistants (“PA”)
- Nurse practitioners (“NP”)
- Clinical nurse specialists (“CNS”)
- Audiologists
Diagnostic Services

- X-ray, EKG, Mammogram, Sleep Studies
- Professional component (physician or nonphysician practitioner)
- Technical component (supplier entity)
- Physician supervision requirements
  - General
  - Direct
  - Personal

Source: 42 C.F.R. § 410.32

Hospital Outpatient Department Services

- Items and Services furnished by an entity that meets provider-based requirements.
- Payment has moved from cost-basis to a prospective payment system.
- Provider-Based Test requires compliance with ________. (413.65). See MMI Breakout!
- Only available for services from entities that are financially and clinically integrated with a “main hospital” – as determined from specific criteria
- Criteria differ depending on whether provider based entity is located on the campus of a “main hospital” (defined as 250 yards form the main hospital) or off the campus. Must be located within 35 miles of the hospital or satisfy the 75% rule (designed to ensure provider based entity is serving the same patient base as the main hospital)
Hospital Outpatient Department Services

General Criteria (required for both on- and off- campus entities):

- Licensed under the hospital's license, unless no license, or separate license required by state in which provider based entity is located
- Integration of clinical services with main hospital
- Financial integration with main hospital
- Held out to the public as part of main hospital
- Satisfy obligations of hospital outpatient departments (e.g., compliance with anti-dumping rules, billing with correct site of service indicator, and compliance with 72 hour rule)
- Supervision standards applicable to the provision of diagnostic and therapeutic services. See _________ MMI Session.

Ambulatory Surgery Centers (ASC)

- Furnishes outpatient surgical procedures in a non-provider based (or free-standing) setting.
- Key requirement: ASCs must limit surgical services to those not requiring overnight hospitalization.
- ASCs need not be located in a separate building and may operate under common ownership and control of a hospital, physician's office, or clinic.
- ASC must be physically separated from other services by at least semi-permanent walls and doors, and generally may not commingle functions in common space.
Additional Services Under Part B

✓ Clinical laboratories (including clinical and anatomic path)
✓ Comprehensive outpatient rehabilitation facilities (“CORFs”)
✓ Outpatient PT, OT, SLP suppliers (including, rehab agencies, certified rehabilitation clinics, etc.)
✓ ESRD facilities for dialysis
✓ Federally qualified health centers (“FQHCs”)
✓ Rural Health Clinics (RHCs)
✓ Independent Diagnostic Testing Facilities (IDTF)
✓ Portable X-ray suppliers
✓ Radiation therapy centers
✓ Sleep disorder clinics
✓ Ambulance services
✓ Community Mental Health Centers (CMHCs)

Sources: 42 C.F.R. §§, 400.202, 405.2400-2417, 405.2430-2452, 410.10, 410.31-.35, 410.50, 410.100-.105, 410.170, part 416, 485.701-.729, 486.100-486.110, part 491, part 493

Durable medical equipment, prosthetics, orthotics, and suppliers (“DMEPOS”)

• Includes items that: (i) can withstand repeated use; (ii) are used for medical purposes; (iii) are not useful in the absence of illness or injury; and (iv) are used in the home
• Examples: Wheelchairs, home oxygen, diabetic testing supplies, braces, urological supplies, CPAP devices, TENS (limited).
• Prosthesis: replace functioning of a internal body organs (e.g., infusion equipment). Also includes total parenteral nutrition (TPN).
• Orthotics: correct deformities/improve mobility (e.g., artificial limbs).
• Inhalation drugs covered under Part B! (but not inhalers, covered under Part D)
• Parenteral/Enteral nutrients (“PEN”)....but, not IDPN (covered under Part D).
Drugs under Part B*

• Inhalation drugs (nebulizers)
• Vaccines, serums, etc.
• Intravenous drugs (e.g., antibiotics, chemotherapy).
• Oral chemotherapy drugs
• Blood clotting factors
• Immunosuppressive drugs
• Epoetin (EPO)
• Drugs or biologicals necessary to the performance of outpatient diagnostic tests

*Note, a number of Part B Drugs are covered, but only certain limited circumstances. Payment for these drug therapies may cross-over to Medicare Part D.

Sources: 42 U.S.C.A. §§ 1395w(s), 1395w(o); 42 C.F.R. §§ 410.10, 410.40-.41, 410.110, 410.28-.30

And down the rabbit hole we go..
Payment Systems Under Part B:  
**General**

- Physician fee schedule
  - CMS Common Procedure Coding System ("HCPCS")
  - Payment amounts derived from the "resource based relative value scale" ("RBRVS")
- Outpatient Prospective Payment System ("OPPS")
- Separate fee schedules (e.g., DMEPOS & Clinical Laboratory)
- Prospective payment system for ASCs.

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The Lion's Share:  
**Physician* Payments under Part B**

- Medicare payment amount is 80% of the lesser of: physician’s actual charge, or fee schedule amount (beneficiary is responsible for remaining 20%)
- RBRVS/Relative Value Units ("RVUs")

1. Physician work (physician’s time and intensity of effort, skill, training and medical judgment)
2. Practice expense (overhead), and
3. Malpractice insurance
Physician* Payments

Physician Fee Schedule/RBRVS Basics

– “Site of service differential”
  • Office setting
  • Reduction in practice expense RVUs
  • Excludes certain medical specialties (e.g., radiology), and non-office settings (e.g., hospital outpatient departments).

– Exceptions
– Geographic adjustment
– Conversion Factor (including “sustainable growth rate”)
– Payment adjustments

Calculating Medicare Physician* Payments

STEP 1

• Multiply the physician work, non-facility practice expense, and professional liability insurance RVUs by the appropriate GPCIs; add the figures thus obtained to get the total geographically adjusted RVUs for the office visit.

• Total non-facility RVUs for CPT code 99213

(Work RVUs x Work GPCI) + (Non-Facility Practice Expense RVUs x Practice Expense GPCI) + (MP RVUs x MP GPCI)

(0.97 x 1.000) + (1.10 x 1.009) + (0.07 x .751)
Calculating Medicare Physician* Payments

STEP 2

- Multiply the total geographically adjusted RVUs by the Medicare Conversion Factor to obtain the physician payment for the office visit.
- 2011 Medicare Conversion Factor (CF) = $34.023
- RVUs (before geographic adjustments) = 2.14
- RVUS (after GPCI adjustment) = 2.132

Total Medicare payment for the provision of CPT code 99213 in Austin, TX

\[2.132 \times 34.023 = 72.55\]

Sample 2011 Payment Calculations:
99203 New Patient, Office Visit

<table>
<thead>
<tr>
<th>Medicare Locality</th>
<th>Payment</th>
<th>RVU</th>
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</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$96.60</td>
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</tr>
<tr>
<td>Anaheim/Santa Anna, CA</td>
<td>$117.14</td>
<td>3.45</td>
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<tr>
<td>Los Angeles, CA</td>
<td>$114.50</td>
<td>3.37</td>
</tr>
<tr>
<td>Miami, FL</td>
<td>$115.98</td>
<td>3.41</td>
</tr>
<tr>
<td>Rest of Florida</td>
<td>$104.77</td>
<td>3.08</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$103.62</td>
<td>3.05</td>
</tr>
<tr>
<td>Alaska</td>
<td>$129.99</td>
<td>3.83</td>
</tr>
</tbody>
</table>
Sample Medicare Locality Chart 2011

<table>
<thead>
<tr>
<th>Medicare Locality</th>
<th>Work P</th>
<th>Practice Expense (PE)</th>
<th>Professional Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1.0</td>
<td>.928</td>
<td>.484</td>
</tr>
<tr>
<td>Anaheim/Santa Anna, CA</td>
<td>1.039</td>
<td>1.271</td>
<td>.742</td>
</tr>
<tr>
<td>Los Angeles, CA</td>
<td>1.039</td>
<td>1.220</td>
<td>.722</td>
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<tr>
<td>Miami, FL</td>
<td>1.0</td>
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<td>2.984</td>
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<tr>
<td>Rest of Florida</td>
<td>1.0</td>
<td>.976</td>
<td>1.635</td>
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<tr>
<td>New Hampshire</td>
<td>1.0</td>
<td>1.046</td>
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</tr>
<tr>
<td>Alaska</td>
<td>1.5</td>
<td>1.092</td>
<td>.648</td>
</tr>
</tbody>
</table>

99203 (Austin, TX)

Non-Facility Setting

Reimbursement:

- **Par Amount**: $107.50
- **Non Par Amount**: $102.13
- **Limiting Charge**: $117.45
- **eRX *****: $115.69

Facility Setting

Reimbursement:

- **Par Amount**: $74.20
- **Non Par Amount**: $70.49
- **Limiting Charge**: $81.06
- **eRX *****: $79.84
Physician* Payments

• Applies to Physician services
• “Incident to” services (nonprofessional services covered at 100%)
• Radiology services, cancer treatment services
• OT, PT and SLP
• Diagnostic tests (e.g., IDTFs and portable X-ray suppliers).
• Non-physician practitioners (e.g., nurse practitioners, physician assistants, clinical nurse specialists, etc.) (generally 85% of fee schedule amount, but in some instances as low as 65% and as high as 100%)

Hospital Outpatient Items & Service

• Services paid under OPPS are classified into Ambulatory Payment Classifications or “APCs.”
• APCs are assigned based on HCPCS codes and International Classification of Disease (ICD-9-CM) codes
• Clinically similar classifications by resources
• Separate payment rate per APC (bundled)
• 80% Medicare/20% beneficiary copay per APC
• Adjustments for high cost outliers
• Some pass-thru for implantable devices (very limited).
Hospital Outpatient Items & Services

Watch for special payment rules---

• 3 day payment window—Prohibits payment “separate from DRG” for any service furnished by a hospital or entity wholly owned or operated by a hospital during the 3 days prior to a beneficiaries’ admission. Includes: (1) diagnostic related services and (2) non-diagnostic services related to the hospital admission.

• Supervision Guidelines not assumed.

Attend ____________ MMI.

Drugs & Biologicals under Part B

• Radical revisions under MMA
• Movement to “Average Sales Price” (“ASP”) methodology and away from “average wholesale price” (“AWP”)
• ASP calculated for each National Drug Code (“NDC”)
• Single source drugs: 106% ASP, rather than 85%/95% AWP*
• Multiple source drugs: lesser of 106% ASP or “average wholesale cost” (“AWC”)
• Drug administration fees for certain drugs (e.g., inhalation drugs)
• Vaccines: 95% AWP

*Note, White House proposes further reductions of Part B Drugs to 103% of ASP for 2015.
Other Payment Systems Part B

- **DMEPOS**: Fee schedule
  - Competitive bidding implemented nationwide on certain product classes in specified MSAs.
  - Possibility to expand competitive bidding prices to non-MSAs.
- Comprehensive outpatient rehabilitation facilities (“CORFs”) - 80% of the lesser of actual charge or fee schedule amount
- ESRD facilities – Case-mix adjusted prospective payment system.
- Federally qualified health centers (“FQHCs”) - 80% of an all-inclusive, per-visit encounter rate, subject to an annual payment limit
- Ambulatory surgery centers – PPS-Based system (based upon outpatient PPS)
- Ambulance services – National fee schedule

Sources: 42 U.S.C.A. §§ 1395k(a)(2)(E), (a)(2)(F), (a)(5)(B), (f), (h), 1395m(a), (b), (l); 42 C.F.R. §§ 140.165, 405.2462-.2468, 410.165, 413.170-.198, 414.200-.232, 414.601-414.625, 416.120-416.130

Special Rules Under Part B

- Supervision Standards (radiology & radiation therapy)
- Anti-Markup (f/k/a, Purchased Diagnostic Test Rule
- 3-day Payment Window Rule
- Outpatient Supervision Standards including Non-Surgical Extended Services.
- Provider-Based Compliance
- Physician Self-Referral (IOAS)
- Enrollment Standards
Preventive Wellness Benefit: *New*

- Affordable Care Act Initiative
- Prior to January 1, 2011, Medicare only covered a one-time "Welcome to Medicare" fitness examination.
- As of January 1, 2011, Medicare now provides coverage for continuing annual wellness visits in which beneficiaries will receive personalized prevention plan services that include updating the beneficiary’s medical history, reviewing all prescribed medications, recording body size and vital statistics, and establishing a screening schedule for the succeeding 5 to 10 years.
### Preventive Wellness Services

<table>
<thead>
<tr>
<th>Preventive Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Certain vaccines</td>
</tr>
<tr>
<td>• Screening mammography</td>
</tr>
<tr>
<td>• Screening pap smear and screening pelvic exam</td>
</tr>
<tr>
<td>• Prostate cancer screening tests</td>
</tr>
<tr>
<td>• Colorectal cancer screening tests</td>
</tr>
<tr>
<td>• Diabetes outpatient self-management training services</td>
</tr>
<tr>
<td>• Bone mass measurement</td>
</tr>
<tr>
<td>• Screening for glaucoma</td>
</tr>
<tr>
<td>• Medical nutrition therapy services</td>
</tr>
<tr>
<td>• Cardiovascular screening blood tests</td>
</tr>
<tr>
<td>• Diabetes screening tests</td>
</tr>
<tr>
<td>• Ultrasound screening for abdominal aortic aneurysm</td>
</tr>
<tr>
<td>• Additional preventive services that identify medical conditions or risk factors as determined by CMS</td>
</tr>
</tbody>
</table>

### Part C

Is this future of Medicare?
Medicare Part C

- **Medicare Advantage**
- Formerly Medicare+Choice
- Private entities, called plan sponsors, contract with the federal government to offer Medicare medical benefits
- Centers for Medicare & Medicaid Services (CMS) pays plan sponsors on a capitated (per member, per month) risk basis to manage Original Medicare (Parts A and B) benefits

Key Resources

**MA**
- 42 C.F.R. Part 422
- CMS Medicare Managed Care Manual
- Additional CMS guidance, including HPMS memos sent to plan sponsors

**Part D**
- 42 C.F.R. Part 423
- CMS Medicare Prescription Drug Benefit Manual
- Additional CMS guidance, including HPMS memos sent to plan sponsors
Primary Types of Medicare Advantage Plans

Coordinated Care Plans

- **Health Maintenance Organization (HMO)** – care through contracted network of providers
- **Preferred Provider Organization (PPO)** – contracted network plus out-of-network benefits
- **Special Needs Plan (SNP)** – for individuals with special needs such as nursing home residents, people with chronic or disabling conditions, or Medicaid eligibles

Primary Types of Medicare Advantage Plans

Private Fee for Service (PFFS) Plans

- Pays providers on a fee-for-service basis through contracts or “deeming” that providers accept fees and terms
- From 2011, individual PFFS plans in a service area with two or more network MA plans must have a contracted provider network
Medicare Advantage
Plan Benefits

• Must cover all services covered under Original Medicare
• Can design own benefit structure with co-payments, coinsurance, deductibles or no deductibles
• May offer supplemental benefits
• Follow National and Local Medicare Coverage Determinations and Coverage Guidelines
• May employ utilization management
• Generally must have quality improvement and chronic care management programs
• Mandated out-of-pocket maximum for year

Eligibility for Medicare Advantage

Entitled to Part A and Enrolled in Part B

Does not have end stage renal disease (ESRD) unless an exception applies

Resides in plan service area

Not enrolled in another plan
Primary MA Election Periods

Initial Election Period (IEP)
- 7 month period beginning 3 months before eligible for Parts A and B and ending 3 months after month of eligibility

Annual Election Period (AEP)
- Fall Open Enrollment
- October 15 through December 7

Special Election Periods (SEPs)
- Based on numerous special circumstances such as change in residence or plan termination
- Ongoing SEP for Medicaid eligible and institutionalized
- Ongoing SEP to enroll in 5-Star plans

Provider Network

- MA plans must maintain a network that meets care access requirements
- Need written provider agreements that contain provisions required by regulations
- Regulated credentialing process – initial and re-credentialing at least every three years
- “Non-interference clause” – government is not involved in rate negotiations or disputes between plan sponsors and providers
Providers and Marketing

• Providers may not
  – attempt to induce or steer beneficiaries to a particular plan or plans
  – accept enrollment forms
  – accept compensation directly or indirectly from plan for enrollment activities

• Providers may
  – provide names of plans with which they contract
  – distribute plan marketing materials (not in an exam room setting and not including enrollment applications) for a subset of contracted plans if option available to all contracted plans
  – refer patients to medicare.gov plan comparison tool and print information

Payments to Non-Contracted Medicare Advantage Providers

• **General Rule:** Non-contracted providers must accept Original Medicare payment amounts as payment in full.

• **MA Payment Guide for Out of Network Payments**
  – Describes payment methodology for each provider type
  – Example: For in-patient acute care, use Diagnosis Related Group (DRG) using Prospective Payment System (PPS) (most states)

Sections 1852(a)(2) and 1852(h)(1) of the Social Security Act, 42 CFR 422.214, Ch. 6 of the Medicare Managed Care Manual, § 100
Payments to Non-Contracted Medicare Advantage Providers

• Original Medicare bonuses apply.
  – E-prescribing bonus (annually following end of year)
  – Primary care incentive payment (quarterly)
  – Health Information Technology bonuses
  – Additional incentive bonuses based on zip code
• Is your plan calculating and paying these bonuses accurately?

MA Payment Guide for Out of Network Payments, 9/27/13 Update

CMS Requirements – Payments to Medicare Advantage In-Network Providers

Non-Interference Clause

• Generally, payment terms between MA organization and their contracted providers are the product of private contract negotiations.
• "(iii) Noninterference. . . Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract. . . ."  
• CMS is not involved in MA pricing or contract discussions with providers.

Social Security Act §1854(a)(6)(B)(iii); Social Security Act §§1852(o)(2) and 1852(k)(1); 42 C.F.R. § 421.214; Chapter 6 of the Medicare Managed Care Manual, § 100.
CMS Requirements – Payments to Medicare Advantage In-Network Providers

MA organizations may:

• Use different reimbursement amounts for different specialties or for different practitioners in the same specialty.

• Implement measures designed to maintain quality and control costs, consistent with their responsibilities.

Chapter 6 of the Medicare Managed Care Manual § 50; 42 CFR 422.205(b)

CMS Requirements – Payments to Medicare Advantage In-Network Providers

• Physician incentive plan defined:
  – Any compensation arrangement
  – Between an MA organization and a physician or physician group
  – That may directly or indirectly have the effect of reducing or limiting services to enrolled individuals

• Requirements also apply to subcontracting arrangements with an intermediate entity that contracts with physician groups.

42 CFR 422.208 (b),(c),(e). See also Social Security Act §1852(j)(4); Chapter 6 of the Medicare Managed Care Manual §§ 80, 80.2
CMS Requirements – Payments to Medicare Advantage In-Network Providers

Physician Incentive Plan Requirements

• Only coordinated care MA plans, such as HMO or PPO (not fee for service - PFFS) may offer incentive plans.

• May not directly or indirectly, make any payment as an inducement to reduce or limit the provision of medically necessary services.

• If arrangement places a physician or physician group at **substantial financial risk** for services the physician or group will not furnish itself, they must have either aggregate or per-patient stop loss protection.

42 CFR 422.208 (b),(c),(e). See also Social Security Act §1852(j)(4). Chapter 6 of the Medicare Managed Care Manual §§ 80, 80.2

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What is “substantial financial risk” for physician incentive analysis?

• Payments based on other factors, such as quality of care, are not included in risk calculation.

• 25 percent of provider reimbursement is at risk for the cost of referral services.

• Bonus considered money at risk, along with potential withholds.

• Exception for physician groups with panels of over 25,000 patients (pooling is permitted) under risk arrangements.

• Referral services includes any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders but does not furnish directly.

42 CFR 422.208. Chapter 6 of the Medicare Managed Care Manual §§ 80, 80.2
Physician Incentive Plan Requirements (continued)

- Detailed requirements apply to physician group’s stop loss coverage.
- Specific requirements for pooling of patients for panel size.
- Disclosure requirements for CMS and enrollees
  - Provide assurances to CMS that requirements are met.
  - Provide information about types of incentives and whether stop-loss protection is provided to enrollees who request it.

42 CFR 422.208(b),(c),(e). See also Social Security Act §1852(j)(4). Chapter 6 of the Medicare Managed Care Manual §§ 80, 80.2

Special rules for PFFS plans

- Providers must be reimbursed on a fee-for-service basis.
- Reimbursement cannot place provider at financial risk.
- Reimbursement cannot vary based on utilization relating to the provider.

Section 1859 (b) of the Social Security Act; 42 CFR 422.216; Ch. 16a of Medicare Managed Care Manual
Part D

And why do we need a separate part of the program just to cover drug benefits?

Medicare Part D

- Prescription Drug Benefit
- Created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Commenced January 1, 2006
- Private entities contract with the federal government to offer prescription drug benefits
- CMS makes capitated (per member, per month) payments to the plan sponsor to manage drug benefits
Part D Standard Benefit for 2014

**Deductible**
- Member pays 100%
- Set at $310

**Initial Coverage Phase**
- Plan pays 75%
- Member pays 25%
- Up to $2,850 in total drug costs

**Coverage Gap**
- Member pays 47.5% for brand, 79% generic
- Plan pays 2.5% for brand, 28% for generic
- Manufacturer pays 50% for brand
- Up to $4,550 in Member’s total True Out of Pocket Cost (TrOOP)

**Catastrophic Coverage**
- Government reinsures 80%
- Plan pays 15%
- Member pays 5% (or small copay)

CMS Requirements – Payments to Part D Pharmacies

**Any Willing Pharmacy**
- Part D sponsor
  - Must contract with any pharmacy that meets its standard terms and conditions.
  - Standard terms must be “reasonable and relevant.”
  - May not require pharmacy to accept insurance risk as a condition of participation.
- Standard terms and conditions may vary within service area and by pharmacy type as long as all similarly situated pharmacies are offered the same terms and conditions.
- Waived for plans where 98 percent of enrollee prescriptions are filled through pharmacies owned and operated by plan sponsor.

42 CFR 423.120 (a)(8); Prescription Drug Benefit Manual, Chapter 5, § 50.8
CMS Requirements – Payments to Part D Pharmacies

Capitation Prohibited in Pharmacy Network Contracts

• “Subcapitation of pharmacies” is prohibited under Part D.
  – Inconsistent with Part D payment methodology.
  – Need per-claim payment data.
  – Plan must report per-claim cost and calculate TrOOP.
• CMS permits payment variations reflecting performance-based measures, such as generic substitution.

*Prescription Drug Benefit Manual, Chapter 5 § 50.8.2.*

A Medicaid Primer
Medicaid Basics

• Financing
• Benefits
• Reimbursement
• Eligibility
• Medicaid Expansion and NFIB
• Reimbursement Case Study & Lessons
• Sources of Authority
• Special Medicaid Considerations

Medicaid Basics: Financing

• State Share Required for FFP
  – Provider Fees & Taxes: FY 2013 49 States and DC
• FFP/Federal Medical Assistance Percentage (FMAP) and Relative Poverty of State
  – Services-FMAP Percentage
  – Special Services have higher FMAP
    • e.g. family planning is 90%
  – Expansion Medicaid 90% FMAP in 2020
• Administrative Cost FFP
  – Administrative Percentage Uniform (50%)
## Medicaid Basics: Benefits

### Mandatory
- Physician services
- Lab and x-ray services
- Inpatient hospital
- Outpatient Hospital
- EPSDT for individuals under 21
- Family planning
- Rural and federally qualified health center (FQHC) services
- Nurse midwife services
- Nursing facility (NF) services for individuals 21 and over
- Home health for certain populations

### Optional
- Prescription drugs
- Clinic services
- Dental services, dentures
- Physical therapy and rehab
- Prosthetic devices, eyeglasses
- Primary care case management
- Intermediate care facilities for the mentally retarded (ICF/MR) services
- Inpatient psychiatric care for individuals under 21
- Personal care services
- Hospice services
- Alcohol and Drug Treatment

### Expansion Medicaid
- Essential Health Benefits

## Medicaid Basics: Reimbursement

- Diverse reimbursement schemes
- Managed care, fee for service, cost based
- Provider Rates Controversial – Balancing Budgets
  - Rates must be consistent with efficiency, economy and quality of care;
  - Adequate definition of policy and method used in rate setting
  - Assure appropriate audits for cost based payments
  - Rates must be high enough to enlist enough providers so that services are reasonably available under the plan
- Increased Primary Care Physician Reimbursement ACA
  - Pediatricians, Family Med, General Internal Med reimbursement of 100% Medicare Part B for 2013 and 2014. Increased rate 100% FFP.
- Medicaid Rules are not Medicare Rules
- Reimbursement Rules Unique in Programs
Medicaid Basics: Reimbursement

Waivers Create Laboratories in the States 411 as of March 13, 2014

• **Section 1115:** Research & Demonstration
  – States apply for program flexibility to test new or existing approaches to financing and delivering Medicaid – very creative
  – without additional $
  – 13 Family Planning 1155
  – 50 in 32 States Active
  • Wisconsin and Arkansas each have three
  – 16 Pending – Creative Implementation of Medicaid Expansion Here

Medicaid Basics: Reimbursement

Waivers Create Laboratories in the States

• **Section 1915(b): Managed Care**
  – States apply to provide services through MCO delivery systems or otherwise limit people’s choice of providers
  – 22 Current in 17 States
• **Section 1915(c): Home and Community Based Services**
  – States apply to provide long-term care services in home and community settings rather than institutional settings
  – 328 Current
• **Concurrent 1915(b) and 1915(c): Combined**
  – States apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities as long as all federal program requirements met
  – 1 Current: Michigan
Medicaid Eligibility

- There is more than one Medicaid Type in every Medicaid Program
- Different types of Medicaid include different eligibility criteria and benefit coverage
- Mandatory Populations
- Optional Populations
- Expansion Medicaid

Medicaid Eligibility

- Mandatory Categorically Needy With Various Income Guidelines
  - Pregnant Women
  - Infants up to Age 1
  - Children Age 1-5
  - Children ages 6 to 19
  - Parents at state's 1996 AFDC levels (likely less than 50% FP Guidelines)
  - Elderly and Disabled persons receiving SSI
- Optional Categorically Needy: higher income, resources
- Optional Medically Needy
  - Varies: parents of covered children, disabled, blind, aged individuals
- Legal Immigrants – five year waiting period
- Medicaid Expansion Population – Non-Custodial Adults
Medicaid Expansion & NFIB

• 26 States alleged that Congress exceeded its authority under the Spending Clause of the U.S. Constitution (Art. I, §8, cl.1) by requiring states to expand their Medicaid programs or risk losing certain federal matching funds.
  – For example, ACA increases federal funding to cover the States’ cost in expanding Medicaid coverage, but if a State does not comply with the Act’s new coverage requirements, ACA provides that the State may lose not only the increased federal funding but all of its federal funding. 42 U.S.C. §1396c

Medicaid Expansion & NFIB

• The Court focused on:
  – Requirement to cover all adults, including non-custodial, income up to 133%/138% of federal poverty level (FPL).
  – Requirement to provide essential health benefits package to Expansion Population Medicaid recipients.
  – The federal share of the cost to cover Expansion Population of 100% for FY 2014-2016, decreasing gradually to 90% in 2020 and beyond.
  – State’s failure to cover the expansion population can cost it all of its federal Medicaid funds.
• But there is no definition in NFIB of “Medicaid Expansion.”
• HHS’ position: flexibility – waivers granted and negotiations continue
Medicaid Expansion & NFIB

• **Holding:** 7-2 decision that the Medicaid Expansion under ACA is unconstitutional as written.
  - Chief Justice Roberts’ opinion (joined by Justices Breyer and Kagan) plus the joint dissent’s opinion (Justices Scalia, Kennedy, Thomas, Alito) reaching the same conclusion. Justices Ginsburg and Sotomayor would have found it constitutional.

• **Remedy:** 5-4 decision essentially that Congress can only threaten to take away “new” Medicaid funding.
  - Chief Justice’s opinion (three votes) plus the dissenting opinion of Justice Ginsburg (joined by Justice Sotomayor), who disagreed with holding but stated that they “entirely agree with the Chief Justice as to the appropriate remedy.”
  - Joint Dissent (four votes) disagreed – would have stricken expansion entirely.

Medicaid Eligibility: Expansion

• States may expand to all non-elderly individuals with income up to 133% (+ 5 effectively 138%) FP Guidelines.
  - FFP for Newly Eligible will be 100% from 2014-2016
  - FFP for Newly Eligible will phase down to 90% in 2020 and thereafter

• New Coverage for Childless Adults with increased FFP in 2014 Income of 133/138% FPL

• States must maintain existing income eligibility levels until state exchanges fully operational

• States must maintain existing income eligibility levels for CHIP and Medicaid until 2019.
Medicaid Expansion States (25+D.C.)
as of March 13, 2014

- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Hawaii
- Illinois
- Iowa
- Kentucky
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Nevada
- New Jersey
- New Mexico
- New York
- North Dakota
- Ohio
- Oregon
- Rhode Island
- Vermont
- Washington
- West Virginia
- District of Columbia

Potential Expansion
- Indiana
- Missouri
- New Hampshire
- Pennsylvania
- Utah
- Virginia

NOTES: Data are as of January 28, 2014. *IA and WI have approved waivers for Medicaid expansion; MI has an approved waiver for expansion and plans to implement in Apr. 2014; IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 133% FPL, but did not adopt the expansion.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS. States noted as “Open Debate” are based on KCMU analysis of States of the State addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of Medicaid expansion bill in at least one chamber of the legislature.
Medicaid Reimbursement Case Study

Medicare & Medicaid Dual Eligible Beneficiaries
CMS Innovation Center
SMDL #11-008 (July 8, 2011)

9 Million Dual Eligible Beneficiaries are Covered by Both Medicare and Medicaid

Medicare 37 Million

Medicaid 51 Million

Total Medicare Beneficiaries, 2008: 46 million
Total Medicaid Beneficiaries, 2008: 60 million

SOURCE: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey, 2008, and KCMU and Urban Institute estimates based on data from the FY2008 MSIS.
Reimbursement Lab Case Study:
Dual Eligibility

• Beneficiaries Eligible for Medicare & Medicaid
• 9.6 million – poor, sick, expensive
  – ~7 Million Full Dual: Part B Premium + Wrap
  – ~2 Million Partial: Part B Premium + Cost Share
• Demonstration to Integrate Care and Align Financing and/or Administration
• CMS Proposed Two Financial Models to Align Medicare and Medicaid Benefits for Full Duals
  – Capitated
  – Managed Fee-for-Service

Reimbursement Lab Case Study:
Dual Eligibility

• Up to 2 Million Dual Eligible Beneficiaries
• 26 States Submitted Proposals
• 10 States have signed MOUs (March, 2104)
  – 9 Financial Alignment
  – 1 Administrative Alignment
• 9 States have proposals pending
Reimbursement Lab Case Study:
Dual Eligibility

• Capitated
  – Contract between CMS, State, and Health Plan
  – One prospective payment for all primary, acute, behavioral, long-term services and supports
  – CMS and State share savings
• Managed Fee-for-Service
  – Contract between CMS and State
  – State responsible for full integration of Mcare and Mcaid benefits and care coordination for duals
  – States earn performance bonus
  – Providers paid fee-for-service

Reimbursement Lessons Here?

Significant Variety in Medicaid

• Program to Program
• Eligibility Category to Eligibility Category
• Waivers
• CMS Demonstration Projects
Medicaid Sources of Authority

Note Hierarchy

• Federal Authority
  – Title XIX Social Security Act: 42 U.S.C. § 1396a
  – 42 C.F.R. Subchapter C, Parts 430-456
• State Plan – Contract Between State & Feds -- CMS
• State Authority
  – Statutes
  – Regulations
  – Provider Agreement
• Federal Extra-Regulatory “authority”
  – CMS State Medicaid Director & Survey Letters
  – OIG Audits and Investigations of Medicaid Programs
• State Extra-Regulatory “authority”
  – Manuals & Provider Bulletins
  – State Website – Don’t Forget About This One – Print It!

Special Medicaid Troubles

• Uneven State Audits
• State False Claims Act
• Comparisons to Medicare
• Poor People Agency
• Mandatory Monthly Exclusion Check Required
• Prohibition against reassignment to billing agent if compensation to agent is % basis
  42 C.F.R. § 447.15(f)
Special Medicaid Arguments

Medicaid Programs Need Providers & Access
• Must Pay Sufficient Reimbursement to Ensure Access
• Statewideness: Covered services must be available throughout the State
• Freedom of Provider Choice – who want to participate
• Unique benefits to promote access to care (e.g. transportation)

Medicaid Needs Benefit Coverage
• Comparability: Benefit Package for Medically and Categorically Needy
• Reasonableness: Sufficient in amount, duration and scope of services
• Nondiscriminatory
• Protections from Beneficiary Cost Sharing and Requirements to Bill Program

And Don’t Forget
• The Administrative Procedure Act – State and Federal
• Payor of Last Resort – Trust Me

Medicaid Resources

• Always Start With the Federal Authority
• Title XIX Social Security Act: 42 U.S.C. § 1396a
• 42 C.F.R. Subchapter C, Parts 430-456
• CMS Website
• State Plans
• State Statutes – remember preemption
• State Rules
• State Medicaid Websites
• Kaiser: http://kff.org/medicaid