Medicare FFS Payment Changes and PACE

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Session Objectives

• Overview of question on payments to non-contracted service providers

• Overview of CMS FFS payment system changes

• Overview of payment policies for non-contracted outside service providers

• Points to consider in future contracting discussions concerning payments to providers
The Big Question

• Are PACE organizations required to pay Medicare rates if there is no contract in place?

• For example - if a PO does not have a contract with a hospital that their participant ends up in - must they pay Medicare rates?
The Big Answer

• Yes. Unless there currently exists a contract between a PACE organization and an outside provider of service, the PO will be charged NO MORE than what the Fee Schedule dictates for those services for that particular service setting.
Points to consider

Why should a PO be concerned about the Medicare FFS schedules?

• Unless a PO has a contract in place for services an unexpected bill from an outside provider could be cause for alarm

• Knowing the universe of potential providers and their fee-for-service payment systems could alleviate future headaches

• A close study of these systems could also be used to support contract discussions with outside providers
CMS Payment Systems Changes

Proposed rules
- Outpatient Prospective Payment System (OPPS)
- End Stage Renal Disease Prospective Payment System (ESRDPPS)
- Medicare Physician Fee Schedule (MPFS)
- Home Health Prospective Payment System (HPPS)
- Clinical Diagnostic Laboratory Tests Payment System

New payment model
- Comprehensive Care for Joint Replacement (CCJR) model

Final rules
- Inpatient and Long-Term Care Hospital Services
- Skilled Nursing Facilities
- Inpatient Rehabilitation Facility
- Inpatient Psychiatric Facilities
- Hospice Services
Key common components

Quality Adjustments
- Outpatient quality reporting
- Clinical Measures
- Reporting Measures
- Additional QIP Components

Payment Bundling
- Value-based purchasing
- Bundling of payments

Efficiency and cost reduction
- Patient and caregiver-centered experience and outcomes
- Clinical quality of care
- Care coordination
- Population Health
- Participant/beneficiary safety
Facility services not arranged by an MA plan or a PACE provider

- Coordinated care plans, such as HMOs and PPOs, and PACE plans are generally required to reimburse non-contracting providers at least the original Medicare rate for Medicare covered services.

- Notwithstanding the above, CMS regulations state that if a non-network facility such as a hospital, SNF, or HHA renders services which were not arranged by the plan, a non-PFFS MA plan may pay the lesser of the original Medicare amount or the billed amount when reimbursing for emergency, urgently needed, out-of-area dialysis and post stabilization services.

- However, when a PACE plan receives a claim from a provider that indicates it is submitting a bill for services to the MAO in the same way it bills under Original Medicare, the PACE plan should consider the bill to be a request for payment for the Original Medicare amount (and not the “billed” or “charge” amount from the claim) that Medicare would pay in the case of a similar submission. The PACE plan would then need to pay based on the Original Medicare amount.
42 CFR §422.214  Special rules for services furnished by noncontract providers.

•  (a) Services furnished by non-section 1861(u) providers*. (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan **must** accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

or

•  (b) Services furnished by section 1861(u) providers of service*. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan **must** accept, as payment in full, the amounts that it could collect if the beneficiary were enrolled in original Medicare.

*Section 1861(u) providers of service: means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program.
Payment requirements for services in lieu of contract

42 CFR §417.558  Emergency, urgently needed, and out-of-area services for which the HMO or CMP accepts responsibility.

• (a) *Source of payment.* Either CMS or the HMO or CMP may pay a provider for emergency or urgently needed services or other covered out-of-area services for which the HMO or CMP accepts responsibility.

• (b) *Limits on payment.* If the HMO or CMP pays, the payment amount may not exceed the amount that is allowable under part 412 or part 413 of this chapter.

• (c) *Exception to limit on payment.* Payment in excess of the limit imposed by paragraph (b) of this section is allowable only if the HMO or CMP demonstrates to CMS's satisfaction that it is justified on the basis of advantages gained by the HMO or CMP, as set forth in §417.548.
Payment requirements for services in lieu of contract

42 CFR §422.520 Prompt payment by MA organization.

(a) Contract between CMS and the MA organization. (1) The contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of the “clean claims” within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

(b)(1) Contracts between MA organizations and providers and suppliers. Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider.

(2) The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.

(c) Failure to comply. If CMS determines, after giving notice and opportunity for hearing, that an MA organization has failed to make payments in accordance with paragraph (a) of this section, CMS may provide—

(1) For direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and

(2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

(d) A CMS decision to not conduct a hearing under paragraph (c) of this section does not disturb any potential remedy under State law for 1866(a)(1)(O) of the Act.
Payment Dispute Resolution Process for Non-contracted Providers

• From 2009 until January 31, 2014, CMS contracted the services of an independent entity to adjudicate payment disputes between non-contracted providers, MAOs and other payers.

• As of January 31, 2014, providers should contact the MAO or other payer directly to dispute payments.

• This applies to all non-contracted provider types that perform services for beneficiaries enrolled in MAOs, including PFFS, PACE organizations, Section 1876 Cost Plans, and Section 1833 Health Care Prepayment Plans.
Payment Dispute Resolution Process for Non-contracted Providers

- If a provider has exhausted the plan’s internal dispute process and still maintains it has not been reimbursed fairly, it may file a complaint through 1-800-Medicare in addition to taking other actions it deems appropriate. (CMS does not offer advice to providers on their potential rights in a payment dispute).

- CMS is committed to ensuring that MAOs and other payers follow regulations at 42 C.F.R. §§ 422.214, 417.558, and 422.520 when reimbursing non-contracted providers for services provided to Medicare beneficiaries.

- Non-contracted providers are required to accept as payment, in full, the amount that the provider could collect if the beneficiary was enrolled in Original Medicare.
Food for Thought

• Better to have a contract with external service providers (percentage of FFS for low volume)
• If not, protections exist to prevent overcharging, overpaying and an appeals process for dispute resolutions
• Be aware of the changes taking place with the FFS payment systems
• Educate participants/family members that services must be authorized by their PACE organization
• IDT must continue administering participant care plan during external service provisioning
• Internal communication of participant usage of external service providers
Additional Resources

- **NPA Issue Briefs**

- **Payment Rules**
  - MA Payment Guide for Out of Network Payments
  - 42 CFR §422.214 Special rules for services furnished by noncontract providers
    - [http://www.ecfr.gov/cgi-bin/text-idx?SID=295403ef835dbd6bf02465fa9382efe8&mc=true&node=se42.3.422_1214&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?SID=295403ef835dbd6bf02465fa9382efe8&mc=true&node=se42.3.422_1214&rgn=div8)
  - 42 CFR §422.520 Prompt payment by MA organization
    - [http://www.ecfr.gov/cgi-bin/text-idx?SID=295403ef835dbd6bf02465fa9382efe8&mc=true&node=se42.3.422_1520&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?SID=295403ef835dbd6bf02465fa9382efe8&mc=true&node=se42.3.422_1520&rgn=div8)
  - 42 CFR §417.558 Emergency, urgently needed, and out-of-area services for which the HMO or CMP accepts responsibility
    - [http://www.ecfr.gov/cgi-bin/text-idx?SID=295403ef835dbd6bf02465fa9382efe8&mc=true&node=se42.3.417_1558&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?SID=295403ef835dbd6bf02465fa9382efe8&mc=true&node=se42.3.417_1558&rgn=div8)
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