Medicare Fundamentals

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Agenda

- Background

  - Evolution, Four Parts, Enrollment, Benefits, Eligibility
- Coverage Under Parts A, B, C, D
- Program Administration
- Payment System Under Parts A, B, C, D
- Provider Enrollment
- Appeals Process
- Authority

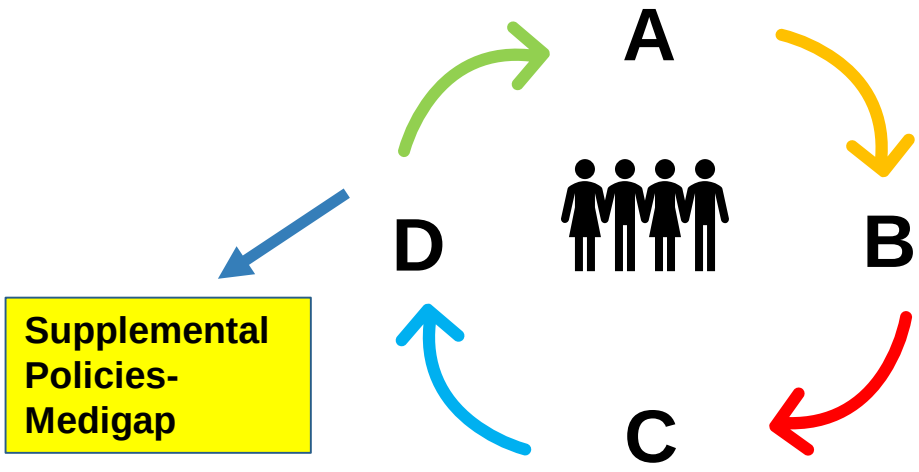
Background

Medicare- federally funded social health insurance program providing universal hospital coverage for Americans 65 years of age or older and long term disabled, individuals requiring renal dialysis and others who buy into program regardless of age.

Medicare- arose under the 1965 amendments to Social Security Act adding Title XVIII (Medicare) and Title XIX (Medicaid) (Pub. L. No. 8987).

Medicare Advantage and Part D programs- created as part of the Medicare Modernization Act of 2003. Unlike traditional Medicare, Parts C and D are defined contribution programs unlike traditional Medicare which is defined benefit program.

Four Parts



Medigap- beneficiaries have option of purchasing supplemental health insurance coverage from private commercial insurers which offer range of coverage options for Medicare excluded services to help defray costs of coinsurance and deductibles beneficiaries; only available to those covered under Part A and Part B.

Enrollment, Benefits, Eligibility

Part A	Part B	Part C	Part D
Covers inpatient hospital stays, skilled nursing facility stays, home health visits, and hospice care; subject to deductible per benefit period and coinsurance.	Covers physician visits, outpatient hospital services, DME, some drugs, diagnostic services; subject to a deductible and cost sharing for most services.	Called Medicare Advantage (“MA”) program; beneficiaries can enroll in private health plan, receive all Medicare-covered benefits.	Voluntary outpatient prescription drug benefit, with additional subsidies for beneficiaries with low incomes and modest assets; offered through private plans that contract with Medicare.

Coverage Under Part A

- Inpatient hospital services and supplies;
- General/acute care hospitals, including “specialty” hospitals like orthopedic hospitals, surgery hospitals, heart hospitals
- Skilled nursing facility (“SNF”) services and supplies
- Home health care
- Hospice care

Coverage Under Part A

- Inpatient hospital services and supplies;
- General/acute care hospitals, including “specialty” hospitals like orthopedic hospitals, surgery hospitals, heart hospitals
- Skilled nursing facility (“SNF”) services and supplies
- Home health care
- Hospice care

Coverage Under Part B

- Physician services
- Non-physician services- must be appropriately licensed and performing within scope of license (e.g., PA, NP, CRNA, clinical social workers, clinical psychologist, anesthesiologist assistant, chiropractor (for spine manipulation), dentist)
- "Incident to" services – supplies or services and not typically self-administered
- Hospital outpatient services
- Diagnostic lab, imaging (x-ray, MRI, CT, etc.) and other diagnostic tests
- Medical supplies, appliances and devices
- "Durable" medical equipment, prosthetics, orthotics
- Ambulance services
- Physical therapy and speech pathology
- Drugs and biologicals
- Home health services - overlaps with Part A
- Renal dialysis and home dialysis

Coverage Under Part B

- Physician Services – no matter where provided, but must be personally performed
- "Incident to" services
  - – Supplies, or services of another individual (e.g., physician assistant) that are integral, though incidental, part of the physician's personal services
  - – Commonly rendered without charge or included in physician's bill
  - – Typically, in physician's office
  - – Physician must be "directly supervising" (e.g., drug injections)

Coverage Under Part B

- Services furnished by specific types of facilities – all outpatient settings:

Hospital outpatient services	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
Ambulatory Surgery Centers (ASCs)	Rural Health Clinics
Independent Diagnostic Testing Facilities (IDTFs)	Federally Qualified Healthcare Centers (FQHCs)

* can include mobile or fixed locations

Coverage Under Part C

- Beneficiaries entitled to standard Medicare A/B Benefit Package; plans must offer all Original Medicare benefits.
- Plans may design cost sharing and benefit design differently than original Medicare, so long as benefit design is actuarially equivalent to original Medicare. (e.g. not required to charge 20% coinsurance to Part B beneficiaries)
- Not required to contract with all providers in service area and may have restrictive networks

Coverage Under Part C

NCD

MA plans must abide by all CMS National Coverage Determinations ("NCDs"); if a particular NCD will result in a "significant change in costs" compared to MA plan's bid, it can defer adoption of NCD for 1 year.

LCD

MA plans must apply Local Coverage Determinations ("LCDs") applicable in their region; MA plans that serve multiple regions can choose to apply an LCD across their entire plan service area.

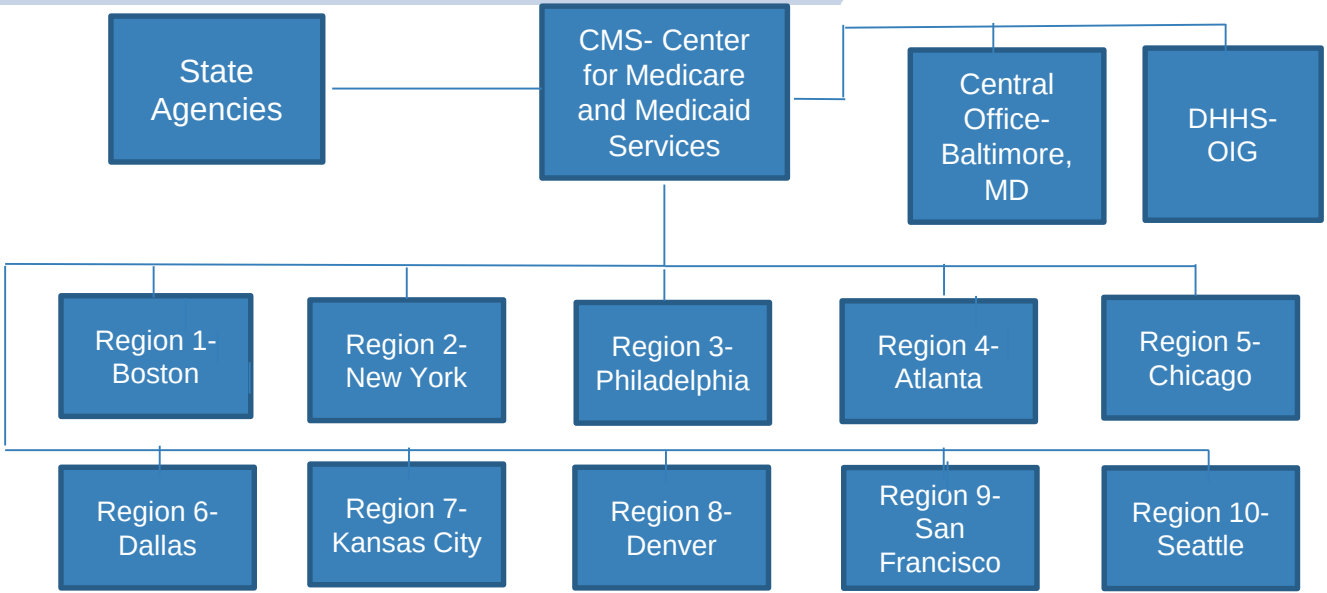
Coverage Under Part D

- Entitlement= “coverage of Part D covered drugs” or standard or actuarial equivalent prescription drug coverage and access to negotiated prices
- Four components to definition:
  - Drug must be approved by FDA
  - Can only be dispensed pursuant to a prescription
  - Must be dispensed for a “medically accepted indication”
  - Coverage not otherwise available under Part A or Part B

Coverage Under Part D

- Plan must cover at least two drugs in every category or class, although not every drug in every category or class.
- Plan may have a formulary (e.g., preferred generic, non-preferred generic, preferred brand, non-preferred brand, specialty tier)
- CMS may not require or institute a formulary, and cannot “interfere in negotiations” between manufacturers, Part D plans, and pharmacies.
- CMS must approve formulary.
- Design cannot discourages enrollment in plan.

Program Administration



Program Administration

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

Private insurers under contract with CMS for:
• provider/supplier enrollment
• claims payment;
• appeals

Practice Point- under Federal Acquisition Regulation, contractors and/or name of entity could change every year; organizations should be reviewed yearly to ensure mail is directed to the correct address.

Payment Under Part A

- Hospital Inpatient Prospective Payment System (“IPPS”)
  - – Payment for operating costs
  - – Most patient care services are reimbursed based on pre-determined flat rate
  - – Rate represents average cost nationally for treating beneficiary
  - – Regardless of actual costs or length of stay
  - – Hospital can “lose” or “win”
  - – Certain costs and adjustments are still reimbursed based on actual and reasonable cost principles

Payment Under Part A

- Steps for determining payment hospital inpatient services:

1. Assignment of Medicare Severity Diagnosis Related Group (“MS-DRG”) and MS-DRG weight
2. Multiplying MS-DRG weight by the standardized amount
3. Add-on for disproportional share and/or teaching activities
4. Additional payments for outliers
5. Other special assignment of MS-DRG and MS-DRG weight payment adjustments, if any applicable

Practice Point- MS-DRG are subject to post-payment gov. audits depending upon what issues are selected by the contractor

Payment Under Part A

- Skilled Nursing Facility (“SNF”) Prospective Payment System (“PPS”):
  - Since July 1, 1998
  - Prospectively determined per diem rate for all routine, ancillary and capital-related costs
  - RUGs instead of DRGs
  - Consolidated billing requirement
- Inpatient Rehabilitation PPS:
  - Since Jan. 1, 2002
  - 60% or more qualifying medical conditions
  - Patient classification based on assessment instrument

Payment Under Part A

- Psychiatric Facility/Unit PPS:
  - Since Jan. 1, 2005
  - Prospectively determined per diem rate
- Hospice payments:
  - Routine home care- now includes a high rate and low rate
  - Continuous home care- now includes Service Intensity Add-On
  - Inpatient respite day care
  - General inpatient day care

Payment Under Part B

- Hospital Outpatient Payment System:
  - – Similar to IPPS, except use Ambulatory Payment Classification (“APC”) instead of Diagnosis-related Group (“DRG”)
  - – No payment adjustments or outliers
  - – multiple layers of physician supervision requirements
- Physician services (until 2019):
  - – Physician Fee Schedule, based on HCPCS coding and RBRVS weighting
  - – 80% of fee schedule amount; patient 20% co-pay

Payment under Part B

- Physician fee schedule applies to:
  - Physician services
  - "Incident to" services
  - Non-physician practitioners (e.g., midlevel providers- NPs, PAs, paid 85% of fee schedule)
  - Radiology services (Professional Component- PC)
  - PT, OT and speech pathology
  - Diagnostic tests (e.g., IDTFs)

Practice Point- If compliance officer or in-house counsel, may receive questions about use of mid-level providers or other billing-related questions

Payment Under Part B

- Medicare Access and CHIP Reauthorization Act (“MACRA”)- begins in 2019
  - – “Quality Payment Program” = “value-based” payment system beginning Jan. 1, 2019
  - – Based on data collection beginning in 2017
  - – Replaces physician fee schedule
  - – End of the “sustainable growth rate” or “SGR” payment adjustment

Payment Under Part B

- Physicians choose between two paths:

1. Merit-based Incentive Payment System (MIPS), a scoring system based on:
   - Physician Quality Reporting System
   - Meaningful Use
   - Physician Value-Based Modifier
   - Clinical Practice Improvement (new)

   *measures performance beginning January 2017 with payments beginning in 2019

   *applies to physicians, PAs, NPs, clinical RNs, CRNAs
2. Advanced Alternative Payment Models (“APMs”), for physicians participating in Accountable Care Organizations (“ACOs”), Patient Centered Medical Homes (“PCMHs”)- qualify for 5% Part B incentive payments between 2019-2024; risk/reward because strict guidelines on reporting care

Payment Under Part B

- 2017 “Transition Year” = four options:
  - – Minimal reporting to avoid payment penalty
  - – Mid-level reporting to avoid payment penalty and possibly qualify for slight positive adjustment
  - – Full Merit-based Incentive Payment System (“MIPS”) reporting for either 90 days or full year
  - – Advanced Alternative Payment Model (“APM”) track

Payment Under Part B

- Clinical labs = fee schedule
- Ambulatory Surgery Centers- prospectively determined payment rates for Technical Component (“TC”)
- Part B Drugs and Biologicals- Lesser of actual charge or 106% of the average sales price, calculated for each drug code
- DMEPOS- Fee schedule, with competitive bidding program for certain DME

Payment Under Part C

- County-based- each assigned a benchmark fee for service rate
- MA plans submit bids to CMS reflecting revenue requirement for Part A/B requirement in county; if plan is below benchmark, 75% of difference is allocated to enrollee (assumes beneficiary health is risk score- 1.0)
- In 2007, CMS adjusted payments to MA plans based on relative risk of enrolled population because MA plans only enrolling health populations
- Plans submit only risk adjustment data to CMS through risk adjustment and data validation ("RADV") process; CMS also adds coding intensity to offset differences in coding and treatment patterns between the FFS section and MA plans

Issues- Part C

- Issue- the higher the risk score, the higher payment to MA plan
- CMS audits risk data using RADV process to determine data is supported by medical record documentation
- MA plans must follow specific submission guidelines

Practice Point- MA Plans are the subject of False Claims Act (“FCA”) filings where gov. has joined

Issues- Part C and D

- Federal laws supersedes any State law or regulations other than State licensing or laws relating to plan solvency
- MA plans have ultimate responsibility with compliance with CMS rules and regulations with plans contract with CMS

Practice Point- MA plans should have downstream contracts with contractors; MA plans should have compliance programs following OIG seven elements of a compliance program

Provider Enrollment

- "Provider" is a:
  - – 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

"Supplier" includes:

- – Durable medical equipment prosthetic orthotic suppliers ("DMEPOS")
- – Ambulatory Surgery Center ("ASC")
- – Independent Diagnostic Testing Facility ("IDTF")
- – Physicians

Provider Enrollment

- "Certification" = meeting Medicare's standards to be approved to participate
  - – Based on Conditions of Participation ("CoPs")
  - – Conditions for coverage (e.g., ESRD facilities)
  - – "Deemed" status (e.g. The Joint Commission)- exempt from routine surveys by State survey agencies to determine compliance with Medicare conditions.
  - – State agencies perform surveys on behalf of CMS

Medicare- Appeals

- Claims
- Cost Reports
- EHR payment incentive determinations
- Enrollment determinations
- Survey findings
- ACA Programs- Non-appealable

Medicare- Appeals

- Claims– final determination can be “reopened”
  - By MAC, or other reviewing body, on own motion or upon provider request
    - Within 1 year for any reason
    - Within 4 years for good cause (*see* 42 CFR § 405.986)
    - At any time, if initial determination procured by fraud or similar fault
    - At any time to correct “clerical errors”
  - By QIC, ALJ or The Council within 180 days for good cause or at any time if fraud

Medicare- Appeals

- Annual cost reports audit results in “Notice of Program Reimbursement” (“NPR”) which can be appealed
  - – Part A providers only (e.g. hospital)
  - – 180 days to appeal
  - – Appeal to MAC, if less than $10,000 in dispute (rare)
  - – Appeal to Provider Reimbursement Review Board (“PRRB”) for $10,000+
    - • 5-person panel of judges
    - • Specific rules and requirements – e.g., jurisdictional requirements
    - • Administrator review and federal court review available

Medicare- Appeals

- Cost report/NPR re-openings
  - Discretionary, and decision not to reopen is not appealable
  - Within 3 years for any reason
  - At any time upon evidence of fraud or similar fault

Medicare- Appeals

First Level- Redetermination	Initial redetermination by MAC – 120 days to request; 60 days to decide; 30 days to stop recoupment
Second Level- Reconsideration	Reconsideration by QIC – 180 days to request; 60 days to decide; 60 days to stop recoupment
Third Level- Administrative Law Judge	ALJ hearing – if $160 or more (2017 threshold); 60 days to request; 90 days to decide; no new evidence unless good cause; backlog
Fourth Level- Medicare Appeals Council	Medicare Appeals Council (“The Council”) – 60 days to request; 90 days to decide; backlog
Fifth Level- Federal Court	Judicial review in federal court – if $1,600 or more in dispute (2018 threshold), 60 days to request

Authority

- Statutes
  - 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
  - Social Security Act §§ 1851 – 1859 (Part C)
  - Social Security Act § 1860D-1 - § 1860D-43 (Part D)
  - 42 C.F.R. § 422 *et. seq.* (Part C)
  - 42 C.F.R. § 423 *et. seq.* (Part D)
  - Medicare Managed Care Manual
  - Medicare Prescription Drug Manual
  - Social Security Administrations Program Operations Manual
  - Annual Call Letter (2017 Call Letter finalized April 4, 2016)
- Manuals- Internet Only Manuals (“IOM”)- IOM is organized by functional area (i.e., program integrity, eligibility, entitlement, claims processing, etc.)
- NCDs, LCDs
- ALJ Decisions

Questions?

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