The National Association of
Community Health Centers, Inc.

Medicare Technical Assistance
ISSUE BRIEF #86

MEDICARE ADVANTAGE PAYMENT GUIDE

How to obtain payment for health center services provided to patients enrolled in a Medicare HMO, PPO, or PFFS plan

June 2006

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This publication was supported by Grant/Cooperative Agreement Number U30CS00209 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

Background

This Issue Brief is the third in a series of NACHC issue briefs examining how health centers should be paid for services provided to Medicare beneficiaries enrolled in private health plans under the renamed Medicare Advantage program (formerly known as Medicare+Choice program).[1]

The Medicare Advantage ("MA") program expanded the types of private health plans available to beneficiaries beyond health maintenance organizations ("HMOs") to include preferred provider organizations ("PPOs") and private fee-for-service ("PFFS") plans. Collectively, all of these types of Medicare health plans are known as Medicare Advantage ("MA") plans.

In addition, certain MA plans have the distinct feature of limiting enrollment to a particular population. A Special Needs Plan ("SNP") is a type of MA plan that restricts enrollment to beneficiaries who are eligible for both Medicare and Medicaid, i.e., "dual-eligibles", beneficiaries who reside in an institutional setting, or beneficiaries with multiple chronic conditions. SNPs tailor their programs to meet the unique needs of the populations they serve.

Other types of MA plans may limit enrollment to beneficiaries who reside in specific geographic area. For example, a Local MA plan may restrict enrollment of beneficiaries to certain counties. In contrast, a Regional MA plan serves beneficiaries in a region composed of one or more states. Local MA and Regional MA plans as well as SNPs may be any type private health plan (e.g., HMO, PPO, or PFFS plan).

Regardless of the type of MA plan a beneficiary is enrolled in, each plan is required to provide all Medicare covered benefits, including FQHC services. However, the payment amount to health centers will vary, depending on whether the health center is a contracted provider of the MA plan, i.e., whether the health center participates in the MA plan's provider network.

This Issue Brief is divided into three parts. Part I provides health centers with a summary of payment rules applicable to patients enrolled in a MA plan. Depending on the services provided by a health center, this Part describes how the payment amount is calculated and the entity to which the health center must submit claims for payment.

[1] Health centers should be careful to distinguish between beneficiaries enrolled in a Medicare Advantage ("MA") plan with those enrolled in the original Medicare program who purchase a supplemental Medicare insurance policy (i.e., Medigap). For example, one type of Medigap policy known as "Medicare Select" operates a PPO-like plan in which beneficiaries have reduced cost-sharing when they select providers who participate in the plan.

Part II provides guidance to assist health centers with becoming contracted providers to MA plans so that they become eligible to receive supplemental wrap-around payments. This Part explains what provisions need to be included in MA contracts and provides a sample contract addendum that may be used to amend MA contracts.

Finally, Part III explains what information health centers need to provide to fiscal intermediaries in order for wrap-around payments to be processed. This Part includes worksheets for converting MA contract rates to per-visit payment rates.

Part I

Payment Rules Applicable to Patients Enrolled in Medicare Advantage Plans

Health centers are entitled to payment for providing any Part B service (e.g., FQHC services, x-ray, or laboratory) to Medicare beneficiaries. This is true regardless of whether the health center has contracted with the particular MA plan to participate as a provider. In other words, health centers are entitled to payment from MA plans as either a participating or non-participating provider.[2]

However, health centers will be paid different amounts based on whether the health center has a contract with the MA plan. In general, health centers that contract with MA plans will receive higher total payments. Additionally, health centers will be paid different amounts based on whether the health center is providing Part B "FQHC services" or other Part B services (e.g., x-ray or laboratory services).

In contrast, health centers will not always be entitled to payment for Part D pharmacy services. As described below, this can occur despite the health center having a contract with the specific MA plan in which the patient is enrolled.

The following discussion reviews the payment rules for health centers under the Medicare Advantage program. ***Table 1 also provides these payment rules in summary form.***

[2] Patients usually have higher cost-sharing obligations when they receive services from non-participating providers. As a result, a portion of the payment for services could be imposed on the beneficiary, not the MA plan.

FQHC Services (a Part B service)

Whenever a health center provides FQHC services, the health center should submit claims to the MA plan in which the beneficiary is enrolled. FQHC services are defined by statute as services provided by a physician, physician assistant, nurse practitioner, clinical psychologist, or clinical social worker, or qualified practitioner of diabetes self-management training and medical nutrition therapy, as well as preventive primary health services under Section 330 of the Public Health Service Act, when such services are furnished to an individual as an outpatient of an FQHC. 42 U.S.C. § 1395x(aa)(3); Section 5114 of the Deficit Reduction Act of 2005.

If a health center has a contract with a MA plan, then the amount the health center will be paid will be governed by the contract. In addition, the health center will qualify for a supplemental wrap-around payment when it provides FQHC services, bringing total payment for the health center to 100 percent of reasonable costs, up to the Medicare per-visit limit. 42 C.F.R. § 405.2469. Health centers must submit an additional claim to its Fiscal Intermediary (e.g., UGS) to obtain the supplemental wrap-around payment. 42 C.F.R. § 422.316.

It is important to emphasize that the lack of a contract with a MA plan does not disqualify a health center from receiving payment for FQHC services it provides to Medicare beneficiaries enrolled in MA plans. In such cases, a health center will be entitled to payment at the rate it receives under original Medicare, i.e., 80% of reasonable costs up to the per-visit limit. 42 C.F.R. §§ 422.214, 422.216.

According to CMS, the MA plan must pay the health center 80% of its reasonable costs (up to the per-visit limit), plus 20% of its actual charges, less the plan's applicable co-pay.[3] However, health centers should be aware that the MA plan's applicable co-pay may be higher for services furnished by non-contracted providers than by contracted providers.

Other Part B Services

Whenever a health center provides services covered under Part B but which are not FQHC services (e.g., laboratory, x-ray, durable medical equipment), the health center should submit a claim to the MA plan in which the beneficiary is enrolled. Because wrap-around payments are not available for these Part B services, health centers should only submit claims to the MA plan, not to the Fiscal Intermediary.

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[3] The Centers for Medicare and Medicaid Services ("CMS") has published a guide to help MA plans in situations they are required to pay the original Medicare rate to out-of-network providers. The payment formula for FQHCs is specifically included in this guide. A link can be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.

Similar to FQHC services above, the payment amount for other Part B services depends on whether the health center has a contract to be a participating provider with the MA plan. For health centers that have contracts, the amount of reimbursement will be established in the contract with the MA plan.

For health centers that do not have contracts, the amount of reimbursement is the amount that could be collected under original Medicare, i.e. the fee-for-service ("FFS") rate. The amounts under the MA contract may be higher or lower than the original Medicare FFS rate.

Part D Pharmacy Services

Unlike Part B services, a health center should not expect payment for pharmacy services provided to enrollees of MA plans. That is because a health center may participate as a provider of physician services in a MA plan, but not be part of the same plan's pharmacy network. Because most physicians do not provide pharmacy services, MA plans typically contract separately for pharmacy services. In fact, many MA plans contract with a pharmacy benefit manager ("PBM") to arrange for such pharmacy services.

As a result, a health center that contracts with a MA plan for physician services should not presume that the health center pharmacy is a contracted provider for pharmacy services under the same MA plan. Similarly, a health center may participate in the PBM's pharmacy network that serves an MA plan, but not have a contract for Part B services with the MA plan.

If the health center participates in the pharmacy network that the patient is enrolled in, then the health center should submit claims for payment as that contract provides. Medicare does not provide wrap-around payments for Part D pharmacy services.

However, unlike Part B services, if the health center does not have a contract to provide pharmacy services with the network that the patient is enrolled in, then the health center is not entitled to payment. <u>This is the only situation in which a health center provides a Medicare covered service but is not entitled to payment from either the plan or the Fiscal Intermediary.</u>

TABLE 1

Summary of Payment Rules for Health Centers under Medicare Advantage

Relationship to MA plan	Service Provided	Total Reimbursement	Amount Due from MA Plan[4]	Amount Due from Medicare	Amount Due from Beneficiary[5]	Submit Claim to
Health center is a contracted provider of MA Plan	Part B FQHC services[6]	100% of reasonable costs (up to per-visit limit)	Contracted payment rate, less plan's cost-sharing amount	Wrap-Around Payment	Plan's cost-sharing amount	MA Plan **and** Medicare FI (i.e., UGS)
	Other Part B services, e.g., laboratory, x-ray	Contracted payment rate (if contract covers such services)	Contracted payment rate, less plan's cost-sharing amount	None	Plan's cost-sharing amount	MA Plan
	Pharmacy Services	If health center pharmacy is part of pharmacy network, then contracted payment rate.	Contracted payment rate, less plan's cost-sharing amount	None	Plan's cost-sharing amount	MA plan
		If health center pharmacy is not part of pharmacy network, then none.	None	None	100% of health center's actual charges	N/A
Health center is **not** a contracted provider of MA Plan	Part B FQHC services[6]	80% reasonable costs (up to per-visit limit), plus 20% of the actual charges, less plan's cost-sharing amount		None	Plan's cost-sharing amount	MA Plan
	Other Part B Services, e.g., laboratory, x-ray	Part B FFS rate, less plan's cost-sharing amount		None	Plan's cost-sharing amount	MA Plan
	Pharmacy Services	If health center pharmacy is part of pharmacy network, then contracted payment rate.	Contracted payment rate, less plan's cost-sharing amount	None	Plan's cost-sharing amount	MA Plan
		If health center pharmacy is not part of pharmacy network, then none.	None	None	100% of health center's actual charges	N/A

[4] The amount of the plan's cost-sharing amount is deducted from the contracted payment rate regardless of whether that amount is actually collected from the patient or waived (or reduced) under the health center's sliding scale.
[5] A beneficiary may be eligible for reduced cost-sharing and charges under the health center's sliding scale.
[6] To be included as a billable visit, the FQHC service must be provided in a face-to-face encounter by a physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, or qualified practitioner of Outpatient Diabetes Self-Management Training Services (DSMT) or medical nutrition therapy (MNT) services.

Part II

Contracting with Medicare Advantage Plans

Wrap-Around Requirements

In order to receive wrap-around payments from Medicare, a health center must have a written contract with the MA plan that contains certain terms specified by regulation. 42 C.F.R. § 422.527. Health centers that contract with another entity, such as an IPA, that has a contract with a MA plan will still satisfy this requirement.

As specified by regulation, health center contracts with MA plans must contain the following three contract terms.

(1) The MA plan must pay health centers a similar amount to what it pays other providers for similar services. [42 C.F.R. § 422.527(a)]

By statute, a similar amount means an amount "not less than the level and amount of payment" that the MA plan would pay for such services if provided by a non-FQHC provider. 42 U.S.C. § 1395w-27(e)(3)(A).

CMS has indicated that it will examine MA contracts to ensure that payment levels for health centers are similar to other providers furnishing similar services to MA plans.

Health centers should consider including a provision in their contracts with MA plans in which the MA plan warrants or represents that the payment rates to the health center are at least the same amount and level the plan would pay if the same services were furnished by a non-FQHC provider.

(2) The FQHC must accept the plan's payment as payment in full, except for allowable cost sharing. [42 C.F.R. § 422.527(b)]

By federal statute, the written contract must state that the health center accepts the MA plan's payment amount and wrap-around payment "as payment in full for services covered by the agreement, except that such health center may collect any amount of cost-sharing permitted under the contract" so long as those amounts are consistent with Medicare limits. 42 U.S.C. § 1395w-27(e)(3)(B).

Health centers should include a provision that closely adopts that specific statutory language.

(3) Financial incentives, such as risk pool payments or bonuses, and financial withholdings, are not considered in determining the payments made by CMS as wrap-around payments. [42 C.F.R. § 422.527(c)]

CMS will not consider financial incentives paid by MA plans as part of the rate paid to health centers for the purpose of calculating wrap-around payments. Because these amounts are excluded from wrap-around payments, any financial incentives will be paid in addition to the MA plan payment and wrap-around payment. This allows for the potential for health centers to receive, in combination, total payment that exceeds 100% of reasonable costs or the per-visit limit.

Health centers would be well-advised to ensure that the MA contract clearly distinguishes between amounts paid for furnishing services under the contract and any financial incentives paid to the health center. To that end, health centers should request that such payment types be described in separate sections of the contract.

All three of the previous terms must be included in a MA contract for a health center to receive wrap-around payment. If the MA plan uses a standard contract for all physician providers, then the health center should return the contract with an addendum that includes the required terms.

To assist health centers with complying with these requirements, a sample contract addendum is provided at the end of this Part.

Payment for Other Services

If a health center wishes to be a network provider of Part B covered services which are not FQHC services such as laboratory or x-ray services, then the health center will need to ensure that its contract with the MA plan covers the provision of those services. To that end, the health center may wish to include a separate fee schedule in its contract with the MA plan related to the provision of those services.

Part D Pharmacy Services

In addition, if a health center provides pharmacy services, then it should request a contract with the MA plan's PBM in order to become part of the MA plan's pharmacy network. This will permit health center patients enrolled in an MA plan to obtain both physician and pharmacy services at the health center.

MEDICARE ADVANTAGE CONTRACT ADDENDUM FOR FEDERALLY QUALIFIED HEALTH CENTERS

This Addendum ("Addendum"), amends the Agreement dated _____ (the "Agreement") by and between _____ ("Provider") with _____ _____ ("Plan") (together, the "Parties"), and is executed on _____, _____, 200 _____.

WHEREAS, Provider is a federally qualified health center ("FQHC") as defined under Section 1861(aa)(4) of the Social Security Act [42 U.S.C. § 1395x(aa)(4)] that provides a wide range of high quality and cost-effective health care services;

WHEREAS, Plan is a Medicare Advantage ("MA") plan as defined in 42 C.F.R. § 422.2 that provides health benefits coverage to Medicare beneficiaries under a policy or contract by the Plan's sponsoring organization with the Centers for Medicare and Medicaid Services ("CMS");

WHEREAS, Provider is eligible to receive supplemental "wrap-around" payments pursuant to Section 237 of the Medicare Prescription Drug Improvement and Modernization Act [42 U.S.C. § 1395w-23(a)(4)] and 42 C.F.R. § 422.316; and

WHEREAS, in order for Provider to receive such wrap-around payments, the Agreement must include certain terms as specified at 42 C.F.R. § 422.527.

Now, therefore, in consideration of the mutual covenants herein contained, the Parties hereto agree as follows:

1. Warranties

(a) Plan warrants that the payments made to a Provider under [section and paragraph] of the Agreement are at least the same amount and level the plan would pay if the same services were furnished by a non-FQHC provider.

(b) The payments described under paragraph (a) and specified in the Agreement at [section and paragraph], are exclusive of any financial incentives available to the Provider, such as risk pool payments or bonuses, or financial withholdings, which are separately provided for in the Agreement at [section and paragraph].

2. Acceptance

Provider accepts the Plan's payments as specified in the Agreement (other than the wrap-around payment) as payment in full for services covered by the Agreement, except that Provider may collect cost-sharing amounts established by the Plan, so long as these amounts comply with the requirements under 42 U.S.C. § 1395w-24(e).

3. Conflicts

To the extent that any provision of the Agreement is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede the Agreement's provisions.

IN WITNESS WHEREOF, authorized representatives of the Parties set their hands as of the date first written above.

By: _____	By: _____
Provider: _____	Plan: _____

Part III

Obtaining Wrap-Around Payments

United Government Services ("UGS") is currently the Fiscal Intermediary for health centers. UGS will calculate wrap-around payments as the difference between an FQHC's approved per-visit rate (i.e., what the FI pays under original Medicare) and the average MA per-visit rate (i.e., how much the average MA plan will pay).

Because MA contract rates are not typically expressed as per-visit rates, health centers will need to convert fee schedules or capitation amounts to a per-visit rate, prior to calculating an average MA per-visit rate. UGS will need to know this average MA per-visit rate to process claims for wrap-around payments.

To that end, UGS has requested that health centers identify each MA plan, provide copies of each MA plan contract, and provide documentation of how it calculated the average MA per-visit rate. These estimates will be used to calculate wrap-around payments until actual MA payments are reflected on health center cost reports.

Based on information NACHC has received from UGS, this Part provides information on how to calculate (and document) a health center's average MA per-visit rate.

Rate Calculation

The following steps offer a method for converting MA payment rates (expressed as either a FFS rate or capitation rate) to an average per-visit rate.[7]

Step 1: Identify each contract the health center has with an MA plan.

MA Number	Plan Name	Contract Term

[7] Typically, MA contract rates are inclusive of any applicable patient cost-sharing amount, e.g., deductible or co-payment. Thus, cost-sharing amounts will not need to be provided to UGS.

Step 2: For each MA plan, calculate the payment rate as a per-visit rate using the method appropriate to the type of payment rate, i.e., FFS or capitation.

Example: Fee-For-Service (FFS) Rate Conversion

Proc Code	Procedure Description[8]	Estimated Units[9]	Plan Rate	Weighted Rate[10]
99201	INITIAL OFFICE VISIT, FOCUSED	2	$ 36.32	$ 73
99202	INITIAL OFFICE VISIT, EXPANDED	62	$ 64.67	$ 4,010
99203	INITIAL OFFICE VISIT, DETAILED	30	$ 96.17	$ 2,885
99204	INITIAL OV, COMPREHENSIVE, MOD. COMPL	21	$136.35	$ 2,863
99205	INITIAL OV, COMPREHENSIVE, HIGH COMPL	3	$ 173.01	$ 519
99211	ESTABLISHED OV, MINIMAL	38	$ 21.16	$ 804
99212	ESTABLISHED OFFICE VISIT, FOCUSED	411	$ 38.15	$ 15,680
99213	ESTABLISHED OFFICE VISIT, EXPANDED	3,596	$ 52.25	$ 187,891
99214	ESTABLISHED OFFICE VISIT, DETAILED	781	$ 82.04	$ 64,073
99215	ESTABLISHED OV, OMPREHENSIVE	58	$ 119.70	$ 6,943
99387	PREV. MED. NEW PT. 65 AND OVER	7	$ 150.87	$ 1,056
99397	PREV. MED. ESTABLISHED OVER 65	191	$ 118.28	$ 22,591
	Totals	5,200		$ 309,388
	Per-Visit Rate[11]			**$59.50**

Source: United Government Services (UGS).

[8] This is a sample list of procedures. Health centers should include all of the procedures that are covered under the FQHC benefit.
[9] "Units" is the health center's estimate of the number of patients who will receive a particular procedure/service.
[10] "Weighted Rate" is the plan rate multiplied by the number of units.
[11] "Per-Visit Rate" is a total of the weighted rates divided by the total number of estimated units.

Example: Capitation Rate Conversion

Age	PMPM	Annualized Capitation per 100	Estimated Visits per 100[12]	Per-Visit Rate[13]
1-12	$13.32	$15,984	299.38	$53.39
13-18	$27.55	$33,060	620.38	$53.29
19-36	$34.35	$41,220	765.60	$53.84
37+	$46.42	$55,704	990.64	$56.23
	Per-Visit Rate			**$54.19**

Blank worksheets, which should be duplicated for each MA contract, begin on the next page.

[12] This is the health center's estimate of the number of visits per 100 enrollees assigned to the health center.

[13] "Per-Visit Rate" is the annualized capitation payment divided by the number of estimated visits.

WORKSHEET FOR CALCULATING PER-VISIT PAYMENT RATE

Fee-for-service (FFS) Rate Conversion

MA NUMBER __________________________

MA PLAN NAME _______________________

Proc Code	Procedure Description	Estimated Units[14]	Plan Rate	Weighted Rate[15]
		Totals		
		Per-Visit Rate[16]		

Per-Visit Rate: ____________________

[14] "Units" is the health center's estimate of the number of patients who will receive a particular procedure/service.
[15] "Weighted Rate" is the plan rate multiplied by the number of units.
[16] "Per-Visit Rate" is a total of the weighted rates divided by the total number of estimated units.

WORKSHEET FOR CALCULATING PER-VISIT PAYMENT RATE

Capitation Rate Conversion

MA NUMBER _____

MA PLAN NAME _____

Age	PMPM	Annualized Capitation per 100	Estimated Visits per 100[17]	Per-Visit Rate[18]
		Per-Visit Rate		

Per-Visit Rate: _____

[17] This is the health center's estimate of the number of visits per 100 enrollees assigned to the health center.
[18] "Per-Visit Rate" is the annualized capitation payment divided by the number of estimated visits.

Step 3: Calculate the average MA per-visit payment rate across all MA plans, weighted by the number of enrollees in each plan.

Example:

MA Number	MA Plan	Enrollees	Weighted Enrollment	Per-Visit Rate	Weighted Rate[19]
12345	A	520	15.48%	$ 59.50	9.21
12346	B	640	19.05%	$ 54.19	10.32
12347	C	250	7.44%	$ 51.58	3.84
12348	D	800	23.81%	$ 57.41	13.67
12349	E	1000	29.76%	$ 59.37	17.67
12350	F	150	4.46%	$ 53.82	2.40
	Totals	3360			
	Average MA Per-Visit Rate[20]				$ 57.11

Submitting Documentation for Wrap-Around

Health centers should file the appropriate documentation supporting wrap-around with UGS after it has entered a contract with an MA plan. Although UGS has not established a deadline for receiving this information, health centers will not be able to submit claims for wrap-around payments until UGS has received and verified such information.

Submitting Claims for Payment

Only after UGS verifies the documentation submitted and notifies a health center of its supplemental wrap-around rate may the health center begin to submit claims for wrap-around payments. Such claims should be submitted using a 73x type of bill and 0519 revenue code.

UGS will begin to process claims for wrap-around payments after June 4, 2006.

[19] "Weighted Rate" is the plan's weighted enrollment multiplied by the plan's per-visit rate.
[20] "Average MA Per-Visit Rate" is the sum of each plan's Weighted Rate.

Conclusion

To maximize revenue, health centers should understand how they will be paid under the Medicare Advantage program and take steps to contract appropriately with MA plans so that they are eligible to receive supplemental wrap-around payments.

After a health center signs a contract with an MA plan, it must provide documentation to UGS that will allow it to process claims for wrap around payment. This documentation must explain how the health center converted its MA payment rates to a per-visit rate and must include the filing, or refiling, of its calculation of the average MA per-visit payment rate.

For more questions about contracting under the Medicare Advantage program, contact Roger Schwartz, NACHC's Legislative Counsel, at rschwartz@nachc.com.