What is Medicare Advantage?

- Medicare beneficiaries were first given the option to receive their Medicare benefits through private health plans in the 1970's.
- Balanced Budget Act of 1997 named these plans Medicare+Choice.
- Medicare Modernization Act of 2003 renamed these plans Medicare Advantage.
- Authorized by Part C of Title XVIII of the Social Security Act and administered by CMS.
- Often referred to as Medicare Part C.
Who is enrolled?

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2016

In millions of people:

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
</tr>
<tr>
<td>2000</td>
<td>6.8</td>
</tr>
<tr>
<td>2001</td>
<td>6.2</td>
</tr>
<tr>
<td>2002</td>
<td>5.6</td>
</tr>
<tr>
<td>2003</td>
<td>5.3</td>
</tr>
<tr>
<td>2004</td>
<td>5.3</td>
</tr>
<tr>
<td>2005</td>
<td>5.6</td>
</tr>
<tr>
<td>2006</td>
<td>6.8</td>
</tr>
<tr>
<td>2007</td>
<td>8.4</td>
</tr>
<tr>
<td>2008</td>
<td>9.7</td>
</tr>
<tr>
<td>2009</td>
<td>10.5</td>
</tr>
<tr>
<td>2010</td>
<td>11.1</td>
</tr>
<tr>
<td>2011</td>
<td>11.9</td>
</tr>
<tr>
<td>2012</td>
<td>13.1</td>
</tr>
<tr>
<td>2013</td>
<td>14.4</td>
</tr>
<tr>
<td>2014</td>
<td>15.7</td>
</tr>
<tr>
<td>2015</td>
<td>16.8</td>
</tr>
<tr>
<td>2016</td>
<td>17.6</td>
</tr>
</tbody>
</table>

% of Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>18%</td>
</tr>
<tr>
<td>2000</td>
<td>17%</td>
</tr>
<tr>
<td>2001</td>
<td>15%</td>
</tr>
<tr>
<td>2002</td>
<td>14%</td>
</tr>
<tr>
<td>2003</td>
<td>13%</td>
</tr>
<tr>
<td>2004</td>
<td>13%</td>
</tr>
<tr>
<td>2005</td>
<td>13%</td>
</tr>
<tr>
<td>2006</td>
<td>16%</td>
</tr>
<tr>
<td>2007</td>
<td>19%</td>
</tr>
<tr>
<td>2008</td>
<td>22%</td>
</tr>
<tr>
<td>2009</td>
<td>23%</td>
</tr>
<tr>
<td>2010</td>
<td>24%</td>
</tr>
<tr>
<td>2011</td>
<td>25%</td>
</tr>
<tr>
<td>2012</td>
<td>27%</td>
</tr>
<tr>
<td>2013</td>
<td>30%</td>
</tr>
<tr>
<td>2014</td>
<td>31%</td>
</tr>
<tr>
<td>2015</td>
<td>31%</td>
</tr>
<tr>
<td>2016</td>
<td>31%</td>
</tr>
</tbody>
</table>

NOTE: Includes MSA, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2016

National Average, 2016 = 31%

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2016.
Why choose Medicare Advantage?

- Medicare Advantage plans must provide beneficiaries basic Medicare benefits, but the plans can also expand on those benefits and networks.
- One of the most advantageous benefits for seniors, is the lower yearly maximum out of pocket.
- Additional coverage- vision, dental, nursing home, etc. may be available.
- Privatization is supposed to equal better and cheaper access to care.
Change to Medicare Advantage under PPACA

- Reduces payments to the plans over time, in order to bring them closer to the average cost of care under traditional Medicare.
- Provides for bonus payments to plans based on quality ratings
- Beginning in 2014, plans must maintain a Medical Loss ratio of at least 85%, reducing the share of premiums used for administrative costs and profit.
**Types of Plans**

Private Fee for Service - Closest to Traditional Medicare

- Enrollment in this type of plan has declined significantly
- In 2016, estimated to account for only 1% of Medicare Advantage enrollment

HMO/PPOs - Contract with Provider Networks to Deliver Medicare Benefits

- HMO’s account for 64% of the MA enrollment in 2016
- PPO’s account for 23% of the MA enrollment in 2016

Other plans include:

- Regional PPO’s (7%)
- Other Private Plans (4%)
- Special Needs Plans
Medicare Advantage contractors administer their plans and benefits under their contracts with the Federal Government and under Federal Law.

The State is only involved in licensing the plans and to some extent monitoring solvency. Therefore, State Law does not apply.

The relevant claims arise under the Medicare Act.

Medicare Advantage Plans are not private insurers offering private insurance. They are government contractors, administering government benefits.
Is it an Insurance Policy?

- The short answer is no
- The beneficiaries are not purchasing or applying for a policy. They are electing a way to receive their Medicare benefits through a statutory framework.
- Therefore, they have no contractual policy rights. All disputes must be handled through the Medicare appeals process, just as with traditional Medicare benefit determination appeals.
- Providers also likely must exhaust the Medicare Appeals process prior to engaging in litigation
Contracted vs. Non-Contracted Plans

- Fee for Service plans follow all traditional Medicare Rules and Regulations and payment schedules.
- HMO and PPO plans may include some additional contractual requirements on providers and/or clarify or add to traditional Medicare requirements and fee schedules.
- All Medicare Advantage plans are to provide basic services and make payment to all contracted and non-contracted providers in a timely manner and in accordance with Medicare law.
Deemed Provider

- Applies only to MA Private Fee for Service Plans
- 2 criteria:
  - The provider is aware in advance of furnishing services, that the patient is enrolled in a PFFS plan.
  - The provider has reasonable access to the plan’s terms and conditions of payment.
    - Reasonable access exists if you can call, fax, email, mail, or view a website.
- The provider does not have to accept a PFFS patient (except in emergency situations). However, once the service is provided, if the provider had advanced knowledge, they will be deemed contracted provider.
What do they pay?

- What you agreed to in your contract OR no less than the Medicare Rate
- Medicare coverage and payment is contingent upon a determination that:
  - A service is in a covered benefit category;
  - A service is not specifically excluded from Medicare coverage by the Act; and
  - The item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member, or is a covered preventive service.
- MA plans need not follow Original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.
Medical Necessity

- MA plan must have policies and procedures- coverage rules, practice guidelines, payment policies, utilization management, for medical necessity determination.
  - Therefore, they should provide it or be able to direct it to you, if you ask.
- All fully or partially adverse medical necessity decisions are to be reviewed by a licensed physician or healthcare professional, before being issued.
  - Ask for proof of review
- Medicare Program Integrity Manual- If the plan approved the furnishing of services through an adverse determination of coverage, it may not later deny for lack of medical necessity.
Common MA Pitfalls

Pre-Certification
• Look to Medicare Regulations and/or Contracts
• ER Patient Status Changes
• Additional Contractual Requirements listed on websites

Emergency Services
• Providers required to treat patient and accept the plan

Provider Network Changes
• Bills have been introduced into Congress limiting the MA plans ability to make changes

Implied Contract
• Statements in pre-registration
• Not providing notification on non-coverage

Appeals
• Missing Deadlines for Medicare Appeal Process
Does the Provider have to accept Medicare Rate from a non-contracted MA plan?

- The short answer is yes, in most situations, if you accept the patient, provide the service, and bill the MA plan.
  - The only way around this is to explicitly tell the patient you do not accept the coverage before treatment and not bill the plan.
- CFR 422.214 (b)
  - Non contracted provider must accept as Payment in Full the amounts it could collect if the beneficiary was enrolled in traditional Medicare
Assignee

- Assignee: A non-contract physician or other non-contract provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

- A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal. Completing that waiver makes the provider an assignee.
Employee Retirement Income Security Act of 1974
ERISA is Federal Law so it preempts all State Law
Applies to Self-Funded health plans
  Can be difficult to tell a plan is ERISA based on a Health Insurance Card
  Access to Plan Documents
The law is mostly Fiduciary in nature. Very little substantive health plan regulation.
Section 503

Plans subject to ERISA are required to maintain reasonable claims procedures and to allow for a full and fair review of denied claims. The regulations under ERISA section 503 set forth numerous requirements regarding claims and appeals, including the following:

1. A description of the process must be included in the summary plan description;
2. No fee to file or other requirement may be imposed that unduly inhibits claimants;
3. In determining claims, the provisions of the plan must be consistently applied;
4. The process must comply with certain time periods in responding to both claims and appeals, with the time periods varying depending on the type of claim (for example, emergency care claims must be responded to on an expedited basis);
5. Notices of adverse determinations must include specific items regarding the determination and a description of the review process;
6. Appeals must be determined by a fiduciary who is not the person who made the decision being reviewed (or his or her subordinate), and no deference may be given to the earlier decision; and
7. The process may not require more than two levels of internal appeals before the claimant may file an action in court, and the claimant's right to sue cannot be eliminated (for example, the plan cannot require arbitration).
Timing

- ERISA’s regulations provide that a health insurer must respond to a claim within 30 days of receiving it.
- If the insurance company needs more time to consider the claim, it must notify the medical provider that it needs additional time.
- If the notification for more time is sent before the 30 days expires, then the insurer gets an additional 15 days.
- If the health insurer does not meet either the initial 30-day deadline or an extended deadline, the late-arriving explanation of benefits (EOB) is invalid.
- EOBs must contain specifics. A non specific EOB, is equal to no EOB at all.
ERISA Standing

2 Ways Providers Pursue ERISA claims

1) **Direct Standing** as a beneficiary under ERISA
   
   • Most courts have declined to recognize providers as beneficiaries

2) **Derivative Standing** through assignment of right’s clause in admission agreements
Anti-Assignment Clauses

What happens if the plan documents contain an anti-assignment clause?

• Bloom v. BCBS- July 2015- Eastern District Court
  • Even with an anti-assignment clause, the providers may have derivative Standing
    • Clause may be unenforceable, if it is ambiguous
    • Clause may be waived by the plan making past payments to the hospital
  • However, there remains a 50/50 split at the District and Circuit Court level regarding anti-assignment clauses. There does seem to be agreement that the defense may be waived if not presented early.

• Providers should include assignment with appeals letters
Reasonable Charges and ERISA

ERISA’s provisions, set forth in 29 U.S.C. § 1104(A), (B), and (D), require fiduciaries of the Plan to act prudently and pay only the reasonable expenses incurred by the Plan.

Non-contracted plans use this provision to reprice claims. Providers do have the option to appeal, however, many times they ask the Provider to sign a non-recourse provision. Additionally, due to Federal Preemption the Provider’s rights in Court may be limited.
Contact Information

Elizabeth S. Richards, Esq.
Divisional Vice President
(770) 261-1065
Elizabeth.Richards@bolderhealthcare.com
www.avectushealth.com

AVECTUS
aBOLDER Healthcare company