Medicare Advantage Contract Terms

Medicare Advantage plans each develop their own standard contract template for hospitals and other health care facilities. These template agreements must contain certain minimum provisions mandated by federal CMS regulations. They often contain common terms that may not be required by law, but are best practices in contract formation for managed care agreements. Medicare Advantage plan contracts also may contain terms that are neither required, nor necessarily favorable to the hospital. Recognizing in which category a provision falls and options for requesting revisions is critical to formulating a strong agreement to protect the hospital.

Managed Care Agreement Basics

Typically, major payors develop a base agreement with terms that apply to all plans and products a company offers. Often, additional documents are appended to this base agreement with state-specific terms; regulatory requirements for specific plans; and fee schedules for various products. Companies that only offer Medicare Advantage plans may combine all of these into a single contract document.

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Kansas Hospital Association

Medicare Advantage Required Terms

Definitions

Hospital Responsibilities

Plan Responsibilities

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Medicare Advantage Plan Contracts Requirements

No Interference with Medical Advice

42 C.F.R 422.206

MA plan cannot prohibit provider from advising or advocating for a patient about health status, medical care, or treatment options; risks, benefits, and consequences of treatment or non-treatment; nor rhe opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

No Requirement to Indemnify Plan

42 C.F.R 422.212

MA plan cannot require hospitals indemnify the Medicare Advantage organization against any civil liability for damage caused to an enrollee as a result of the MA organization's denial of medically necessary care.

Balance Billing

42 C.F.R 422.216

Providers are limited to billing MA members cost sharing amounts and balance billing amounts permitted under the plan at no more than 15% above the contract rate established under the contract. The MA organization must require the hospital, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to not less than $500— (i) Notice that balance billing is permitted for those services; (ii) A good faith estimate of the likely amount of balance billing, based on the enrollees presenting condition; and (iii) The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

Provider Credentialing

42 C.F.R 422.216

Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements.

Preclusion List

42 C.F.R 422.222

An MA organization must not make payment for a health care item, service, or drug that is furnished, ordered, or prescribed by an individual or entity that is included on the preclusion list.

Exclusion List

42 C.F.R 422.224

An MA organization may not pay, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General (OIG) or is included on the preclusion list.

Definitions

Balance Billing

Balance billing generally refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer (for example, the original Medicare program) will pay for the service plus any cost-sharing by the individual. Source: 42 C.F.R. 422.2

Clean Claim

Kansas law: a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Kansas health care prompt payment act. Source: K.S.A. 40-2441

Medicare Advantage: a claim that has no defect, impropriety, lack of any required substantiating documentation that prevents timely payment. Source: 42 C.F.R. 422.500

Covered Service

Items and services for which a member is entitled to receive benefits under the terms and benefits of a health plan.

Clean Claim Considerations

- Whether a claim is 'clean' impacts whether interest and penalties accrue for a plan's failure to pay the clean claim promptly

- Laws do not explain how pre- and post-payment reviews of claims impact interest and penalties. Ideally, these scenarios can be addressed contractually.

Covered Service Considerations

- Often, providers are prohibited from balance billing patients for covered services above the negotiated allowable amount.

- Agreements may not specify whether patients can be balance billed for non-covered services. Ideally, this is clarified and addressed in writing.

- Contracts may not clarify whether services deemed not medically necessary are non-covered, which can impact whether patients could be held financially responsible.

Emergency Condition, Services

EMTALA: acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs. Source: 42 C.F.R. 489.24

Kansas: the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. K.S.A. 40-4602, 40-22a13

Medicare Advantage: a medical condition, mental or physical, manifesting by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual; serious impairment to bodily functions; serious dysfunction of any bodily organ or part. Source: 42 C.F.R. 422.113

Emergency Service Considerations

Where multiple definitions exist, consider either creating a single definition combining all elements or establishing different definitions based upon the law that applies.

Definitions

Good Cause

New and material evidence is presented, or there was a clear error on the face of evidence used to make a determination.

Medically Necessary, Medical Necessity

Kansas: any goods, service, item, facility, or accommodation, that a reasonable and prudent provider under similar circumstances would believe is appropriate for diagnosing or treating a recipient's condition, illness or injury. Source: KSA 21-5926

**Note: definition falls under Medicaid laws and is not binding on commercial plans; commercial insurance laws don't define medical necessity.*

Medicare Advantage: items and services reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Source: Social Security Act 1862(a)(1)

Organization Determination

A decision regarding the benefits a member is entitled to receive under an MA plan which can include basic Medicare benefits and mandatory and optional supplementary benefits. Organization determinations also include the amount the member is required to pay for care. Organization determinations include the plan's refusal to provide or pay for services, in whole or in part including the type or level or services and also include the MA plan's failure to approve, furnish, arrange for, or provider payment for services in a timely manner. Source: 42 C.F.R. 422.566

Policy, Protocol

Policies, procedures, protocols of the health plan including, but not limited to, claims processing requirements, appeal procedures, provider manuals, clinical policy bulletins, and other documents as modified from time to time.

Covered Service Considerations, *cont.*

Consider specifying that covered services for MA plans include all those basic Medicare benefits available to members under traditional Medicare under terms and conditions that are no more restrictive than traditional Medicare.

Medical Necessity Considerations

Consider adding language clarifying how plan medical necessity determinations are made, referencing 42 C.F.R. 422.101. These regulations require MA plans determine medical necessity based on traditional Medicare benefits, NCDs, *applicable* LCDs, and the member's unique medical history.

Policy, Procedure, Protocol Considerations

Defining policies, procedures and protocols is important. Plans often create new policies and revise existing policies frequently. Agreements require Hospital follow these policies *See Hospital Responsibilities.* Consider clarifying what types of documents constitute policies, including any document that Hospital is held to in making claim determinations regardless of the title used for such document (e.g. manual, guideline)

Organization Determination Considerations

Any refusal to provide or to pay for services, in whole or in part, is an organization determination regardless of the name a plan ascribes to the action (e.g. payment review). Detailing what constitutes an organization determination is important so that *adverse* determinations can be defined. Rights and recourse for adverse determinations are available to both patients and providers.

Hospital Responsibilities

It is common for health plan agreements to outline the responsibility of the hospital to:

- Provide services 24/7
- Accept negotiated rates as payment in full
- Update plan of changes in services
- Not discriminate against members in the quality of care, nor based on protected characteristics
- Maintain licensure, accreditations
- Comply with law (e.g. Stark self-referrals, kickbacks)
- Avoid offshoring services without notice to plan
- Consent to audits
- Maintain insurance

Hospital Responsibility Considerations

- ☑ Specify any limits on access to services 24/7. Agreements are often not written with the limitations of small or rural hospitals in mind.
- ☑ Eliminate any licensure, accreditations not applicable to your facility (e.g. Joint Commission).
- ☑ Evaluate your contracted services to determine if any information involves offshoring, the way this term is defined by the plan. Disclose and obtain consents at execution of the agreement and ensure your own vendor agreements address offshoring.
- ☑ Examine the scope of plan's right to audit and add reasonable limits, such as advance notice of onsite audits, record request limits, exclude privileged documents. Using record request limits under the RAC program may be a helpful tool to base audit limits off an established model under the Medicare program.
- ☑ Define the lookback period in which MA plan may reopen a claim for pre- or post-payment review and the circumstances (e.g. good cause).
- ☑ Ensure your facility's insurance meets the minimum requirements specified by the plan.

MA Plan Responsibilities

It is common for health plan agreements to outline the responsibility of the hospital to:

- Identification cards to members, mechanism to check eligibility
- Include hospital in participating provider directory
- Maintain license, accreditations
- Maintain insurance
- Comply with applicable law
- Maintain good standing and eligibility for health program participation
- Make policies, procedures, protocols available in advance
- Pay claims
- Describe when claims can be audited and appeal rights

MA Plan Responsibility Considerations

- ☑ Specify recourse for failure to provide updated identification cards, provisions to hold Hospital harmless for erroneous eligibility information.
- ☑ Determine if any payor accreditations are desirable as a reciprocal expectation to Hospital accreditation (e.g. NQF, CORE, or even MA plan star ratings).
- ☑ If Hospital is expected to produce insurance certificates periodically (e.g. specified frequencies or upon request), consider making responsibility reciprocal.
- ☑ Address consequences for failure of MA plan to maintain contract with CMS, active, registration with State Department of Insurance (e.g. remain liable for the payment of claims for covered services rendered prior to contract termination date).
- ☑ Address MA plan's responsibilities with respect to offshoring confidential information. While offshoring data is addressed between the MA plan and CMS, it also potentially impacts the hospital if there is an offshore data breach of shared member/patient data.
- ☑ Address MA plan's responsibility to screen employees and contractors against preclusion lists, criminal background, federal SAMS, and OIG Exclusion Lists.
- ☑ Require plan to make any policy to which Hospital will be held available to Hospital in advance of the rules taking effect, including any periodic updates to those policies.

Utilization Management, Prior Authorizations

Many contracts between Hospitals and MA plans do not address prior authorizations, or when they do, they include very minimal details surrounding the process. MA plans have specific requirements for utilization management programs and prior authorizations. To ensure the requirements under their contract are carried forward to their agreement with the Hospital, the following items may be prudent to discuss and negotiate as terms into an MA plan contract.

- MA plan has policies and procedures for making individual medical necessity determinations. 42 C.F.R. 422.112
- MA plan has UM committee led by medical director, which reviews all UM policies and procedures, including prior authorization, that involve benefit determinations. 42 C.F.R. 422.137(b)
- Majority of UM committee is practicing physicians; at least 1 free of conflict to the plan; at least 1 physician expert in geriatric medicine; and members representing various clinical specialties. 42 C.F.R. 422.137(c)
- UM committee reviews all UM policies and processes including prior authorization
- No UM policies or processes can be approved if they fail the standards at 42 C.F.R. 422.101(b) to ensure coverage and payment for basic Medicare benefits. 42 C.F.R. 422.137(d)(2)
- Provide Hospital access to copies of documentation demonstrating the plan's UM committee and policies have been met
- Define prior authorization
- Explicitly identify effect of prior authorization in the MA program
- Prohibit prior authorization for emergency services
- Plan makes prior authorization information available to any contractors performing pre-, post-payment reviews

Utilization Management, Prior Authorizations Considerations

- **Prior authorization:** A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. IOM 100-16 Chapter 4 Section 110.1.1.
- Consider clarifying that, notwithstanding any ability of the plan to create and update policies, they cannot contradict HIPAA standard transactions and code sets including their official guidelines.

Utilization Management, Prior Authorizations Considerations

- **Prior authorization:** A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. IOM 100-16 Chapter 4 Section 110.1.1.
- If the plan approves the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity. CMS Pub. 100-16 Chapter 4 Section 10.16.
- Plan employs a medical director who has an unrestricted license to practice medicine in the United States and who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. CMS Pub. 100-16 Chapter 4 Section 10.16.
- Prohibit the use of prior authorization procedures for emergency services. 42 C.F.R. 422.111.
- **Emergency services:** covered inpatient services and covered outpatient services furnished by a qualified provider needed to evaluate **or stabilize** an emergency medical condition. The physician treating the patient decides when the patient is safe for transfer or discharge and that decision is binding on the MA plan. 42 C.F.R. 422.113(b).
- **Post-stabilization services:** covered services *related to* an emergency medical condition provided after a patient is stabilized, to maintain the stabilized condition or to improve or resolve the condition.
- The MA plan is financially responsible for covering and paying for emergency services, regardless of whether there is prior authorization and regardless of the final diagnosis.
- The MA plan is financially responsible for the coverage and payment of post-stabilization care approved by a plan provider if the MA plan does not respond to a request for pre-approval within 1 hour; cannot be contacted; or the MA plan and provider cannot agree concerning care and a plan physician is not available.
- Prior authorizations are limited to confirming the presence of a diagnosis or other circumstance needed to meet medical necessity criteria.
- MA plan must make internal coverage criteria publicly available.

Submission and Payment of Claims

MA plan agreements often describe the process for preparing and submitting claims for reimbursement. Ideally, these provisions would address each step of the process, such as:

- Reference to rules for required data elements to qualify as a clean claim
- Standard claim form (e.g. UB-04)
- Use of HIPAA standard code sets and their official rules and requirements
- Timely filing - usually proposed as 90-180 days
- Prompt payment of clean claims within 30 days
- Pay amounts negotiated in MA fee schedule, less patient cost sharing
- Standards for denials and adverse determinations
- Appeal procedures
- Payment for copies of medical records

Submission and Payment of Claims Considerations

- ☑ Consider detailing various transaction standards *both parties* must follow (e.g. using standard reason remark codes on remittance advices).
- ☑ Consider clarifying that, notwithstanding any ability of the plan to create and update policies, they cannot contradict HIPAA standard transactions and code sets including their official guidelines.
- ☑ Address what *starts* the timely filing period (e.g. discharge, encounter date) and what *ends* the timely filing period (e.g. submission of the claim by Hospital, receipt of claim by plan).
- ☑ If timely filing ends upon plan's receipt of a claim, address exceptions. For example, when receipt is prevented due to no fault of the provider, such as a demographic data error in the plan's system that causes clearinghouse to reject a claim before it is accepted in the plan's claim system and "received". Address circumstances when Hospital did not know of member's coverage by the plan due to member's failure to produce an ID card or presenting wrong coverage information.
- ☑ Consider aligning MA plan timely filing with traditional Medicare - 12 months.
- ☑ Address prompt payment of clean claims, including interest and penalties for failure to pay timely. Discuss the impact of pre- and post-payment audits on prompt payment.

Submission and Payment of Claims Considerations

- ☑ Address ability of plan to unilaterally re-code services (e.g. emergency department coding, DRG downcoding).
- ☑ Consider clarifying impact on interest, penalties under prompt payment rules if an underpayment is appealed or otherwise corrected at a later date, with respect to the amount underpaid or in dispute if eventually overturned in Hospital's favor.
- ☑ Consider specifying that denials must be clearly identified as such on remittance advices, as opposed to contractual write-offs, and in accordance with national NUBC standard reason remark codes.
- ☑ Consider detailing the standards upon which the health plan must make coverage determinations. For example, in a manner no more restrictive than traditional Medicare's coverage for basic benefits, in compliance with NCDs and applicable LCDs, and to the extent the plan is permitted to develop internal coverage criteria under 42 C.F.R. 422.101(b)(6), such coverage criteria must meet all requirements of such regulation. Consider specifying Hospital should be held harmless for the imposition of criteria that do not meet those requirements.
- ☑ Specify content requirements for adverse organization determinations:
  - use approved notice language in a reasonable and understandable form;
  - state specific reasons for the denial in accordance with CMS Pub. 100-04 Chapter 29 (explain the policy, regulation, policy guidance, and/or laws used to make the determination; include clear rationale with an explanation of why the claim can or cannot be paid based on the particular set of facts at issue, the logic used to reach the decision, and references in support. Mere conclusions that services are denied or non-covered are not sufficient; **See also 88 Fed. Reg.*
  - include a right to a reconsideration.
- ☑ Consider adopting language aligning with that at CMS Pub. 100-08 Chapter 3 Section 3.5.2.4 explaining that if a line item must be up coded, down coded, or otherwise adjusted the plan "shall not deny the entire claim but instead shall adjust the code and adjust the payment".

Appeal Procedures

MA plans must include opportunities to dispute unfavorable coverage and payment determinations. These disputes may have different names, such as reconsiderations or appeals. Under the MA program, reconsiderations are a type of appeal with specific rights and procedures. Detailing all steps of the appeal process - regardless of the name ascribed to the process, helps protect Hospitals' procedural due process, member access to benefits, and provides clearer means for enforcement when procedures are not followed.

- Timeframe to appeal: 60 days
- Opportunity to submit evidence
- Qualifications of reviewers
- Timeframes for appeal responses: 30 -60 calendar days from receipt
- Who must review appeal
- Number of appeal levels available
- Impact of favorable appeal decision on payment amount owed
- Burden of demonstrating coverage and payment
- Describe when claims can be audited and appeal rights

Appeal Procedure Considerations

- ☑ Parties to MA plan organization determinations should have at least 60 days to submit a request for a reconsideration (a form of appeal). Source: 42 C.F.R. 422.582.
- ☑ Consider clarifying that to the extent any payer policy limits the consideration of additional evidence submitted for an appeal, those policies do not apply to an appeal of an MA plan's organization determination. Parties to an MA appeal, such as Hospitals, must be provided an opportunity to submit evidence. Source: 42 C.F.R. 422.586.
- ☑ Consider adopting the standards at CMS Pub. 100-08 Chapter 3 Section 3.3.1.1 that determinations interpreting and applying official guidelines for coding must be made by certified coders.
- ☑ Consider explicitly referencing the requirements of 42 C.F.R. 422.566(d) and 629(k)(3) that adverse determinations involving medical necessity must be reviewed by a physician. To the extent services involve other clinical professional disciplines, the determination may be made by a professional with expertise in the field of medicine appropriate for the services at issue.

Appeal Procedure Considerations, cont.

- Define a penalty or other recourse for failure to respond to Hospital's appeals within 30 calendar days for requests for service and 60 days for requests for payment. Source: 42 C.F.R. 422.590. Examples may include withdrawing/rescinding the adverse organization determination.
- Consider defining when an appeal is deemed received by the plan to include an assumption of receipt within three (3) days of Hospital's transmission by U.S. mail, sometimes called the mailbox rule; the date of transmission by facsimile; and/or the date of transmission by electronic mail or other electronic portal designated by the plan.
- A person not involved in making the initial organization determination must review an appeal. If the decision involves medical necessity, it must be made by a physician with expertise in the field of medicine appropriate for the services at issue - generally in the same specialty as the treating physician. Source: 42 C.F.R. 422.590.
- Discuss impact of interest, penalties or other recourse if an appeal is ultimately favorable to Hospital/patient.
- Consider clarifying when a determination is a medical necessity determination. For example, denial of prior authorization; clinical validation (as distinguished from DRG validation).
- Consider establishing which party (Hospital or plan) bears the burden during an organization determination to demonstrate services are/are not covered. For example: Hospital bears initial burden to demonstrate a prima facie claim for reimbursement. The burden then shifts to the plan to demonstrate whether, and why, such claim for reimbursement cannot be paid. Otherwise, payment is made at the contracted rate.