PRIVATE FEE-FOR-SERVICE (PFFS) Q&A: QUESTIONS SUBMITTED AT THE CONFERENCE, PFFS 360°

Current PFFS Challenges and Results from CMS Monitoring Efforts

Q1) Will CMS make available the PFFS Secret Shopper audit checklist?

A) Not at this time. However, CMS has issued a best practices memo via HPMS, dated March 6, 2008, that is informed to a considerable degree by what we learned from secret shopping observations and review of the training programs of 40 MA organizations that offer PFFS plans. Please also see Q3 below.

Q2) This question is in regard to PFFS verification calls for enrollments on the last day of the month, Chapter 2 states that a member can only cancel their application prior to their effective date. The May 24th guidance directs plans to make 3 attempts to reach applicants by phone within 10 days of receiving their application. If you can't reach them on the first attempt plans must send attachment 4, which states "you must notify us of your intent to cancel the processing of your enrollment within 7 calendar days after receiving this letter or by the last day of the month in which they request was received, which ever is later.

First, there appears to be a conflict between Chapter 2 and the guidance and information in attachment 4 (that came with the guidance). Secondly, can you share CMS's perspective on how verification should be done on last day of the month enrollments and if cancellations post the effective date are ok (and if Chapter 2 will be updated)?

A) The MA enrollment and disenrollment guidance (Chapter 2), section 60.2 states that: "Unless otherwise directed by CMS, an individual may cancel his/her enrollment only by contacting the organization prior to the effective date of the enrollment."

The PFFS verification process, as required by the May 25, 2007 HPMS guidance memo, includes that an individual may decide not to enroll

following the required verification contact. This opportunity to "cancel" the enrollment is consistent with the MA enrollment guidance, even if it occurs after the effective date of enrollment (but within the timeframes for the verification process).

Q3) When will we learn about the enrollment verification calls conducted on our own plans?
When will we learn about the secret shopper events for our own plans?
Can we get a copy of the secret shopper audit tool?
You reference issues 71 deficiencies – when can we learn more about the deficiencies/sanctions themselves? (Not interested in plan specific)

A) CMS is working on a summary report that will be issued to all plans that have been observed as part of CMS's PFFS Monitoring Plan. That report will include both a summary of how that particular plan performed on each of the monitoring activities, and a discussion of major findings across PFFS plans as a whole. The secret shopper audit tool will not be shared. However, plans that had deficiencies have received letters informing them of the deficiencies. Please also see answer to Q1 in this section.

Q4) Will HPMS sales event module be modified to allow additions and deletions of sales seminars to be reported?

A) We will be modifying this functionality in our June release to give the plans more flexibility in reporting their marketing events, including adding and canceling events. CMS continues to note dramatic variations in the due diligence exercised by plans in reporting and updating events, and notes this as a potential area for increased monitoring in the future.

Q5) Is the requirement to conduct the verification call within 10 days after receipt of the complete application or initial application?
Note: Incomplete application may not result in enrollment so it is best to conduct once is a complete and valid enrollment. Please clarify CMS requirement.

A) Outbound education and verification calls should be made after the MAO receives complete and valid enrollment forms from beneficiaries.

Q6) The broker training requirements includes general Medicare training. Has CMS considered creating standard training that brokers can take to reduce the amount of redundant training for brokers that sell for multiple MAOs?

A) PFFS plans have the option of developing their own training and testing requirements or using/contracting with a third party. It is acceptable to CMS if a plan accepts the training and testing of another organization or third party in order to meet CMS' training and testing requirements. CMS has recently released a best practices memo to provide MAOs with recommended elements of a successful broker/agent training program.

Q7) Although an audit guide for PFFS was sent out for comment as a draft, a formal version has not yet been released publicly. When will that occur? (Although it may come to plans with their audit engagement letter, it is important to have it earlier) Please clarify.

A) The new PFFS Audit Guide is on HPMS and accessible to Plans.

Q8) Are PFFS plans able to cite CMS statistics with respect to customer satisfaction, for example, as they relate to CAHPS data or even data from CMS' own recent PFFS monitoring plan projects? Specifically which marketing materials must carry the CMS PFFS disclaimer statement?

A) Plans cannot use the customer satisfaction statistics from our monitoring activities for marketing purposes because these statistics are only a snapshot of customer satisfaction and CMS would look for sustained evidence of similar customer satisfaction before determining high overall customer satisfaction a fact. Please refer to the May 25th HPMS memo for information on the CMS PFFS disclaimer statement. An updated disclaimer statement is available in the 2009 Call Letter under the PFFS section.

Q9) If you ask whether there is a CMS Representative or a secret shopper in the audience during sales presentations, does the individual have to identify themselves?

A) CMS representatives or secret shoppers will not identify themselves at sales presentations, even if asked. However, even if a secret shopper chooses to identify him/herself or is detected in some other way, a marketer must continue to hold a public presentation with the secret shopper in the room. Public presentations are open to anyone – including competitors, or SHIP personnel – as long as those individuals are not disruptive to the presentation.

Key Issues Related to Offering Employer/Union-Sponsored PFFS Plans

Q1) **Agent and broker training and licensure requirements are not applicable to retiree group PFFS sales"**
Our employed staff frequently makes sales to group purchasers. Does this mean that the commercial sales staffs that make these PFFS sales don't need to meet the training requirements?
Requirements verses Best Practice

A) These particular requirements that apply to sales of PFFS products to individual beneficiaries do not apply to employer sponsored group plans.

Q2) **Outbound education & verification calls are not required for employer group retirees. Is CMS excluding the employer group retirees from their post-enrollment audit calls to beneficiaries?**

A) These particular requirements that apply to sales of PFFS products to individual beneficiaries do not apply to employer sponsored group plans.

Q3) **MAOs are required to "ensure employer sponsor understanding? In several areas. How will CMS test/audit this understanding?**
RFP responses?
Sales presentations to groups?
Meeting notes with group?
Attestations from group?

A) CMS is currently in the process of developing an approach to ensure compliance with these requirements. Also, these requirements will be included in future application attestations and contracts/addenda.

Q4) **Group only PFFS Plans: Are we (Group PFFS plans) required to have terms and conditions of payment on the internet? We understand that we have to make sure that providers can obtain the T&Cs.**

A) Yes - the same requirements apply that apply to individual plans.

Q5) **When expressing that networks are not required for employer group, does that mean that a network HMO MAPD does not have**

to provide a network to EG retirees?
How are there network differences for employee group 800 plans verses individuals in a non-network PFFS product?
Are we required to let members dis-enroll if their provider does not accept the non-network PFFSs product?
When will the EG managed care chapter that was drafted last year be finalized?

A) No, a HMO MAPD has to provide a network to employer group retirees. The same policy that applies to beneficiaries in individual plans applies to employer group plan beneficiaries. However, as with all employer group sponsored Medicare products, the MAO needs to closely coordinate all communications with retirees with employer group plan sponsors and also make sure retiree fully understands potential consequences to them and their dependents if they choose to disenroll from employer PFFS plan. We are working on re-drafted chapters to be released for comment soon.

Q6) **How much discretion does the EGWP have to determine eligibility rules? Can the EGWP require that a group member enroll in a particular MA plan in order to be eligible for Employer group benefits that go beyond those covered under the MA plan (i.e., deny those extra benefits to otherwise eligible group members who are enrolled in a different MA plan, an MA-PD plan, or original Medicare)?**
Can the EGWP implement eligibility rules that are more stringent than CMS rules? For example, can the EGWP set the eligibility age at 70, even if CMS rule is 65 years old?

A) An employer group has the ability to determine eligibility for its Employer group benefits that go beyond those covered under a Medicare Advantage plan. It can require that enrollees enroll in a particular Medicare Advantage plan to get such additional benefits.

With respect to imposing requirements for enrollment in a particular EGWP that are more strict than Medicare eligibility requirements (such as a requirement that the individual be 70), a waiver would be required to permit such an arrangement. Such restrictions would also have to otherwise be permissible under applicable State and Federal law.

Q7) **Many times the employer group will offer choices to retirees and**

allow sales agents to discuss their plan options with retirees. In those cases when the retiree is making a choice based on information provided by the agent, shouldn't the verification be required and the agent be required to be licensed and trained?

A) These are not CMS-imposed requirements, although the MAO may consider them as good business practices when selling employer group plans.

Q8) May a plan sponsor offer a MA-PD or MA medical only product to an employer group for its "working aged"? Can an employer who decides to become an MAO offer this?

A) MAOs (including employers that contract with CMS to become an MAO) may enroll employer group plan active employees. However, MAOs and employer group sponsors must be sure to comply with any applicable Medicare Secondary Payer (MAP) requirements.

Q9) Is my understanding correct that individual PFFS members are allowed to choose a PDP for their Part D coverage but Group Retiree members cannot because an employer can choose a single PDP for all retirees?

A) Yes, your understanding is correct. Since an employer is funding the coverage for retiree members, the employer can choose coverage for the entire group. A retiree, of course, always has the right to enroll in an individual product – but they must be made aware that they could lose the employer coverage. Therefore, CMS recommends that retirees are fully informed before they make an enrollment decision.

Risk Adjustment, Medical; Records Requests, Model Terms and Conditions

Q1) While many parts of the terms and conditions document are plan specific, is CMS able to provide a model document with specific (recommended) language? Or best practice?

A) CMS is currently working to develop a model template for PFFS terms and conditions of payment. We expect to have the model template completed as early as possible in 2008. Additional information regarding this topic can also be found in the 2009 Call Letter under the PFFS section.

Q2) Can non-network PFFS plans do retrospective medical records review to determine medical necessity of service delivery? (not related to Risk Adjustment Process)

A) PFFS plans can perform retrospective review of claims for the purpose of verifying medical necessity and that the service furnished is a covered service. However, PFFS plans should have a claims payment system that can identify non-covered or non-medically claims at the time of adjudication.

Q3) Can you require pre-certification, pre-notification to review for medical necessary prior to services rendered. For example: 1. inpatient, 2. homecare and 3. skilled nursing facility.

A) PFFS plans cannot require enrollees or providers to obtain prior authorization from the plan as a condition of coverage. PFFS plans can establish a prior notification requirement. Under a prior notification requirement, the plan may charge lower cost sharing for a health care service if the enrollee or provider notifies the plan before the service is furnished. Detailed information on prior authorization and prior notification is available in the 2009 Call Letter under the PFFS section.

Q4) Can you "deem" on your website terms & conditions prior authorization/pre-certification requirements? And if you can, do you penalize the member or the provider if they did not follow the requirements?

A) PFFS plans cannot require enrollees or providers to obtain prior authorization from the plan as a condition of coverage. PFFS plans can establish a prior notification requirement. Under a prior notification requirement, the plan may charge lower cost sharing for a health care service if the enrollee or provider notifies the plan before the service is furnished. Detailed information on prior authorization and prior notification is available in the 2009 Call Letter under the PFFS section.

Q5) Can you deny services for non-medical necessary services ("post review") after the services are provided? For example – skilled nursing facility stay. Would the member be responsible?

A) A PFFS plan can deny services that are not medically necessary after the service has already been furnished. In this case, the beneficiary may be liable for all of the cost of the service if he/she did not ask for

an advance coverage determination.

Q6) When submitting a written request to CMS RO asking for permission to obtain a sample of beneficiary medical records, do plans do this on a case by case basis or is one request sufficient for all beneficiaries? Also, how long will it usually take for CMS to respond?

A) PFFS plans should submit a written request to the CMS RO asking for permission to obtain a sample of beneficiary medical records on a case by case basis. The CMS RO will respond to the written requests as quickly as possible. The 2009 Call Letter has more information on this topic under the PFFS section.

Q7) Can Plans update Terms and Conditions for risk adjustment medical record requests without sending Terms and Conditions to CMS for approval?

A) We strongly encourage PFFS plans to submit changes to their terms and conditions to the CMS Regional Office for approval with a summary regarding the requested changes. This allows the Regional Office and PFFS plans to track CMS approval of its terms and conditions accordingly.

Q8) Will any consideration be given to the fact that, although deemed, plans have no ability to enforce proper documentation requirements upon providers who are not directly contracted (e.g. signed notes)?

A) This is recognized. This is one of the reasons why PFFS MAOs do not have to comply with the same Quality Improvement requirements as other MA organizations.

Provider Payment and Dispute Resolution

Q1) Does a private payer need to be able to identify co-located hospitals or is this already part of their billing process and provider number assignment.

A) For Medicare payment purposes, co-location of a LTCH with another provider, is a significant feature of several payment policies. We have requirements that a LTCH HwH or satellite notify its FI of co-located status at 412.22(e) (3) and 412.22(h)(6), respectively. A

similar requirement also exists in 412.532(i), where we apply a payment adjustment to the LTCH PPS stay when the % of interrupted stays involving discharges to co-located providers (even SNFs) exceed 5% in a CRP. We also have established a 25% threshold at 412.534 for discharges to LTCHs from co-located providers that is also dependent upon notification of co-location. Presently, there is no Medicare data collection instrument captures that the provider number of either the hospital that refers patients to the LTCH or SNF, or the hospital to which the LTCH or SNF discharges patients.

Q2) Will CMS publish the list of NPI#'s of the providers that qualify for the PQRI bonus?

A) Yes, we intend to provide a file to MAOs that will include the NPIs of PQRI-eligible physicians and practitioners. We will provide further detail on the file layout at a later date

Q3) What is CMS's stance on applying a "lesser of" logic when a claim is received for a PFFS member and the provider's total charge is less than the Medicare rate?

A) When an MA coordinated care plan enrollee sees a provider under "arrangements" that an MA organization has made (but where no reimbursement amount is stipulated by contract), the MAO must pay at least the FFS rate, even if a lesser amount is billed – this is true of physician services, hospital services (PPS or otherwise), and for any other provider type.

Q4) How should NAH (and BBRA NAH add on) be processed by MA plans?

A) The BBRA NAH add-on is a small amount and is paid by the FI as part of GME. MAOs do not have to pay this on their members' behalf to non-contracting PPS hospitals. The cost based NAH amount is a larger amount and is the responsibility of the MAO when reimbursing non-contracting PPS hospitals. This is explained in the MA Payment Guide.

Q5) Have there been any issues or concerns from using box 25 on the CMS 1500 for the up code of point of pickup for ambulance services when this field has been designated as a field for preauthorization #s?

Have other plans communicated problems?

A) There are no national requirements to use block 25 to indicate preauthorization for ambulance services.

Q6) Can the plan require RHC's to submit reimbursement rates from FI for accurate claims processing? Or should this be requested from the FI directly?

A) Yes. The plans should require the clinics to submit their current rates.

Q7) Is CMS creating (or already have) a centralized data set for plans to confirm the most recent provider interim rate?

A) No. We are however investigating the future possibility.

Q8) Has CMS communicated to Congress that if they do not rescind the 10% fee schedule reduction which goes into effect 1-1-08 that PFFS non-contracted model could see an increase in providers who may decline to see PFFS members.

A) This became a moot issue once the President signed the Medicare, Medicaid, and SCHIP Extension Act of 2007, on December 29, 2007.

Q9) Is it acceptable to denote bad debt or other payment rules in a proxy grid referenced by the Terms & Conditions rather than listing specific payment details in the terms themselves (as long as the materials reference once another.)

A) MAOs should state their policy on "bad debt" as clearly as possible. For instance; "We pay 80% of 'bad debt' related to our members' IP hospital cost sharing;" or "We pay 75% of 'bad debt' related to our members' skilled nursing facility cost sharing." If the MAO requires the provider to document its effort to collect member cost sharing in a specific way, then the terms and conditions should stipulate that.

Q10) Does the pricer handle DSH payment cap for Medicare dependent hospitals?

A) Medicare Dependent Hospitals do not have a payment cap for DSH. However, Sole Community Hospitals and rural hospitals with less than 50 beds do have a DSH payment cap, and Pricer does have the logic built in to recognize this.

Q11) **Under sole community hospitals Medicare makes an add-on payment for some services of qualifying SCH's. What are the services and how do I know they qualify?**

A) For operating IPPS payments, SCHs receive the higher of either the Federal (IPPS) rate or a hospital-specific rate. The Federal rate includes the usual add-ons that a regular IPPS hospital would receive [such as, wage index, DSH, IME, outliers, or a low volume adjustment (which is referred to in question Q12), if applicable]. On the other hand, the hospital-specific rate which is based on costs in a base year updated to the current year and adjusted for changes in a provider's case mix does not include any add-ons.

Q12) **How do you administer the additional payment not to exceed 25% for low volume hospitals?**

A) FIs enter a 'Y' in position 74 (Temporary Relief Indicator) if the hospital is considered low volume in the Provider Specific File. Pricer makes the payment adjustment based on the presence of 'Y'.

Q13) **Cancer and Children's Hospitals out patient services are identified as having different reimbursement which is more cost based than regular acute care hospitals. Is this pricing part of the OPPS APC pricer? We found the Medicare (CCN) provider id listed in the OPPS pricer file we received.**

A) TOPs payments are not automatically calculated and paid through PRICER. Instead, the shared systems maintainers create a FISS program that the FIs use to pay monthly interim TOPs payments, which are then reconciled at cost report settlement. The payments that a hospital receives through PRICER influences the TOPs payments that a hospital receives.

Q14) **For hospitals that submit interim rate letters from their FI that equates to a per diem rate for reimbursement, is there a settlement process that needs to be developed and performed each year for cost settlements and payment information for out of network providers?**

A) No, MAOs do not need to cost settle with providers that cost settle with original Medicare. Paying the full interim rate is sufficient.

Q15) **1. With the move of ASCs to the out patient Prospective Payment System, is CMS going to change the claim form**

submitted by this provider type from the CMS 1500 to the UB04?

2. **The Acute Care Hospital pricer from the CMS website does not have a place to enter the patient status indicator. How is acute to acute or acute to sub-acute transfer pricing done via the pricer if the PS indicator is not entered? Are there additional edits within the claims processing system applied to accommodate transfer pricing?**
3. **For acute to sub-acute transfers, there appears to be a set of DRGs that apply (qualify for this reimbursement.) Where can the list of approved DRGs be found?**

A) 1. No. We are not changing the ASC claim form from the CMS 1500 at this time.

2. The PC Pricer on the web asks if the case is a transfer/post acute care transfer or not. The user enters 'Y' if the case is a transfer (acute to acute) or 'Y' for post acute care transfer (acute to SNF, HHA, IRF, LTCH, cancer, children's, psych). The PC Pricer determines whether to apply the transfer payment with the 'Y' and if the length of stay is less than the average length of stay for the DRG and the DRG is PAC.

In the Mainframe Pricer (the one that FIs use), the FISS system converts the patient status code from the bill to a review code. That review code is passed to Pricer and the transfer payment is applied dependent upon the DRG and length of stay.

There are additional edits in the claims processing system (CWF) if the hospital does not code a transfer and the CWF finds that patient in a "post acute" facility on the same day as discharge and all of the policy components fit, then CWF will instruct the FI to cancel the hospital claim and the hospital must rebill the with the correct patient status code.

3.Table 5 of the IPPS Final Rule (72 FR August 22, 2007 page 47539) lists which DRGs are subject to the post-acute transfer policy (and of those, which are under the special payment methodology).

Q16) **What would a provider contract look like for PFFS plans, considering payment terms for providers within a class need to be uniform and that a contract cannot specify special terms and conditions? Also, isn't it true that the contract cannot be to secure access to the provider since it cannot supersede the basic right that providers have to be "deemed?"**

A) PFFS plans have the option of establishing written contracts or agreements with a sufficient number and range of providers to furnish covered services in order to meet Medicare access requirements. This approach is required of those PFFS plans that establish payment rates that <u>are less</u> than original Medicare rates. Contracts or agreements may be established for a particular category of health care provider, or with providers for all covered services. CMS intends to issue guidance on this topic soon.
PFFS plans that meet access requirements by establishing payment rates <u>at or above</u> original Medicare rates may also enter into direct contracts with providers. In this case, PFFS plans are executing direct contracts in order to ensure access to specific providers and to ensure that these specific providers will always agree to be "deemed." Members of such plans are ensured they will have access to at least these providers who have already agreed to accept the plan's terms and conditions of payment. The 2009 Call Letter provides more information on this topic in the PFFS section.

Q17) If CMS releases original Medicare payment rates a month or more after they were effective, what is CMS' expectation of PFFS plans that are paying original Medicare rates? Do such PFFS plans need to automatically re-process claims and pay the higher rate in the retroactive period? Or do they only need to do so if they are asked to do so by affected providers?

A) The contract PFFS plans have with CMS specifically say that PFFS plans must implement payment updates consistent with original Medicare. In most cases original Medicare payment updates are announced prospectively and PFFS plans must implement the update by the effective date of change. If original Medicare announces a retroactive payment update, then PFFS plans should implement the update as soon as possible and apply the update to all claims that have not been paid as of the date of the release. For claims that have already been paid, PFFS plans should attempt to identify and reprocess claims in the retroactive period. When interim rates change for a cost-reimbursed provider, the provider should submit the most recent interim rate letter with the claim. Generally, PFFS plans should work with providers and reprocess claims, when necessary.

Q18) Who does CMS recommend that plans contact when they are

unable to obtain payment rates or methodologies equivalent to Medicare?

A) The Regional Office Plan Manager.

Q19) RHC's and FQHC's are reimbursed at facility specific "per visit? Rates. These rates are not published publicly. MA's must ask each RHC/FQHC for their per visit rate every year. Considering there are approximately 7000 such facilities nationally, this is an immense and cumbersome task. Would CMS consider consolidating all RHS/FQHC per visit rates, and publish such a file on CMS's website? The same question may be applied to Critical Access Hospital's interim rates (although these may be estimated using cost reports) and Children's Cancer Hospitals inpatient payment.

A) We are investigating the possibility of providing this database in the future.

Q20) Can you please address sanctions (if any) applied to plans for inaccurate interpretation of CMS payment guidelines resulting in inaccurate reimbursement to providers? At what point does CMS become aware of these discrepancies and/or apply sanctions or CAPs?

A) In PFFS it is critical for providers to be paid correctly and promptly because provider satisfaction with reimbursement has a direct bearing on enrollee access and availability. PFFS MAOs who enter into a contract with CMS attest that they have the knowledge and system to pay providers correctly and promptly on a fee for service basis. Typically, CMS becomes aware of inaccurate or delayed payments from provider complaints. These complaints are investigated and CMS works with the PFFS MAO to resolve the problems. Failure on the part of the PFFS MAO to correct these problems could result in CAPs and/or sanctions. CAPs have been issued when CMS has become aware of plans with repeated PFFS reimbursement issues.

Q21) Does CMS expect to encourage or contract with intermediaries/carriers to work with plans in order to reveal the payment rates for particular services (when not accessible otherwise)?

A) We are investigating the possibility of retaining a contractor, with

extensive Medicare Fee for Service experience, to test the accuracy of PFFS payment practices.

Q22) With the ability to provide payments at an estimated rate (when unable to acquire solid evidence of rate otherwise), what is the methodology expected by CMS to set the estimated rate?

A) Medicare's payment contractors (FI's or MACs) work directly with the providers during the course of the provider's fiscal year to set estimated (aka "interim") rates for certain services that are paid based on their costs rather than based on a fee schedule. These interim rates may change one or more times during the year for any given provider. The plan should pay the rate that is in effect at the time of service.

Q23) In a member reimbursement situation, is it appropriate to pay flu shots to drug fee schedule (ASP/AWP) rates?

A) The member should be reimbursed the amount that original Medicare would have paid and informed that a refund from the provider is due, where appropriate, or that the provider is due additional money, where a lesser amount was billed/paid.

Q24) In contracting with providers for PFFS can there be variability in the terms and conditions of the contract if payment terms are the same for all providers in the class. For eg.- prompt pay requirements variations.

A) It is not possible to answer this question in its entirety without details regarding the specific variations reference in the question. However, we can respond to the example included in the question regarding variability in the terms and conditions related to prompt payment requirements. Prompt payment requirements cannot be changed or varied. Please see section § 422.520 of the regulations for additional information on prompt payments.

Q25) We understand that FFS Medicare is adopting "NEVER EVENT" policies later in 2008. What if the plan already has a corporate policy in place not to pay for NEVER EVENTS? Can we deny payments before 10/1/08?

A) Since PFFS plans must pay the same as Medicare, to the extent original Medicare will continue to pay for services related to "never events" until 10/1/2008, an MAO sponsoring a PFFS plan must do

likewise.

Q26) Where do you get more in-depth CMS training on claims payments? Are there classes at CMS?

A) No such training is being offered at this time. Please check the CMS training schedule for future training on this subject. There are third parties that provide assistance on Medicare Fee for Service claims payment practices and policies, but CMS cannot recommend any particular party.

Q27) Are there any dollars in the pass thru component of reimbursement related to educational expenses (IME) for teaching hospitals that we should not be paying?

A) MAOs are responsible for payment of "capital" IME, while they are not responsible for payment of "operating" IME. The FIs pay hospitals for "operating" IME related to MAO patients.

Q28) Is there a base terms and conditions document that should be used and modified by carriers as needed?

A) CMS is currently working to develop a model template for PFFS terms and conditions of payment. We expect to have the model template completed as early as possible in 2008. Additional information regarding this topic can also be found in the 2009 Call Letter under the PFFS section.

Q29) Are plans supposed to cost settle w/RHC, FQHC and Critical Access Hospitals in order to pay like Medicare.

A) MAOs are not required to cost settle. The interim rate is sufficient compensation to cost-reimbursed providers. Sometimes the provider "wins" when the cost settlement is downward, sometimes the MAO "wins" when the cost settlement is upwards.

Q30) How can the bonus payments be required when MA is not part of the mandate? PFFS is an MA product. Asking plans to do it will certainly cause provider confusion and Plan issues for implementation and separation between MA PPO/HMO and CMS.

A) In short, our belief is that in order for all MAOs to pay "the same as Medicare," they must all also provide the higher payment (up to an additional 1.5% for physician fee schedule services) to doctors and

other practitioners that have qualified for the "bonus" under original Medicare. We are creating a file to help facilitate the payment of this "bonus" to appropriate providers by MAOs.

Q31) Would carriers and FI's be willing/able to contract w/PFFS plans to adjudicate claims w/Medicare payment mechanism against the plan benefit designs—or could they price the claims and we could feed that info. into our claims processing systems?

A) Some MAOs offering PFFS plans have such arrangements with FIs. Such arrangements are legal.

Q32) If PFFS contract with providers – can they pay provider at a rate that is different than what FFS Medicare would pay? Are MA plans required to provider HPSA (Health Practitioner Shortage Area) bonus payments? Can an MA plan who has a contract with a FQHC contract with the FQHC to pay the all inclusive encounter rate rather than what is pays over non FQHC providers?

A (1) PFFS plans with a direct contracting network of providers that meet Medicare access standards can pay the network providers at payment rates for Medicare Parts A & B services that are less then what Original Medicare pays. CMS will issue guidance on this topic in March 2008.(2) PFFS plans are required to pay HPSA bonuses to the extent they would have been paid by original Medicare. (3) Yes, in fact it would have to pay that rate, unless it had a complete network of contracted providers of that category or type.

Q33) Will CMS be improving the "calculator & pricers"? Today they are very manual.

A) Some plans and third party administrators have already automated their own versions of Medicare's Pricers. CMS is considering ways to improve the utility of the internet version of the various Pricers.

Q34) How can health plans get payment rates of new coverages/services (either due to new NCDs or LCDs)? Pricer is quarterly and new coverage can be updated after recent pricer release.

A) The provider should submit most recent interim rate letter with claim to PFFS plan. There is no better or more expeditious way.

Q35) What authority does CMS have when a provider/state refuses to coordinate Medicaid benefits with dual eligible members who enroll in a PFFS plan?

A) CMS has no authority to require providers and States to coordinate Medicaid benefits for dual eligible members enrolled in a PFFS plan; however, CMS encourages both entities to work with plans for the mutual benefit of the beneficiary and the entity.
There are several key issues that PFFS plans should consider when marketing to dual eligible beneficiaries: whether the beneficiary is eligible for medical benefits under Medicaid; how cost sharing will be different under the PFFS plan compared to Medicaid; and whether the beneficiary will need help to find providers who accept both Medicare and Medicaid.

Q36) In the discussion yesterday around provider dispute resolution, there was an implication that any/all providers payment challenges may be treated, tracked reported as we must for a formal member appeal. Are you eliminating the need, where applicable for there to be a documented Agent of Record form before the provider can "appeal"? Is the expectation that each/every provider office rate query is treated with all the bells and whistles of a formal appeal process? Is there guidance to support this?

A) CMS provides guidance to PFFS plans regarding the creation of a process for resolving provider payment disputes in the 2009 Call Letter under XI Private Fee-For-Service Plans, section F, page 41.

Q37) How are interrupted stays appropriately priced by CMS when there is no place on the website Pricer to enter occurrence span codes and dates? Same issue for benefits exhausted.

A) Under SNF and HH PPS, we have worked out a process that we call "split bills." The initial payer (FFS or another MA plan) shows a discharge and the second (new) payer (FFS or another MA plan) shows an admit. On the issue of how claims are paid when benefits have been exhausted, generally this depends on the plan's benefit structure and the contracts it has with providers. Under FFS, some claims for services received while an individual is an inpatient, but after inpatient hospital benefits have been exhausted, will be paid by FFS as outpatient hospital claims. MAOs would also need to reimburse for such claims, since they are covered by FFS.

Q38) **CMS requires certain services to be paid at "cost". For these CMS does not always publish "cost". For example: Home Health Agencies billing flu/influenza/PPV and osteoporosis drugs are to be paid at "cost". Short of asking each provider for cost data, how does CMS suggest these services be reimbursed?**

Will CMS consider publicly publishing these values? Or would CMS consider requiring payment be made according to the drug (ASP/AWP) fee schedule?

A) At this time CMS has not developed a better method than asking each provider for cost data.

Q39) **What is CMS doing in making the provider FISCAC Intermediary letter and cost report more available to the payers?**

A) At this time the interim rate letters are all that is available. There are technical problems with updating the information on CMS systems in a timely manner and making them available to the public. We will continue to work on this issue.

Q40) **Does the PQRI bonus apply strictly to procedures that are listed on the MPFS with a non-zero RVV? For example, the 1.5% bonus would not apply to DMEPOS, Clinical lab, "C" status (carrier priced) codes, drugs (ASP/AW) etc., right?**

A) The PQRI bonus applies to the professional component of all Part B services billed by an eligible professional and paid by Medicare. The 1.5% incentive applies to all MPFS covered professional services, but not, for instance, to the technical component of labs or DME.

Q41) **Providers are having claims denied by CMS where the member is covered under an MA-PD plan. Why can't CMS send back a message to the provider and identify the MAO that the member is enrolled with? This is a major problem when the providers are not able to identify which plan to submit claims to.**

A) CMS is examining this issue in an effort to mitigate the problem.

Q42) **How do I know if a hospital is still eligible for TOPS?**

A) There is currently no central repository of TOPS hospitals. If a hospital continues to be eligible for TOPs, it should produce an

interim rate letter for the PFFS plan.

Q43) What actions will CMS implement to help plan sponsors comply with the "excluded" payment provision of Chapter 9 of the Prescription Drug Benefit Manual? Currently, there is no model language in the EOC or SB to "notify the member" that their provider has not been excluded from receiving payment from the federal government. This is a significant compliance issue given the growth of non-participating providers. Finally, there are no PDE reject codes for excluded or deceased providers.

A) Part C and Part D excluded providers are listed in the OIG Sanction/Reinstatement Report, or can be accessed at the National Practitioner Database - http://oig.hhs.gov/fraud/exclusions.html. MAOs should be careful not to deny payment unless there is an exact match.

Q44) Is there any listing or electronic database available of physicians who accept Medicare assignment? With the reimbursement cut retirees are concerned about finding a doctor who accepts Medicare & PFFS terms and conditions.

A) The MEDPAR lists physicians who have always agreed to accept assignment when treating Medicare patients. The recent enactment (12/29/07) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 should somewhat mitigate retiree concerns.

Q45) Is there a website for identifying Medicare Dependent Hospitals, sole Community Hospitals and low volume hospitals?

A) Not at this time. However, you can use PC Pricer for Medicare Dependent and Sole Community Hospitals, and then pay the greater of 95% of the hospital specific rate, or 100% of the national rate.

Key Stakeholders Experiences with PFFS

Q1) What type of assistance is CMS providing in influencing providers to participate?

A) CMS has met with several medical and provider organizations to answer questions and provide information on PFFS. CMS believes in giving providers accurate information on PFFS so each provider can make an informed decision about accepting PFFS enrollees. CMS

Regional Offices also periodically meet with provider associations (for example, state hospital associations and medical societies) in their Region to educate them on all types of Medicare Advantage issues as well as other CMS topics. Regional Offices also periodically conduct outreach in their Region to provider associations and serve as speakers at some of their meetings to answer Medicare issues. PFFS has been a common topic of discussion.

The May 25, 2007, HPMS Memo on PFFS includes a provider-directed letter that MAOs offering PFFS plans can use to increase provider awareness of PFFS. CMS also developed provider frequently asked questions that are posted on the CMS website and can be accessed by providers. To directly assist providers, CMS has posted on its website all the PFFS plans' contact information concerning PFFS plan terms and conditions of payment. CMS has required PFFS plans to have staff available to assist providers with questions concerning plan payment and payment accuracy. CMS has also directed PFFS plans to ensure that they have a provider payment dispute process in place and described in its terms and conditions of payment. Ultimately, provider participation in PFFS will be determined by the ability of PFFS plans to be good business partners with providers, and CMS reminds PFFS of the importance of paying claims promptly and accurately.

Q2) "Get providers under contract if possible,…"

1. **When is it permissible to contract providers under a PFFS non network?**
2. **Are there any special provisions that apply under these contracts? (i.e. Can I agree with hospitals, under contract, to pay a per diem rate as opposed to DRG?)**
3. **If the answer is that the contracting process is available under a non-network PFFS, can we decide to contract some specialty types and not others?**

A)

1. It is permissible to contract with providers under a PFFS non-network model when a PFFS plan wishes to help its enrollees locate providers who simply agree in advance to accept the plans terms & conditions of payment.
2. Yes, contracts have to be consistent with the plan's approved terms & conditions.
3. Yes, a PFFS plan may offer some Medicare required services on a non-network basis and others on a network basis. Those

services offered on a network basis have to meet MA access and availability requirements.

CMS intends to issue guidance on this topic soon.

Q3) Does CMS have any suggestions or Best Practices for handling non-quality of care complaints against providers? As they are not contracted, how do we reach out to those providers or enforce standards?

A) The PFFS plan can contact providers directly to communicate beneficiary complaints to them. Also, the plan can advise its members to select another provider who accepts the plan terms and conditions of payment. The best way to reach out to providers is to have a robust provider education and outreach program. CMS provides guidance to PFFS plans on establishing provider education and outreach programs in the 2009 Call Letter under XI Private Fee-For-Service Plans, section C, page 38.

Q4) Has CMS ever considered required for Medicare providers to accept PFFS plan members?

A) CMS does not have the statutory authority to require providers to accept PFFS plan members.

Q5) Although providers have the right to see members on a "service by service basis" (per visit decision) – this is not any different than original Medicare FFS. Does CMS publicly make that correlation? Currently it is presented as unique to PFFS but it is not.

A) CMS did make this point in the past and continues to do so.

Q6) Can you expand on comment made regarding contracting with providers – messaging has always been you cannot contract with PFFS providers?

A) PFFS plans have the option of establishing written contracts or agreements with a sufficient number and range of providers to furnish covered services in order to meet Medicare access requirements. This approach is required of those PFFS plans that establish payment rates that are less than Original Medicare rates. Contracts or agreements may be established for a particular category of health care provider or with providers for all covered services. CMS intends to issue guidance on this topic soon.

Q7) Can a provider refuse service to one PFFS, but see a different PFFS member when the terms and conditions are the same?

A) Providers have the right to decide on a patient-by-patient and visit-by-visit basis whether to treat PFFS plan enrollees.

Q8) Can you deny services during the service period if it is not medically necessary? Who would be responsible?

A) A PFFS plan is required to cover medically necessary plan-covered service. The beneficiary may be responsible for the cost of services that are not medically necessary. Both enrollees and providers may request a PFFS plan to make an organization determination regarding the benefits an enrollee is entitled to receive under the plan. The PFFS plan must have a procedure in place to notify the enrollee of its determination as expeditiously as the enrollee's health condition requires but no later than 14 calendar days after the date the organization received the request.

Q9) One of the panelists suggested that PFFS Plans should provide assurances that we won't implement the 10% cut to the physician fee schedule on January 1. Is that a decision CMS will allow plans to make or are we required to implement the payment cuts until Congress acts?

A) This became a moot issue with enactment of S.2499 on 12/29/07.

Q10) Are there any concerns regarding the continuity and quality of care of members when a physician has seen the member two times and then refuses to see the member on the third visit. Who is responsible for the care of these members if there is a bad outcome?

A) CMS is concerned any time a member's continuity and quality of care is compromised. Providers have the right to choose to provide care to a member on a case by case basis under PFFS as would providers in Original Medicare. It is hard to state who would be responsible based upon question posed. More facts would be need to known.

Q11) There was much discussion concerning educating providers about PFFS, how can you do this when they are non-contracted, you can do on your website, but how can you do it in person with all providers.

A) CMS provides guidance to PFFS plans regarding provider education and outreach programs in the 2009 Call Letter under XI Private Fee-For-Service Plans, section C, page 38.

Q12) Can we get MMA comments as they identify some interesting provider education needs area where it should be focused?

A) CMS provides guidance on establishing PFFS provider education and outreach programs in the 2009 Call Letter under the PFFS section.