

**CMA ON-CALL: The California Medical Association's Information-On-Demand Service**  
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**Document # 0152**  
**Medicare Managed Care / Medicare Advantage**

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In addition to providing increased access to prescription drugs, a major goal of the Medicare Prescription Drug, Improvement Modernization Act of 2003 (MMA) (Public Law No. 108-173) was to expand managed care plan choices available to Medicare beneficiaries. In keeping with that overall objective, the Legislation and its implementing regulations promote, through the "Medicare Advantage" (MA) program, the establishment of new plans for Medicare beneficiaries and participation in those plans using a variety of mechanisms. **As these plans proliferate and more beneficiaries become enrolled in them, physicians who traditionally provided care to their patients under the original Medicare program may increasingly find themselves subject to the terms and conditions of Medicare managed care plans, even when they have no written contract with those plans.** Below is a brief description of the types of plans that are currently being offered, how physicians become participants in them and relevant payment and contracting protections/implications for physicians. For information on challenging denials from a Medicare managed care plan, see [CMA ON-CALL document #1026, "Medicare Managed Care: Denials."](#)

### **IMPLICATIONS OF A FEDERAL MANAGED CARE PROGRAM**

There are three significant implications for physicians with respect to this expansion of the Medicare managed care program:

- Physicians lose the benefit of state law managed care reform laws;
- Depending upon whether the plan has an adequate network or the terms of a physician's contract with the plan, physicians may lose the benefit of having the Medicare fee schedule and its associated payment edits and rules as a reimbursement floor; and
- Physicians may find themselves bearing the burden of health plan obligations, such as having to provide language assistance to persons with limited English proficiency.

#### **1. Do any of the state laws protecting physicians apply to Medicare managed care plans?**

No, despite the plethora of physician and patient protections contained within California law, generally speaking, these laws have no application to plans offered by Medicare Advantage (sometimes referred to as "MA") organizations. Indeed, with the MMA, Congress significantly broadened the scope of federal preemption of these state laws by clearly stating that Medicare Advantage standards supersede all state law and regulation, with the exception of state licensing laws and laws relating to plan solvency. *See* 42 U.S.C. §1395w-26; *see also* 42 C.F.R. §422.402. Further, the exception for state laws that relate to "state licensing" is limited to state requirements for becoming licensed as a health plan. It does not extend to any requirements the state might impose on licensed health plans as a condition of licensure. *See* Fed. Reg. Vol. 70 No. 18, p. 4663. Under these circumstances, state law protections for physicians dealing with managed care plans, such as those relating to disclosure, fair contracting, and payment would not apply to care rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan.

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**2. If I participate in a Medicare managed care plan, am I entitled to at least official Medicare rates?**

Not necessarily. Even apart from the loss of state protections, depending upon the rates of payment that a physician has agreed to, (either through a contract with an MA plan or through "deemed" status in a private fee-for-service plan), the amount of reimbursement may be lower than which would have been received under the original Medicare program fee schedule. See discussion below for what constitutes a "deemed" provider. Under these circumstances, it is absolutely essential that physicians review all their contracts carefully, including those with commercial payers containing "all products" clauses, which extend to the health plan's Medicare products, and review all materials concerning their patient's status as an MA plan enrollee so that they understand their rights and responsibilities with respect to the Medicare Advantage program. For more information on all-products clauses, including protections available pursuant to the RICO Settlements, see [CMA ON-CALL document #1075, "All Products/Affiliates Clauses."](#)

**3. Does participation in a Medicare Advantage plan mean that I am accepting "federal funds" for the purposes of the Civil Rights and other federal laws?**

The health plans certainly think so. For example, a recent version of Blue Shield's Independent Physician's Agreement provides at ¶4.5:

If this Agreement applies to Medicare Advantage Members, provider acknowledges that payments made by Blue Shield are, in whole or in part, derived from federal funds. Provider agrees to comply with all applicable Medicare laws, regulations and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require their subcontractors to do the same. In the event that, (1) absent this Agreement, Provider would not be obligated to comply with any such laws, or, (ii) there is a new interpretation of or change to existing law that imposes new obligations on Provider, and, (iii) Provider reasonably determines that compliance with such laws would represent a material cost to Provider, Blue Shield agrees to meet with Provider in good faith to discuss the additional compensation. If Blue Shield and Provider are unable to reach agreement regarding additional compensation, the Provider may terminate this Agreement upon sixty (60) days notice to Blue Shield.

The federal government has interpreted the Civil Rights Act, for example, to require recipients of federal funds to take adequate steps to insure that limited English proficiency persons have language assistance necessary to afford them meaningful access to the recipient's services. For more information, see [CMA ON-CALL document #0813, "Language Interpreters."](#) CMA disagrees that physicians receiving payments from plans are receiving "federal funds" for the purposes of these laws and is working to change this interpretation. Nonetheless, in the meantime, to the extent physicians incur costs to comply with these laws, physicians are urged to renegotiate their contracts to secure adequate funding. Moreover, physicians should be aware that the MA regulators themselves require that physicians provide "culturally competent" communication, as well as "effective" communication for individuals with disabilities. (42 C.F.R. §422.206(a)(2).)

## **TYPES OF MEDICARE ADVANTAGE PLANS**

In the MMA, Congress established the Medicare Advantage (MA) program under part C of the Medicare program, replacing the Medicare+Choice program.

Consistent with MMA's goals of increasing health plan participation and beneficiary enrollment in private Medicare plans, the MMA authorized the creation of both local and regional plans. An MA regional plan is a coordinated care plan structured as a Preferred Provider Organization (PPO) that serves one or more entire regions. (Local MA plans, on the other hand, generally consist of a full county or

counties). This regional approach requires plans to serve extensive geographic areas specified by the Medicare program and to ensure that areas not previously served by private plans, particularly in rural counties, will have private, coordinated care options available. California is designated as a Region, and WellPoint (Blue Cross of California) is the only health plan which will be acting as the Medicare Regional Plan in California until at least 2008. A chart compiled by the American Medical Association listing all Medicare Advantage plans operating nationwide as of November 16, 2006, may be found at [www.ama-assn.org/ama/pub/category/15304.html](http://www.ama-assn.org/ama/pub/category/15304.html).

#### **4. What types of plans are being offered?**

Medicare Advantage organizations can offer the following products:

##### **Coordinated Care Plans**

- Coordinated care plan – a coordinated care plan is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by Medicare. (42 C.F.R. §422.4.) Coordinated care plans may include mechanisms to control utilization, such as referrals from a gatekeeper and financial arrangements that offer incentives to providers to furnish high-quality and cost-effective care. Coordinated care plans currently operating in California consist of:
  - HMOs – with these plans, patients must generally get their care from primary care physicians, specialists or hospitals in the plan’s network, except in emergency cases. Patients that go outside the network may have to pay for those services themselves if they are determined to be non-covered, as non-covered services need not be reimbursed by the plan.
  - PPOs (Regional or local) – in these plans, beneficiaries that use network physicians pay less. These beneficiaries may see out-of-network providers, though it will usually cost extra.
  - Provider sponsored organizations – these are entities that are established or organized by health care provider and provide a substantial portion of the health care services under the MA contract directly through that provider.

##### **Private Fee-For-Service Plans**

- Private Fee-For-Service (PFFS) plan – a Medicare Advantage plan that
  - pays physicians a rate determined by the plan on a fee-for-service basis without placing the placing the physician at financial risk;
  - does not vary those rates based on the utilization of that physician’s services; and
  - does not restrict enrollee’s choice among providers that are lawfully authorized to provide services and agree to accept the plan’s terms and conditions of payment. (42 C.F.R. §422.4(a)(3).)

Many plans (including small ones such as "Sierra Optima" and "Today's Options") offer PFFS products in California. Unless it is an emergency, or the physician has opted out of Medicare entirely and has entered into a private contract with the enrollee, PFFS enrollees must use only participating providers (either one who is contracted and who is deemed to be contracted) for their health care needs. See discussion below.

## **Medicare Cost Plans**

In addition to Medicare Advantage plans, Medicare offers other plans. The most commonly used "other Medicare" plan in California is the "Medicare Cost plan". Medicare Cost plans use many of the same rules as Medicare HMOs. However, in a Medicare Cost program, if a beneficiary goes to a non-network provider, the services are covered under the original Medicare plan (that is, they are not then "non-covered services".)

## **PHYSICIAN PARTICIPATION IN MEDICARE MANAGED CARE PLANS**

### **Direct Contract Not The Exclusive "Contracting" Mechanism**

There are number of ways that a physician can be a participant in a Medicare managed care plan. Significantly, a "direct" contract with a Medicare plan specifically for the provision of services to Medicare beneficiaries is not required. Thus, a physician may participate in a Medicare Managed Care plan without a direct contract. The two additional ways in which physicians can be participants are through "all products" clauses contained in their current managed care plan contracts or through "deemed" status (for PFFS plans only).

### **All Products/Affiliates Clauses**

Some health plans adhere to an "all products" policy that requires that physicians also join the plan's other current and future products, including its HMO, Medicare, and workers compensation products. CMA has serious concerns as to whether or not such contracts are "fair and reasonable" as required by California law. However, absent a health plan enjoying such large market power that the activity restrains competition in violation of the antitrust laws, "all products" clauses are not flatly prohibited by California law. For more information on other products clauses including protections available pursuant to the RICO Settlements, *see* [CMA ON-CALL document #1075, "All Products/Affiliates Clauses."](#) *See* also "Managed Care Contracts Deciphered – The Physicians' Guide to Their Rights and Obligations" contained within CMA's "Managed Care Contracting Toolkit" - a guide that identifies potentially problematic provisions in managed care contracts and laws that relate to those areas, and offers alternative contract language to consider. This guide is available at minimal cost to CMA members by visiting CMA's website at [www.cmanet.org](http://www.cmanet.org).

Under the contracting rules for Medicare Advantage, it is unclear whether the physician must have a contract to participate in the Medicare Advantage product itself, as opposed to a contract with the managed care company offering the MA product. *See*, for example, 42 C.F.R. §442.4(a)(1)(v) (stating, generally, that plans have a network of providers that are under contract with the organization (as opposed to the MA product itself) offering the MA plan.) Arguably, physicians who have signed an "all products clause" with an organization offering a MA plan may be contractually bound to provide care to Medicare beneficiaries under that plan. Because of the importance of this issue, the AMA is currently attempting to clarify this issue with the Medicare program.

Under these circumstances, it is essential that engaged in managed care contracting, physicians are alert to a number of issues during the contracting process:

- whether or not the contract contains an "all products clause" and whether that clause extends to plans offering benefits to Medicare beneficiaries;
- whether and in what format the plan will notify physicians of the existence of these other products;
- whether and in what format the plan will notify physicians of any Medicare patients enrolled in these products;

- what the payment terms of any Medicare plans are, as compared to original Medicare; and
- whether physician has the ability to "opt out" of these products.

Physicians should not be unwittingly forced into plans with unfair payment terms and conditions. If, upon examining these factors, the physician is being coerced into a plan's product under unfair circumstances, the physician is urged to contact CMA's Health Law Information Specialists at (415) 882-5144 so that CMA can follow up with the Legislature and regulators, as appropriate.

**5. Blue Cross has a Medicare Advantage plan and has an "All Products" clause in its contract with me. Does this mean I need to participate in Blue Cross' MA Plans?**

With respect to all products clauses, it should be noted that in its settlement of the class-action RICO lawsuit against it, WellPoint agreed to the following in ¶7.13(b):

Company agrees that it shall not require a Participating Physician to participate in a capitated fee arrangement in order to participate in Product Networks in which such Participating Physician is compensated on a fee-for-service basis. Company further agrees it shall not require a Participating Physician to participate in its Medicare Advantage or Medicaid Product Network in order to participate in its commercial Product Networks. Except where a Participating Physician (or Physician Group comprised of Participating Physicians or Physician Organization) has agreed in an Individually Negotiated Contract to participate in more than one Product Network for a specified period of time, in which case the terms of such Individually Negotiated Contract shall govern, if a Participating Physician (or Physician Group comprised of Participating Physicians or Physician Organization) either (a) chooses not to participate in all Company Product Networks or (b) terminates participation in some Company Product Networks, then the reimbursement levels (e.g., fee-for-service maximum allowable amount, capitation rate or other reimbursement methodology) offered to or applied by Company to such Participating Physician (or Physician Group or Physician Organization) for the Product Network(s) in which such Physician (or Physician Group or Physician Organization) continues to participate shall not be lower than Company's standard reimbursement levels (e.g., fee-for-service rate or other) in that geographic market. (Notwithstanding the foregoing, Company may offer a higher reimbursement level (e.g., fee-for-service maximum allowable amount, capitation rate or other reimbursement methodology) or other incentive to any Participating Physician (or Physician Group or Physician Organization) who elects to participate (or elects to continue participation) in more than one of Company's Product Networks. Nothing in this paragraph shall obligate Company to pay more than the lesser of the Physician's billed charges or the Company's applicable fee-for-service amount.

Thus, under this provision, WellPoint will not require physicians to participate in its Medicare Advantage or Medi-Cal networks in order to participate in its Prudent Buyer network if they chose not to. Physicians who, after reviewing the plan's terms and conditions, individually decide not to participate in that plan should contact Blue Cross in writing and inform them that they are exercising their rights pursuant to ¶7.13(b) of the Settlement to not participate in the organization's Medicare and/or Medicaid product network. *See* Sample Letter One.

**DEEMED CONTRACT PROVIDERS (PRIVATE FEE-FOR-SERVICE PLANS ONLY)**

The Medicare Advantage rules also provide for "deemed" contract status for certain providers who provide the care to beneficiaries enrolled in a private fee-for-service plan. Specifically, except for emergency services furnished in a hospital, any provider furnishing health services to enrollee in a MA PFFS plan and who has not previously entered into a contract to furnish services under the plan will be treated as having a contract in effect if the following conditions are met:

- a) The services are covered in the plan and are furnished:

- i) to an enrollee of an MA PFFS;
  - ii) provided by a provider of services that does not have in effect a signed contract with the MA organization; and
- b) Before furnishing the services, the provider was informed of an individual's enrollment in the plan and was informed (or given a reasonable opportunity to obtain information) about the terms and conditions of payment under the plan.
  - c) The information was provided in a manner that was reasonably designed to effect informed agreement. (42 C.F.R. §422.216(f).)

**6. Does a physician need to agree affirmatively to the PFFS terms and conditions?**

No. The physician's affirmative consent to participate in the PFFS is not required. A physician who provides services to a Medicare patient enrolled in a PFFS plan is a "deemed" provider if (1) in advance of furnishing the service, he/she knows that the patient is enrolled in a PFFS plan, and (2) the physician either possesses or has access to the plan's payment terms and conditions.

**7. What information is necessary for "deemed status" to occur?**

All the law requires is that enrollee information be provided and PFFS payment terms and conditions information be accessible. Enrollment information can be provided by an enrollee presenting an enrollment card or by CMS, the Medicare carrier or MA organization itself sending notice attesting to enrollment. The MA organization can make payment terms and conditions available through one of two very general methods, that is, by providing the information through the regular mail, electronic mail, fax or telephone to either the provider, his or her employer or billing agent, partner, or party to which the provider makes an assignment or reassigns benefits, **or** by providing a procedure under which the provider can receive instructions on how to request payment information and responding to the request before the entity furnishes the services. (42 C.F.R. §422.212(h).)

**8. What happens if the "deemed" physician goes ahead and furnishes care to a PFFS patient?**

If the physician chooses to furnish services to the enrollee and has access to the plan's terms and conditions information, then the physician is automatically a "deemed" provider (for that episode of care with that enrollee) and must accept the PFFS plan's terms and conditions.

**9. How does a physician know that a Medicare beneficiary is enrolled in a PFFS plan, rather than Original Medicare?**

The beneficiary should present the provider with an enrollment card identifying the patient as a member of a PFFS plan. In addition, the enrollment card will give a toll-free phone number and / or a web address for the plan's terms and conditions of participation.

**10. If I am "deemed" a contracting provider, then does that mean I am "deemed" for all my patients enrolled in a PFFS plan?**

No, the "deeming" laws are patient and episode specific; they only apply on a per patient basis. However, once a physician is "deemed" for one patient in a plan, the physician is likely to be deemed to understand the plan's payment terms for all future patients in that plan. Thus, the only way that physician would not be "deemed" for every other patient enrolled in that plan to whom the physician provides services is if the patient failed to provide a current enrollment card. It is therefore essential that, if the physician is "deemed," the physician understand the plan's payment terms and conditions. If the rates, payment terms, or other conditions are unacceptable to the physician, the physician may wish to negotiate for better rates

with the plan going forward or notify existing patients that the physician will be unable to continue to provide services to those patients who are covered by that plan.

### **11. What if I do not agree to the PFFS plan terms and conditions?**

Except in emergency situations, you do not need to furnish care to the plans' enrollees. CMS instructs enrollees that:

"Providers are not required to furnish services to enrollees in a Private Fee-For-Service Plan. If your providers [sic] does not want to participate in your Private Fee-For-Service Plan, then you must seek care from another provider who is willing to furnish services to Private Fee-For-Service enrollees."

and that:

". . . providers are not required to accept enrollees of a private fee-for-service plan."

See CMS Private Fee-For-Service – Beneficiary Questions and Answers, located at <http://www.cms.hhs.gov/PrivateFeeForServicePlans/Downloads/benqa.pdf>.

Thus, even if the "deeming" circumstances were met, i.e., you had knowledge of your patient's enrollment in a PFFS plan and had access to a plan's "terms and conditions", you need not participate in that plan against your will. If you believe those terms and conditions are unfair or otherwise not acceptable, options include opting out of Medicare entirely and entering into a private contract with your patient or terminating your relationship with that patient. Prior to doing the latter, however, to avoid charges of patient abandonment, see [CMA ON-CALL document #0805, "Termination of the Physician-Patient Relationship."](#) It may be advisable to copy the PFFS plan on the letter informing the patient that you will not be able to continue as their physician, and let the patient know that the PFFS plan is responsible for finding them a physician who will agree to provide services under that plan. See Sample Patient Notification letter at the end of this document.

### **12. If I have opted out of the Medicare program entirely, then could I provide care to a PFFS enrollee?**

Yes. If you have opted out of the Medicare program entirely and contract with your Medicare patients privately, CMA believes that you may continue to see a PFFS patient. See 42 U.S.C. §1395a(b) (providing that nothing in the Medicare Act shall prohibit private contracting.) For more information, see [CMA ON-CALL document #0151, "Medicare Participation \(and Non-Participation\) Options."](#)

### **13. Then when, if ever, would I be considered a "non-contracting provider"?**

If a physician furnishes services to a PFFS enrollee but the deeming requirements are not met, then the physician becomes a non-contracting physician. According to CMS, a physician cannot become "deemed" in circumstances where he/she does not know in advance of furnishing services that a patient is a member of a PFFS plan. This could occur in an emergency where a physician cannot communicate with the patient before furnishing care, or in certain situations where the patient does not inform the physician of their enrollment in a PFFS plan. As a further example, a physician cannot become a deemed provider if the physician has not received or does not have reasonable access to a PFFS plan's terms and conditions of participation prior to furnishing services to a PFFS enrollee. See [www.cms.hhs.gov/privatefeeforserviceplans/downloads/provqa.pdf](http://www.cms.hhs.gov/privatefeeforserviceplans/downloads/provqa.pdf). But in those cases, physicians would still be paid the lesser of their billed charges or what they would be entitled to under the Medicare program.

**14. But if I accept assignment, am I required to accept a PFFS member for care?**

No, again providers are not required to see an enrollee in a PFFS plan. However, if a provider furnishes care to a PFFS enrollee, and the deeming conditions have been met, the provider is bound by the PFFS plans terms and conditions of participation. See [www.cms.hhs.gov/privatefeeofserviceplans/downloads/provqa.pdf](http://www.cms.hhs.gov/privatefeeofserviceplans/downloads/provqa.pdf).

**15. But this whole thing seems so terribly unfair to both me and my patients. What can I do to minimize the burden of this program on my patients and my practice?**

- **Check out the plans in your area.**

First look at the terms and conditions of the plans that are operating in your area. You may find that some of them will reimburse you at acceptable levels. You can see which and what type of plans are in your area by searching for Medicare health plans on the CMS website at [www.medicare.gov/mppf/include/datasection/questions/searchoptions.asp](http://www.medicare.gov/mppf/include/datasection/questions/searchoptions.asp). Make sure to evaluate both the fee schedule and the payment rules, as PFFS plans are free to impose claims edits or impose other payment rules that may significantly reduce the payment you will receive.

- **Train your office staff.**

Make sure your staff understands which PFFS plans you do not wish to accept. Enrollees should be notified that you will refuse to accept the plan's terms and conditions (and therefore treat them) before they are given an appointment whenever feasible.

- **Notify your patients.**

If you cannot ethically or financially accept the plan's terms and conditions for your current patients, notify them of that fact and that therefore you will be unable to treat them unless they change to another plan or return to the original Medicare program. (See Sample Letter, "Patient Notification.") You may also wish to urge them to write their Congressional Representatives to let them know how unfair PFFS plans can be for both patients and their physicians.

- **Read CMA Alert regularly.**

This issue continues to be on CMA's Federal legislative agenda. CMA Alert will keep you updated and let you know how you can help. CMA members who are not currently receiving this excellent weekly e-mail update can subscribe by sending an e-mail to [kgallia@cmanet.org](mailto:kgallia@cmanet.org).

**REIMBURSEMENT FROM MEDICARE ADVANTAGE PLANS**

**Contracting Physicians**

Physicians who participate in an MA plan through a contract (either directly or potentially through an all products clause) are bound to accept the reimbursement rates and policies identified in the contract with the plan.

**Deemed Physicians (PFFS plan)**

Private fee-for-service plans must either have payment rates that are not less than the rates that apply under original Medicare or have contracts or agreements with a sufficient number and range of providers to furnish services covered under the plan (42 C.F.R. §422.114). Thus, if a PFFS plan does not have a

sufficient number of contracts or agreements, "deemed" physicians are entitled to at least original Medicare rates from the plan. If on the other hand, if there is a sufficient network (possibly through an all products clauses), "deemed physicians" may be obligated to accept the plan's payment terms, even if they are less than the Medicare fee schedule. CMA is currently working with Medicare to determine when a plan is considered to have a "sufficient" number of contracts and how physicians will have knowledge of that fact so that they can be sure they are being reimbursed properly. CMA would like to be informed of any PFFS that are paying less than original Medicare rates and urges physicians to contact CMA's Health Law Information Specialists at (415) 882-5144.

### **Non-Participating Physicians May Still Be "Deemed"**

Both participating and non-participating physicians may be deemed to be participating in private fee-for-service plans. Assuming the plan is paying original Medicare, this may result in lower payments to non-participating physicians. Thus, non-participating physicians should be vigilant in determining what the terms and conditions of the plan are prior to treating the patient.

#### **16. If I am a "deemed" physician, who do I bill?**

The Medicare program will not accept bills for enrollees in a PFFS plan. The physician must send bills to the address provided in the PFFS plan's terms and conditions of participation. Those terms and conditions will specify the form and content of the bill the provider submits to the PFFS plan. The provider is also responsible for collecting the allowable cost sharing amount from the enrollee.

#### **17. Are the cost sharing amounts for contract and "deemed" providers the same?**

Yes. By law they must be. (42 C.F.R. §422.216.)

#### **18. Can a provider bill the beneficiary if the PFFS organization will not pay?**

Any provider who furnishes care can only collect from the beneficiary the amount allowed under the plan's terms and conditions of participation. Thus, the provider collects the plan allowed cost sharing from the enrollee and the PFFS plan pays the remainder of the amount due for the services furnished. The PFFS plan is accountable for any other amounts owed the provider for covered care. If the care is not covered under the plan, the provider can collect from the beneficiary for the non-covered care. For example, if the plan does not cover hearing aids, but a provider furnishes a plan member hearing aids, the provider may collect payment for them from the beneficiary. See [www.cms.hhs.gov/privatefeeforserviceplans/downloads/provqa.pdf](http://www.cms.hhs.gov/privatefeeforserviceplans/downloads/provqa.pdf).

#### **19. I heard I can balance bill under a PFFS plan? Is that true?**

Not in the traditional sense that the term is understood. Depending upon the plan's terms and conditions, providers may be allowed to charge beneficiaries for up to 15% over the plan's payment amount for their services. See 42 C.F.R. §422.216. This is in addition to the cost-sharing amount established by the plan. Thus, depending upon what the plan permits, contracted and "deemed" physicians may be allowed to balance bill up to 15 percent of the PFFS plan payment rate. (Non-contract physicians cannot "balance bill" PFFS enrollees.)

### **Non-Contract Physicians**

Any provider of services that does not have in effect a contract (or is not a "deemed" provider) establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept as payment in full the amount that it could collect if the beneficiary were enrolled in original Medicare. See 42 C.F.R. §422.214. Thus, depending upon whether the physician participates in Medicare, he/she would be allowed the amount for

participating physicians or the limiting charge. In either case, the physician collects the plan allowed cost-sharing from the beneficiary and the plan pays the provider the remainder.

**Non-Covered Services.** The result is different with respect to non-covered services, however. When a beneficiary enrolls in a Medicare managed care plan, the Center for Medicare and Medicaid Services (CMS) has stated that that beneficiary has "Medicare coverage only to the extent that the services are covered under the risk plan according to the plan's rules for coverage." (63 Fed.Reg. 211 (Nov. 2, 1998), p. 58851.) For example, if the beneficiary obtained care from a non-network physician without receiving prior authorization, and coverage was limited to network physicians, there would be no plan coverage of that service and the beneficiary is fully liable for the full charge of the service. According to CMS:

In these types of situations, the physician or practitioner may charge the beneficiary without regard to the limiting charge for the service furnished, and no claim need be submitted [to the plan] for the non-covered service. (*Id.*)

A few important caveats must be noted, however. Again, if the services provided by the non-contracting provider are covered by the plan, such as emergency services, which are always covered services, the physician must bill the plan directly and accept from the plan the amount that could have been collected if the beneficiary were enrolled in original Medicare. (42 C.F.R. §422.214.) Second, following receipt and payment from the patient of your bill for non-covered services, the beneficiary may always attempt to seek payment from the plan. If the plan pays for the service, the physician would need to refund to the beneficiary the amount he/she received in excess of the Medicare allowed amount (if the physician participates in original Medicare) or the Medicare limiting charge (if the physician does not participate in original Medicare).

Thus, prior to billing any beneficiary for non-covered services, physicians are advised to inform the beneficiary that he/she does not participate in the plan, and believes that his/her services are not covered. The physician should also inform the patient that he/she will seek his/her usual charge from the beneficiary, but that the beneficiary has the right to submit a claim with the plan. (Again, if the plan pays, the physician must make a refund to the beneficiary.) While the law does not require an Advanced Beneficiary Notice in this situation, to protect a physician from charges of inappropriate balance billing, physicians may also wish to confirm with the plan, prior to rendering the service, that the service, in fact, would not be covered under the plan's rules. In these cases, the physician may charge the beneficiary without regard to the limiting charge for the service furnished. (42 U.S.C. §1395mm(j).)

## **PROMPT PAYMENT PROVISIONS**

The contract between the Centers for Medicare and Medicaid Services and the Medicare Advantage organization must provide that the organization will pay 95% of "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of a MA private fee-for-service plan or are claims that are not furnished under a written agreement between the organization and the provider. (42 C.F.R. §422.520.) The MA organization must pay interest on "clean claims" that are not paid within 30 days. (*Id.*) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. (*Id.*)

Significantly, CMS declined to provide similar protection for contracted providers in MA plans other than in a PFFS plan. Specifically, CMS felt it was appropriate that the contracts between MA organizations and providers contain a prompt payment provision, the terms of which are developed and agreed to by both the organization and the physician. Under these circumstances, physicians are urged to ensure that their contracts comply with their prompt payment provisions of California law, that is, payment no later than 30 working days (for a PPO) or 45 days (for an HMO) after receipt of the claim. *See* Health & Safety Code §§1371, 1371.35, and Insurance Code §10123.13. For more information on California laws and the additional protections available through the RICO Settlement, *see* [CMA ON-CALL document #0124, "Late Payment."](#)

## **PLAN RELATIONSHIP WITH PROVIDERS**

In addition, CMS has included a number of regulatory provisions theoretically designed to foster a good relationship between health plans and health professionals. They can be summarized as follows:

### **Physician Participation**

MA organizations providing a coordinated care plan must generally provide for reasonable procedures for physician participation that include the following:

- a) written notice of the rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions;
- b) written notice of material changes and participation rules before the changes are put into effect.;
- c) written notice of participation decisions that are adverse to physicians; and
- d) a process for appealing adverse participation procedures, including the right of physicians to present information and their views on the decision.

According to 42 C.F.R. §422.202(a) these protections extend not only to directly contracting health care professionals, but also to those with subcontracted agreements. (42 C.F.R. §422.202(c).) On the other hand, because participation a PFFS plan is virtually limitless, due to the potential for "deemed" status, these participation rules are not applicable to physicians participating in those plans.

### **Medical Guidelines**

The MA organization must establish a formal mechanism to consult with the physicians who have agreed to provide services under the MA plan offered by the organization, regarding the organization's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met:

- a) practice guidelines and utilization guidelines:
  - i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
  - ii) consider the needs of the enrolled population;
  - iii) are developed in consultation with contracting health care professionals; and
  - iv) are updated and reviewed periodically.

These guidelines must be communicated to providers, and as appropriate, to enrollees. Further, any decisions with respect to utilization management, enrollee education, coverage of services and other areas in which the guidelines apply must be consistent with these guidelines. (42 C.F.R. §422.202).

### **Suspension or Termination of the Contract**

Further, there are some contracting protections. An MA organization that operates a coordinated care plan or network MSA plan and suspends or terminates an agreement with a provider for cause must give the individual written notice of the following:

- a) The reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.

- b) The physician's right to appeal the action and the processing time for requesting such a hearing. During the hearing, the MA organization must ensure that the majority of the hearing panel members are peers of the effected physician.

With respect to without cause terminations, an MA organization and contracting provider must provide at least 60 days written notice to each other before terminating a contract without cause. (42 C.F.R. §422.202)

### **Gag Clauses**

An MA organization may not prohibit or otherwise restrict a physician from advising, or advocating on behalf of an individual patient about the following:

- a) The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;
- b) The risks, benefits, and consequences of treatment or nontreatment; or
- c) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions. (42 C.F.R. §422.206(a).)

### **Culturally Competent, Effective Communication**

Health professionals must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Further, physicians must ensure that individuals with disabilities have effective communications with participants throughout the health care system in making decisions regarding treatment options. (42 C.F.R. §422.206(a)(2).)

### **Hold Harmless Clauses Prohibited**

An MA organization may not contract or otherwise provide, directly or indirectly, for physicians to indemnify the MA organization against civil liability for any damage caused an enrollee as a result of the MA organization's denial of medically necessary care. (42 C.F.R. §422.212.)

As can be seen, there are a myriad of laws affecting physicians and their patients involved in Medicare Advantage programs. Physicians need to be vigilant in reviewing their contracts and any notifications that they get from their enrollees concerning their status of their patients' participation in one of these programs.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA ON-CALL, or refer to CMA's California Physician's Legal Handbook. This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available on a fully searchable CD-ROM, or in a seven-volume, softbound format. To order your copy, call (800) 882-1262 or visit CMA's Bookstore at [www.cmanet.org](http://www.cmanet.org).

## **SAMPLE LETTERS AND FORMS: INSTRUCTIONS**

The following sample letters do not constitute and is not a substitute for legal or other professional advice:

1. [Medicare Advantage or Medicaid Product - Sample Letter Requesting Opt-Out of Blue Cross of California Product](#)
2. [Medicare Advantage - Sample Patient Notification of Non-Acceptance of PFFS Plan](#)

Users should consult their own legal and other professional advisors as necessary for individualized guidance with respect to each particular situation.

To use these documents, delete or replace all text that appears in brackets ("["add"]") with the correct information, and make sure all blank spaces are filled in correctly.

**Medicare Advantage or Medicaid Product - Sample Letter Requesting Opt-Out of Blue Cross of California Product**

[Physician's Letterhead]

Blue Cross of California  
Freedom Blue  
21555 Oxnard Street, AC8D  
Woodland Hills, CA 91367

Re: Dr. \_\_\_\_\_ Non-Participation in Medicare Advantage or Medicaid Product

Pursuant to ¶7.13(b) of the July 11, 2005 Settlement that Blue Cross of California entered into in the class action RICO case brought by the California Medical Association, among others, I hereby exercise my right to not participate in the following network:

[LIST NETWORKS]

Under these circumstances, I expect I will be paid at rates at least equal to that offered by the [Medicare or Medi-Cal] program for my services.

Thank you in advance for your attention to this matter.

Sincerely,

\_\_\_\_\_  
[Physician's Name], M.D.

## Medicare Advantage - Sample Patient Notification of Non-Acceptance of PFFS Plan

[Date]

Dear [Name of Patient]

Unfortunately, because of financial and other reasons, I am unable to accept the terms and conditions for participation in your plan [     Name of Plan     ]. Under these circumstances, Federal law does not allow me to continue to be your physician unless I opt out of the Medicare program entirely.

I view this situation as extremely unfair to both you and me. It is my understanding that you chose this plan believing that you could see any physician you wanted. This simply is not the case. In fact, only those physicians who have a contract with your plan or who agree to the plan's terms and conditions may treat you.

I have greatly appreciated the opportunity to serve as your physician and will be very pleased to continue in that role. If you wish to continue to receive medical services from our office, you will need to switch to another type of Medicare plan, or return to the Original Medicare program. I can let you know what plans I still contract with, if you wish to and have the opportunity to change plans. You can compare Medicare plans by going to [www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp](http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp).

You can leave a PFFS plan between November 15 and March 31 of each year. If you want to leave your Private Fee-for-Service Plan and return to the Original Medicare Plan, you can:

- Write or call your plan; or
- Call (800) MEDICARE (1-800-633-4227).

Tell them you want to leave your Private Fee-for-Service Plan and return to Original Medicare.

Further, you may wish to lobby your congressional representatives on this issue explaining the unfairness of the situation.

As a long standing member of this community, I am deeply committed to the health of the community and regret very much this intrusion into our relationship. I hope I can continue to be of service to you and will work with you should you change your Medicare coverage so that I may continue to serve as your physician. If not, your plan should be able to assist you in finding a new physician.

Sincerely,

\_\_\_\_\_, M.D.

Physician's Name

cc: [ Name of Plan ]

