Medicare Managed Care Manual
Chapter 6 - Relationships With Providers

Table of Contents
(Rev. 67, 08-12-05)

10 - Introduction
(Rev. 24, 06-06-03)

Chapter 6 of this manual focuses on the requirements for relationships between Medicare Advantage organizations (MA organizations) and the physicians and other health care professionals and providers with whom they contract to provide services to Medicare beneficiaries enrolled in an MA plan. This chapter also contains some requirements that apply to non-contract providers that furnish services to beneficiaries enrolled in an MA organization. The policies in this chapter are derived from Subpart E of Part 422 of the Code of Federal Regulations, and include additional instructions intended to provide further guidance on implementation of regulatory requirements. The statutory basis for the regulations at 42 CFR, Part 422 is set forth in the preambles to three final rules published in the "Federal Register": a June 26, 1998, Interim Final Rule requesting public comment (63 FR 35068), and two final rules responding to public comments on the interim final rule, published on February 17, 1999 (64 FR 7980) and June 29, 2000 (65 FR 40316).

Note that other policies relevant to providers are addressed in other chapters:

See Chapter 11, "Contracts with Medicare Advantage Organizations," for information on:

- MA organization oversight responsibility for contractors, subcontractors, and related entities (see 42 CFR 422.502(i)): It is the responsibility of the MA organization to ensure through written arrangements that all applicable laws, regulations, and other instructions are followed.

- Prompt payment by MA organizations to contracting and non-contracting providers (see 42 CFR 422.502(c), 422.520).

- Beneficiary financial protections from inappropriate liability in the event of provider terminations (see 42 CFR 422.502(g)).

See Chapter 4, "Benefits and Beneficiary Protection," for information on:

- When the MA organization must pay non-contract providers (see 42 CFR 422.100(b)). Section 100 of this chapter also contains information on what non-contract providers must accept as payment in full (see 42 CFR 422.214).

- Notice to beneficiaries in the event of provider terminations (see 42 CFR 422.111(e)).

See Chapter 10, " Organization Compliance With State Law and Preemption By Federal Law," for information on:

- Federal preemption of state law (see 42 CFR 422.402). Pursuant to §1856(b)(3)(ii) of the Social Security Act, state laws or regulations relating to inclusion or treatment of providers are specifically superseded by Federal law.

Note that 42 CFR 422.216, Special rules for MA private fee-for-service plans, is not included in this chapter.

20 - Provider Involvement in Policy-Making
(Rev. 24, 06-06-03)

20.1 - Physician Consultation in Medical Policies
(Rev. 24, 06-06-03)

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 assurance/improvement programs and medical management procedures and ensure that the following standards are met:

1. Practice guidelines and utilization management guidelines:

    - Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
    - Consider the needs of the enrolled population;
    - Are developed in consultation with contracting physicians; and
    - Are reviewed and updated periodically.

2. The guidelines are communicated to providers, and, as appropriate, to enrollees.

3 Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

An MA organization that operates an MA plan through subcontracted physician groups must provide that these policies apply equally to physicians within those subcontracted groups.

(Source: 42 CFR 422.202(b) and (c).)

20.2 - Consultation in Development of Credentialing Policies
(Rev. 24, 06-06-03)

Credentialing and recredentialing standards for types of providers and for specialists should be reviewed by clinical peers, through establishment of a credentialing committee or other mechanism. In addition, there should be a process for peer review when the MA organization is considering employing or contracting with a provider who does not meet its established credentialing standards.

(Source: 42 CFR 422.204(b)(2)(iii) and additional instructions.)

30 - Written Information on Physician Participation
(Rev. 24, 06-06-03)

An MA organization that operates a coordinated care plan or network Medical Saving Account (MSA) plan must provide for the participation of individual physicians and the management and members of groups of physicians, through reasonable procedures that include:

1. Written notice of rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions;

2. Written notice of material changes in participation rules before the changes are put into effect; and

3. Written notice of adverse participation decisions and a process for appeal (see §60.4).

An MA organization that operates an MA plan through subcontracted physician groups must provide that these participation procedures apply equally to physicians within those subcontracted groups.

(Source: 42 CFR 422.202(a) and (c))

40 - Interference With Health Care Professionals' Advice to Enrollees Prohibited

(Rev. 24, 06-06-03)

An MA organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an MA plan about:

1. 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 provide an opportunity for the patient to decide among all relevant treatment options;

2. The risks, benefits, and consequences of treatment or non-treatment; or

3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Health care professionals must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Health care professionals must ensure that enrollees with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

The general rule prohibiting an MA organization from interfering with providers' advice to enrollees does not require the MA plan to cover, furnish, or pay for a particular counseling or referral service if the MA organization that offers the plan:

1. Objects to the provision of that service on moral or religious grounds; and

2. Through appropriate written means, makes available information on these policies as follows:

    - To CMS, with its application for a Medicare contract, within 10 days of submitting its adjusted community rate (ACR) proposal or, for policy changes, in accordance with 42 CFR 422.80 (concerning approval of marketing materials and election forms) and with 42 CFR 422.111 (concerning disclosure requirements).

    - To prospective enrollees, before or during enrollment.

    - With respect to current enrollees, the MA organization is eligible for this exception if it provides notice of such change within 90 days after

adopting the policy at issue; however, under regulatory disclosure requirements, notice of such a change must be given in advance.

Nothing in this provision may be construed to affect disclosure requirements under state law or under the Employee Retirement Income Security Act of 1974.

An MA organization that violates provisions of this section is subject to intermediate sanctions.

(Source: 42 CFR 422.206)

50 - Provider Anti-Discrimination

(Rev. 24, 06-06-03)

Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing, and the requirement that all Medicare-covered services be available to all MA plan enrollees, an MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the affected provider(s) on the reason for the decision.

This prohibition does not preclude any of the following actions by an MA organization:

1. Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).

2. Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.

3. Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

(Source: 42 CFR 422.205)

60 - Provider Participation
(Rev. 24, 06-06-03)

60.1 - Notice of Reason for Not Granting Participation
(Rev. 24, 06-06-03)

As noted directly above, if an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the affected provider(s) on the reason for the decision.

60.2 - Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks
(Rev. 24, 06-06-03)

Excluded Providers

The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. The MA organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. The MA organizations should check the Office of the Inspector General (OIG) Web site at http://www.oig.hhs.gov/fraud/exclusions/list of excluded.html for the listing of excluded providers and entities. The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR 1001.1901.

Opt-Out Providers

If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. The MA organization must check this list on a regular basis.

(Source: 42 CFR 422.204(b)(4) and 42 CFR 422.220 and additional instructions.)

60.3 - Credentialing, Monitoring, and Recredentialing
(Rev. 24, 06-06-03)

An MA organization must have written policies and procedures for the selection and evaluation of health care professionals that conform with the following credentialing requirements and the provider anti-discrimination policy discussed directly above. Credentialing is the review of qualifications and other relevant information pertaining to a health care professional who seeks appointment (in the case of an MA organization directly employing health care professionals) or who seeks a contract or participation agreement with the MA organization. Note that MA organization oversight of credentialing in contracted, subcontracted, and other related entities is an MA organization contract requirement imposed by 42 CFR 422.502(i)(4)(iv) and is addressed further in Chapter 11, "Contracts With Medicare Advantage Organizations."

Credentialing is required for:

- All physicians who provide services to the MA organization's enrollees, including members of physician groups; and

- All other types of health care professionals who provide services to the MA organization's enrollees, and who are permitted to practice independently under state law.

Credentialing is not required for:

- Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner;

- Hospital-based health care professionals who provide services to enrollees incident to hospital services, unless those health care professionals are separately identified in enrollee literature as available to enrollees; or

- Students, residents, or fellows.

Initial Credentialing

Procedures for initial credentialing involve a written application; verification of information from primary and secondary sources; confirmation of eligibility for payment under Medicare; and site visits as appropriate. A limited set of procedures for newly trained health care professionals permits initial credentialing for a period of up to 60 days.

Written Application

The credentialing process begins with the completed application and attestation of correctness signed by the health care professional. The application must be signed, dated and include an attestation by the applicant of the correctness and completeness of the application. The information collected must be no more than six months old on the date on which the health care professional is determined (for example, by a credentialing committee) to be eligible for appointment or contract. All items must be verified prior to the appointment of the health care provider, with the exception being in the case of a pending Drug Enforcement Agency (DEA) number.

The application includes a work history covering at least 5 years and a statement by the applicant regarding: (1) Any limitations in ability to perform the functions of the position, with or without accommodation; (2) History of loss of license and/or felony convictions; and (3) History of loss or limitation of privileges or disciplinary activity. (**NOTE:** Work history refers to relevant work that is applicable to the position being sought. If the applicant is a new health care professional, he/she may not have 5 years of relevant work history.)

Verification of Information

Some information may be verified from a primary source and some information may be verified from secondary sources. A "primary source" is an organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys. Primary source verification may be achieved through the use of industry-recognized verification sources. The nationally recognized accrediting organizations specify which sources they consider to be appropriate primary sources for verifying credentials. In some instances, except for licensure, a secondary source will be considered acceptable provided that the secondary source verifies the information from the originator. If the MA organization uses one of the primary sources identified by one of these nationally recognized accrediting organizations, CMS will consider that source acceptable. If questioned, the MA organization should be able to reference which organization identified that source. In addition, although the National Practitioner Data Bank (NPDB) does not have any legal responsibility for issuing a document, it is generally considered an appropriate source of verification by most private accrediting organizations as well as by CMS.

Primary Source Verification Required

An MA organization must verify the following from primary sources and include in the credentialing records:

1. A current valid license to practice: Verification must show that the license was in effect at the time of the credentialing decision.

2. Education and training records, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, if applicable: Verification is required only for the highest level of education or training attained. For example, health care professionals who have completed residency, then the verification from the residency program is the highest credential to be verified, and for those who only completed medical school, the medical school verification must be obtained. When verifying the highest level of education or training through primary sources, the assumption is that all other education or training requirements prior to the highest level achieved have been met. This assumption is consistent with current credentialing practices.

3. Board certification in each clinical specialty area for which the health care professional is being credentialed if he/she states that he/she is board certified on the application: If board certification is verified, CMS will accept this as also satisfying the requirement to verify education and training, provided that board uses primary source verification for education and training.

Primary Source Verification Not Required

Following are other credentialing requirements that must be verified and included in the credentialing files. Previously, these requirements also stipulated primary source verification. This change from primary source to secondary source aligns these requirements with current industry standards. Secondary sources of information for these requirements are widely accepted and appropriate. The sources of and methods for obtaining the designated credentialing requirements listed below are suggested appropriate sources/methods; however, this is not intended as an all-inclusive listing of sources/methods that an MA organization may employ to acquire the requisite information.

1. Clinical privileges in good standing at the hospital designated by the health care professional as the primary admitting facility if the physician or other health care professional has admitting privileges: Health care professionals who have the ability to have admitting privileges may choose not to have them, as they may not manage care in the inpatient setting. However, if a health care professional does have admitting privileges, he/she is required to list those privileges. Lack of privileges does not exclude a health care professional from participation in a MA organization. Information obtained by an MA organization on applications from physicians and other health care professionals that lists the current status and type of admitting privileges would meet this requirement. (This information may be obtained by contacting the facility, obtaining a copy of the practitioner directory or attestation by the health care professional.)

2. Current, adequate malpractice insurance meeting the MA organization's requirements: (This information may be obtained via the malpractice carrier, a copy of the insurance face sheet or attestation by the health care professional.)

3. A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate in effect at the time of the credentialing decision: However, if a health care professional's DEA certificate is pending, the MA organization may credential the practitioner provided the MA organization has adopted and implemented a process under which other DEA-certified contracted practitioners write all prescriptions that require a DEA number. The process must also include verification of the newly issued DEA certificate. If a health care professional states that he/she does not prescribe, this requirement is not applicable. (This information can be obtained through confirmation with CDS, entry into the National Technical Information Service (NTIS) database, or by obtaining a copy of the certificate.)

4. A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the health care professional: (This information can be obtained from the malpractice carrier or from the National Practitioner Data Bank.)

5. For physicians, any other information from the National Practitioner Data Bank.

6. Information about sanctions or limitations on licensure from the applicable state licensing agency or board, or from a group such as the Federation of State Medical Boards.

7. Eligibility for participation in Medicare. (See excluded and opt-out provider checks above.)

Site Visits

The MA organization must establish a policy for conducting site visits. It is the responsibility of the MA organization to decide the frequency of site visits, as part of its site visit policy. The CMS does not, however, require MA organizations to conduct initial credentialing or recredentialing site visits. Each MA organization's site visit policy will be reviewed pursuant to CMS' monitoring protocol.

An MA organization's site visit policy must include procedures for detecting deficiencies and have mechanisms in place to address those deficiencies. At a minimum, the MA organization should consider requiring initial credentialing site visits of the offices of primary care practitioners, obstetrician-gynecologists, or other high-volume providers, as defined by the MA organization. If the organization chooses to conduct site visits for "high volume" providers, the organization's procedures may specify the criteria for

determining that a provider is "high-volume". The organization may also consider developing criteria that target high-volume providers, or those against whom grievances have been filed.

The site visit should include an evaluation of the site's accessibility, appearance, and adequacy of equipment, using standards developed by the MA organization. Each MA organization must send appropriately qualified personnel to conduct site visits. Those personnel may or may not be clinicians, depending on the focus of the evaluation and the evaluation criteria established by the MA organization.

In addition, the visits should include a determination of whether the site conforms to the MA organization's standards for medical record keeping practices and the confidentiality requirements discussed in Chapter 4. Although CMS is not establishing a methodology for conducting medical record reviews, each MA organization is directed to verify that its practitioners' enrollee health records meet its own standards.

Initial Requirements for a Newly Trained Health Care Professional

In an effort to promote access to services for beneficiaries and allow a newly trained healthcare professional to begin providing care at an earlier date, CMS has established a temporary, streamlined credentialing guideline for these newly trained individuals. In the case of a newly trained health care professional who has completed all appropriate training and education within the last 12 months, the MA organization may establish a policy that permits initial credentialing for a period of up to 60 days if the MA organization:

1. Verifies that the practitioner has a current, valid license from primary sources;

2. Verifies malpractice settlements from the last 5 years. (This may be done by verifying with the malpractice carrier or the National Practitioner Data Bank; attestation is not accepted.);

3. Has a policy and procedure which ensures that the practitioner meets all standard credentialing requirements after 60 days; and

4. Ensures that the Credentialing Committee has reviewed the case and makes the final determination about granting such an initial 60-day credentialing period.

Monitoring

The MA organization must develop and implement policies that address the ongoing monitoring of sanctions and grievances filed against health care professionals. The MA organization must regularly obtain and review reports and other documentation as

indicated below. The MA organization must also provide, through documentation, evidence that its policies have been implemented.

The CMS requires ongoing monitoring of lists of practitioners who have been sanctioned and of practitioners who opt-out of accepting Federal reimbursement from Medicare (see above for details), as well as ongoing monitoring and resolution of beneficiary grievances. In addition to these standing requirements, MA organizations are also required to monitor sanctions and limitations on licensure on a regular basis between recredentialing cycles.

In the event that an MA organization finds an incidence of poor quality or any type of sanction activity against a health care professional, it should intervene and correct the situation appropriately.

If the MA organization becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, the MA organization will be expected to perform a site visit as soon as possible to assess the facility and identify corrective actions.

While the MA organization is required to ensure that all credentialing requirements are current at the time of initial credentialing and/or recredentialing, the MA organization is not required to monitor and account for any expiration dates on a continuous basis unless required to do so by the state.

Recredentialing

The MA organization must have procedures for recredentialing, at least every 3 years, through a process that updates information obtained in initial credentialing, considers performance indicators such as those collected through the QAPI program, the utilization management system, the grievance system, enrollee satisfaction surveys, and other activities of the MA organization, and that includes an attestation of the correctness and completeness of the new information.

Licensure must be re-verified from primary sources. Board certification must be re-verified only if the provider was due to be recertified or states that he/she has become board certified since the last time he/she was credentialed or recredentialed. The following must also be re-verified in the same manner as performed under the Initial Credentialing Requirements: admitting privileges; malpractice coverage; and DEA/CDS certificate. In addition, the MA organization must perform another search of the National Practitioner Data Bank and obtain updated sanction or restriction information from licensing agencies and Medicare (see above for details). If a provider is confirmed eligible to participate in Medicare, the MA organization should require that a provider, who has been otherwise disciplined, have a corrective action plan in place, and the MA organization should have procedures to ensure that the provider's plan is followed and is

effective. The MA organization is not required to conduct site visits as part of its recredentialing policies, but may choose to do so at its own discretion.

(Source: 42 CFR 422.204(b)(2)(i) and (ii) and additional instructions)

60.4 - Suspension, Termination, or Nonrenewal of Physician Contract
(Rev. 24, 06-06-03)

Advance Notice for Suspension or Termination

An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating a contract without cause.

Reporting of Suspensions or Terminations Due to Quality Deficiencies

An MA organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

Suspension, Termination, or Nonrenewal of Physician Contracts

Specific requirements for an MA organization that operates a coordinated care plan or network MSA plan providing benefits through contracting physicians and that suspends, terminates, or non-renews a physician's contract are as follows:

1. The MA organization must give the affected physician written notice of 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.

2. The MA organization must allow the physician to appeal the action, and give the physician written notice of his/her right to a hearing and the process and timing for requesting a hearing.

3. The MA organization must ensure that the majority of the hearing panel members are peers of the affected physician.

Preamble to the February 17, 1999, final rule responded to public comment that notice and appeal requirements apply regardless of whether suspension or termination of the physician contract is due to quality deficiencies or not, unless the physician voluntarily agreed to leave the organization's network. In addition, it was clarified that these requirements apply to nonrenewal of contracts.

An MA organization that operates an MA plan through subcontracted physician groups must provide that these procedures apply equally to physicians within those subcontracted groups.

(Source: 42 CFR 422.202(c) and (d) and preamble of February 17, 1999, rule.)

70 - Institutional Provider and Supplier Certification
(Rev. 24, 06-06-03)

Regardless of the MA organization's usual policies for determining that an institutional provider or supplier is qualified to serve its enrollees, the MA organization must determine that each institutional provider or supplier that has signed a contract or participation agreement with the MA organization has met the following three requirements. Current documentation should be obtained at least every 3 years, and contracts should provide for notice from the provider of any change in its Medicare approval, state licensure, or accreditation status.

1. Medicare Approval

   An MA organization must ensure that Medicare-covered basic benefits are provided only by providers that have signed participation agreements ("provider agreements") with CMS, and by suppliers approved by CMS as meeting conditions for coverage of their services. The following types of providers and suppliers must have met requirements for participation in Medicare (also specified at 42 CFR 498.2):

   - Hospitals (either JCAHO accreditation or Medicare certification). Note that Medicare also certifies organ procurement organizations (OPOs) and that organ transplants must generally be performed in certified organ transplants centers;
   - Home Health Agencies (HHAs);
   - Hospices;
   - Clinical laboratories (a CMS-issued CLIA certificate or a hospital-based exemption from CLIA);
   - Skilled Nursing Facilities (SNFs);
   - Comprehensive Outpatient Rehabilitation Facilities (CORFs);
   - Outpatient Physical Therapy and Speech Pathology Providers;

- Ambulatory Surgery Centers (ASCs);
- Providers of end-stage renal disease services;
- Providers of outpatient diabetes self-management training;
- Portable x-ray Suppliers; and
- Rural Health Clinic (RHCs) and Federally Qualified Health Center (FQHCs).

Inquiries regarding the Medicare participation of specific providers and suppliers can be directed to the regional office plan manager.

In addition, MA plans must also comply with all aspects of an approved benefit, including the use of approved facilities, as applicable. Note that being certified as a Medicare approved facility is required for performing certain procedures, such as carotid artery stenting, VAD destination therapy, bariatric surgery, certain oncologic PET scans in Medicare-specified studies, and lung volume reduction surgery. Please see link: *http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage* for further information and for lists of approved facilities.

2. Is licensed to operate in the state, and is in compliance with any other applicable state or Federal requirements.

3. Is reviewed and approved by an appropriate accrediting body, or meets the standards established by the MA organization itself. Accrediting bodies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Community Health Accreditation Program (CHAP), and the Continuing Care Accreditation Commission. This standard does not require that an MA organization accept the findings of an accrediting body in determining whether to contract with a provider, or that it reject providers that are not accredited. However, an MA organization that does not rely on independent accreditation must develop its own standards for approval of institutional providers and determine that such providers meet those standards before including them in its network. Primary source verification of accreditation and licensure is not required, unless otherwise provided in the MA organization's Medicare contract. Accordingly, an MA organization may rely on documentation supplied by the institutional provider.

(Source: 42 CFR 422.204(b)(1) and (3) and additional instructions.)

80 - Physician Incentive Plans

80.1 - Requirements and Limitations

(Rev. 67, Issued: 08-12-05; Effective: 08-01-05)

Definitions

Bonus means a payment made to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation means a set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Physician Group means a partnership, association, corporation, individual practice association, or other group of physicians that distributes income from the practice among members. An individual practice association is defined as a physician group for this section only if it is composed of individual physicians and has no subcontracts with physician groups.

Physician Incentive Plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

Potential Payments means the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of substantial financial risk.

Referral Services means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish directly.

Risk Threshold means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk.

Substantial Financial Risk, for purposes of this section, means risk for referral services that exceeds the risk threshold.

Withhold means a percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

Applicability

The requirements in this section apply to an MA organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes, but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group, such as those specified at 42 CFR 422.4.

Note that there is a statutory prohibition on physician incentive plans for MA private fee-for-service plans. Accordingly, an MA private fee-for-service plan may not operate a physician incentive plan.

(Source: §1859(b)(2)(A); 42 CFR 422.208(e).)

Basic Requirements

Any physician incentive plan operated by an MA organization must meet the following requirements:

1. The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

2. If the physician incentive plan places a physician or physician group at substantial financial risk (as determined below) for services that the physician or physician group does not furnish itself, the MA organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection (as described below

3. For all physician incentive plans, the MA organization provides to CMS the information specified in §80.2.

Determination of Substantial Financial Risk

Substantial financial risk occurs when risk is based on the use or costs of referral services, and that risk exceeds a risk threshold of 25 percent of potential payments. (Payments based on other factors, such as quality of care furnished, are not considered in this determination.)

The following incentive arrangements cause substantial financial risk within the meaning of this section, if the physician's or physician group's patient panel size is not greater than 25,000 patients (shown in the table below):

1. Withholds greater than 25 percent of potential payments.

2. Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

3. Bonuses that are greater than 33 percent of potential payments minus the bonus.

4. Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

$$\text{Withhold \%} = -0.75\ (\text{Bonus \%}) + 25\%.$$

5. Capitation arrangements, if:

    a. The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments; and

    b. The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.

6. Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

Stop-Loss Protection Requirements

The MA organization assures that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

1. Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.

2. For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel and may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled (as described below).

3. Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel Size	**Single Combined Deductible**	**Separate Institutional Deductible**	**Separate Professional Deductible**
1-1,000	$6,000	$10,000	$3,000
1,001-5,000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	None	None	None

Pooling of Patients

Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several MA organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

1. It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group;

2. The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled;

3. The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled;

4. The distribution of payments to physicians from the risk pool is not calculated separately by patient category; and

5. The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

Sanctions

An MA organization that fails to comply with the requirements of this section is subject to intermediate sanctions.

(Source: 42 CFR 422.208.)

80.2 - Disclosure of Physician Incentive Plans

(Rev. 67, Issued: 08-12-05; Effective: 08-01-05)

Disclosure to CMS

Each organization will provide assurances satisfactory to the Secretary that physician incentive plan requirements are met. MA organizations must provide to CMS information concerning physician incentive plans as requested.

Disclosure to Medicare Beneficiaries

Each MA organization must provide the following information to any Medicare beneficiary who requests it:

1. Whether the MA organization uses a physician incentive plan that affects the use of referral services;

2. The type of incentive arrangement; *and*

3. Whether stop-loss protection is provided.

In addition, MA organizations that are included in the Consumer Assessments of Health Plans Study (CAHPS) Survey should give Medicare enrollees a copy of the CAHPS enrollment survey results available on the www.medicare.gov website or direct enrollees to where on the website CAHPS survey results for their plan may be found.

(Source: 42 CFR 422.210.)

90 - Provider Indemnification of MA Organization Prohibited
(Rev. 24, 06-06-03)

An MA organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the MA organization against any civil liability for damage caused to an enrollee as a result of the MA organization's denial of medically necessary care:

1. A physician or health care professional;

2. Provider of services;

3. Other entity providing health care services; and

4. A Group of such professionals, providers, or entities.

(Source: 42 CFR 422.212.)

100 - Special Rules for Services Furnished by Non-Contract Providers
(Rev. 24, 06-06-03)

Consistent with §1852(a)(2) and §1852(k)(1) of the Social Security Act, non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.

- Note that non-contract facility providers identified at §1861(u) of the Social Security Act (the Act), which includes hospitals, skilled nursing facilities and home health agencies, must accept as payment in full payment amounts applicable in Original Medicare less any payments under 42 CFR 412.105(g) concerning indirect medical education payment to hospitals for managed care enrollees and 42 CFR 413.86(d) concerning payment for direct graduate medical education costs.

- In cases where the MA organization has not arranged for the services, if the non-contract provider's bill is less than the Original Medicare amount, the MA organization is only required to pay the billed amount.

In addition, under Federal law, non-contract providers are subject to penalties if they accept more than Original Medicare amounts.

(Source: 42 CFR 422.214 and preamble to June 29, 2000, rule.)