Financial Programs for Tufts Medicare Preferred

The following information applies to Tufts Medicare Preferred HMO only:

Risk Adjustment

Under a Medicare Advantage contract, Tufts Health Plan receives revenue from CMS each month. This payment to Tufts Health Plan, as a contractor, constitutes federal funds and therefore subjects Tufts Health Plan and its participating providers to applicable laws.

The CMS payment amount is based on a risk adjustment methodology used to adjust payments based on the care required to treat a condition. Each year, a member is given a risk score based on their historical diseases and demographic characteristics that impact their costs/payments for that year. Documentation for conditions must be submitted to CMS annually, particularly documentation for chronic conditions. Risk scores may also change annually to reflect changes to the risk score model as determined by CMS.

The risk adjustment model is a lagged model, meaning that current year's CMS revenue is based on the previous year's documented conditions and current demographics. The Enterprise Risk Adjustment Department oversees multiple programs aimed at capturing a more accurate depiction of a member's risk score. These include but are not limited to chart reviews, comprehensive health assessments, and prospective patient assessment forms. Administrative costs incurred and additional revenue realized from these programs are shared with participating groups based on their contract arrangements.

For additional information on risk adjustment, please refer to CMS or the Enterprise Risk Adjustment department.

Reimbursement

Hospital Service Fund (HSF)

Through a contractual arrangement with CMS, an HSF is established for each medical group. Each month, a percentage of the PMPM amount received from CMS is credited to the HSF for a member who has selected a PCP from that medical group. The HSF is included in a Summary of Fund Services table. This summary is not all-inclusive.

PCP Payments

A specified per member per month (PMPM) payment may be paid to the medical group based on the number of Tufts Medicare Preferred HMO members who have selected providers participating through the medical group as their PCPs. The predetermined PMPM amount is paid to the medical group for certain services that the medical group PCPs provide directly to its Tufts Medicare Preferred HMO members. This type of payment arrangement, i.e., capitation, is made to the medical group monthly.

The balance of the medical services fund is held by Tufts Health Plan to pay specialty and other services for which the medical group is financially responsible. Tufts Health Plan is responsible for general program administration and management.

Specialists

Tufts Health Plan makes payments to specialists and other providers. The amount paid is debited against the medical group's medical services fund. Tufts Health Plan administers payment amounts and methodologies, such as fee for service and capitation, according to the specialist's contract. Noncontracting providers are paid according to Medicare regulations.

Out-of-Area Services

Tufts Medicare Preferred HMO's out-of-area benefit covers urgent and emergent events occurring when a member is 30 miles or more from their home hospital (as identified by their PCP selection). A Tufts Medicare Preferred HMO Utilization Management Inpatient Manager manages out-of-area services for both internally and externally managed groups. When a group or PCP (rather than Tufts Health Plan) authorizes out-of-area care in advance of the service or at time of service, the care is the responsibility of the medical group. For additional information, refer to the Referrals, Prior Authorizations and Notifications chapter.

Medical Group Financial Responsibility

Any out-of-area services prospectively authorized by the medical group are the medical group's financial responsibility.

Medicare Advantage regulation requires that Medicare Advantage plans pay for medically necessary dialysis services from any qualified provider chosen by a member when the member is temporarily outside the plan's service area. Furthermore, Medicare Advantage regulation states that Medicare Advantage plans cannot require prior authorization or advance notification for dialysis services as a condition of coverage when a member is temporarily outside the service area.

Because chronic renal dialysis is considered anticipated, regularly scheduled care and the payment of out-of-area routine care for chronic dialysis is the responsibility of the medical group.

Services Received Under Contracts

Tufts Medicare Preferred HMO is a Medicare Advantage plan, as such, Tufts Health Plan may not compensate, directly or indirectly, for services furnished to a Medicare enrollee by a provider or other health care practitioner who has filed with the local Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

Pharmacy Services

All Medicare beneficiaries are eligible to enroll in the Medicare Part D prescription drug plan. Tufts Medicare Preferred HMO members may voluntarily choose an option without pharmacy coverage or with pharmacy coverage. Monthly pharmacy premiums vary by plan design. Tufts Medicare Preferred PPO members have pharmacy coverage included with their benefits.

Stop Loss Reinsurance

Medical

Medical stop-loss is a reinsurance program that may be purchased by the medical group from Tufts Health Plan in conjunction with hospital stop-loss and aggregate stop-loss to cover the costs of medical services that exceed a specified cost-sharing amount per member per calendar year. Under this program, a certain percentage of the cost in excess of the cost-sharing amount is credited back to the MSF at the time of settlement of the fund.

Hospital

Hospital stop-loss is a reinsurance program that may be purchased by the medical group from Tufts Health Plan in conjunction with medical stop-loss. The hospital stop-loss covers the costs of hospital services that exceed a specified cost-sharing amount per member per calendar year. Under this program, a certain percentage of the cost in excess of the cost-sharing amount is credited back to the hospital service fund (HSF) at the time of settlement of the fund.

Aggregate

Aggregate stop-loss is a reinsurance program made available by Tufts Health Plan in conjunction with medical stop-loss and hospital stop-Loss. The aggregate stop-loss provides additional protection to the medical group and its providers against the medical group's share of any deficit in the MSF and HSF.

Reinsurance Coverage

Tufts Health Plan may adjust stop-loss limits and coverage, aggregate or individual, or require the medical group to adjust its own stop-loss and coverage, applicable to services provided to Tufts Medicare Preferred HMO members to comply with state or federal law or regulations or contractual obligations imposed by government entities.

Applicable coverage limits (aggregate or individual) and capitation adjustments are determined by Tufts Health Plan based on information disclosed to Tufts Health Plan by its participating providers. In certain circumstances, upon approval in advance from Tufts Health Plan, the medical group may purchase reinsurance from an outside vendor as an alternative to the stop-loss coverage offered by Tufts Health Plan.

All risk arrangements with providers must meet applicable federal regulations regarding placing providers at substantial financial risk. This may be accomplished by participation in Tufts Health Plan's reinsurance program or by purchase of reinsurance from an outside vendor. Any reinsurance purchased from an outside vendor must meet Tufts Health Plan's requirements in effect from time to time, including compliance with all state and federal regulations.

A summary of the services covered in each fund is listed in the following table. This summary is intended to be illustrative and is not all-inclusive. Refer to the provider's contract with Tufts Health Plan for specific services related to your arrangement.

Summary of Fund Services

Hospital Services Fund (including ancillary services)

- Inpatient hospital care, including behavioral health/substance use disorder (BH/SUD) day treatment
- Skilled nursing facilities (SNFs)

- Hospital-based provider services
- Ambulance transportation
- In-area emergency department (ED)
- Home health care
- Ambulatory surgery, including hospital/surgical
- Dialysis for end-stage renal disease (ESRD)
- Other services including, but not limited to surgical devices, chemotherapy, drugs and radiation therapy

Medical Services Fund (MSF)

- In-area inpatient and outpatient provider services
- Out-of-area provider services (if authorized by the group)
- Outpatient pathology, radiology and diagnostics, including preventive services
- Outpatient behavioral health and substance use disorder (BH/SUD) services
- Outpatient physical and occupational and/or speech therapies (PT/OT/ST)
- Durable medical equipment (DME)
- Health education and preventive services
- Renal dialysis services provided by noncontracting providers while the member is temporarily outside the service area

Health Plan Fund

- All nonelective (primary care and specialty) out-of-area services not authorized by the group
- Vision, fitness, wellness, and weight-loss programs
- Marketing and customer service
- Provider group support programs

Settlement of Funds

Medical Services

The MSF is settled according to contract terms to determine the relationship between credits and expenses. The MSF capitation credit, inclusive of any applicable coordination of benefits and subrogation and any credits relating to the MSF reinsurance coverage, will be compared to the MSF expenses, inclusive of estimated incurred but not yet reported claims.

If the MSF capitation credit exceeds the MSF expenses, the surplus is paid to the medical group. If the MSF expenses exceed the MSF capitation credit, the medical group will be invoiced for the deficit. Future month's capitation payments to the medical group may be adjusted to balance an actual or projected deficit.

Hospital Services

The HSF is periodically settled according to the contract terms to determine the relationship between credits and expenses. The HSF capitation credit, inclusive of any applicable coordination of benefits and subrogation and any credits relating to the HSF reinsurance coverage, will be compared to the HSF expenses, inclusive of the value of the services rendered and estimated incurred but not yet reported claims.

If the HSF capitation credit exceeds the HSF expenses, the surplus is paid to the hospital. If the HSF expenses exceed the HSF capitation credit, the hospital will be invoiced for the deficit. The medical group shares financial risk with the hospital for any deficit or surplus as defined in the group contract. The medical group's share of the hospital surplus or deficit is combined with the settlement of the medical group's MSF.

Pharmacy

Part D requires Medicare Advantage plans to share risk directly with CMS. The medical group is not at risk.

Special Member Status

Hospice Election

Members certified as terminally ill by their PCP or attending provider may elect the hospice benefit. The hospice obtains a copy of the certification and the beneficiary-election document from Medicare directly. The beneficiary election document identifies the effective date and the beneficiary's acknowledgment that certain services are waived, such as the right to therapeutic services in favor of palliative care.

Once a Tufts Medicare Preferred HMO member has elected the hospice benefit, CMS pays Tufts Health Plan a reduced capitation for each Tufts Medicare Preferred HMO member. This reduced capitation is allocated for supplemental benefits (such as routine vision) that Tufts Health Plan offers to each Tufts Medicare Preferred HMO member. A copy of the beneficiary election document should be obtained for Tufts Medicare Preferred HMO records if possible.

For further information about hospice election, refer to the Hospice Payment Policy and the Medicare Managed Care Manual.

Note:

- Members who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors (carrier/fiscal intermediary), as if the beneficiary were a fee-for-service beneficiary, until the first day of the month following the month in which hospice was revoked.
- Therefore, providers need to bill the carrier/fiscal intermediary, and Tufts Health Plan will pay the cost-sharing amount not paid by the carrier/fiscal intermediary.
- Tufts Medicare Preferred HMO remains responsible for providing its members who have elected hospice with the following benefits:
  - All cost-sharing amounts for Medicare-covered services that are not related to the patient's hospice status
  - Any nonhospice services that are not Medicare-covered but are supplemental benefits provided under the plan

Hospice Billing Guidelines

Billing guidelines for hospice members is included in the following sections of the Medicare Managed Care Manual:

- Chapter 7: Risk Adjustment
- Chapter 9 Coverage of Hospice Services Under Hospital Insurance, Section 20.2: Election, Revocation, and Discharge

Additional Benefits Billing Guidelines

Tufts Medicare Preferred HMO covers additional supplemental benefits that are not covered by Medicare. Providers must bill Tufts Health Plan directly for any Tufts Medicare Preferred HMO covered services which Medicare does not cover and which are not related to terminal illness. Tufts Health Plan will make payment directly to the provider of services.

End-Stage Renal Disease

Tufts Health Plan and a capitated medical group receive additional capitation from CMS for reported ESRD members.

The attending provider at the dialysis center completes the ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. The dialysis center sends this form to the Social Security District Office and to the ESRD network.

The medical group must obtain a completed ESRD form from the center providing dialysis treatment and forward a copy to Tufts Health Plan. The additional capitation for ESRD is not paid without verification from CMS.

Tufts Health Plan must provide coverage to a Tufts Medicare Preferred HMO member for renal dialysis services provided by noncontracting providers while the member is temporarily outside Tufts Health Plan's service area. Additional capitation may not be applied to the medical group without appropriate reporting to Tufts Health Plan.

General Guidance on Dual Eligibility

"Dual eligible" are persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

There are several categories of dual eligibility, each having specific income requirements and providing different levels of financial assistance to those who qualify at that level.

For additional information about dual eligibility visit the Medicare and Medicaid government websites.

Member Benefit Coverage

Tufts Medicare Preferred HMO dual-eligible members continue to be entitled to all Tufts Medicare Preferred HMO and MassHealth benefits, and their Medicare coverage will remain the same. However, all MassHealth benefits will be provided within the fee-for-service sector.

According to federal regulation, the providers who receive the additional monies must waive all office visit cost-sharing amounts for the Division of Medical Assistance (DMA)-approved dual-eligible members. Members will not be responsible for cost-sharing amounts for most services and will continue to receive their prescription drug coverage from MassHealth. Whenever they receive covered services, members must present both their MassHealth and Tufts Medicare Preferred HMO ID cards to all health care providers.

Provider Reimbursement for Dual-Eligible Products

Tufts Health Plan will continue to compensate providers minus the cost-sharing amount for all Tufts Medicare Preferred HMO covered services. To obtain payment for the cost-sharing amount and services, providers must submit the appropriate invoice to MassHealth, DMA's claims-processing contractor. The DMA has compiled a manual that details the billing procedures for MassHealth providers.

To be eligible for payment from MassHealth for services provided to the dual-eligible population, in addition to being a Medicare provider, you must also be a MassHealth or Qualified Medicare Beneficiary (QMB)-only provider. To become a MassHealth provider, the provider must contact the MassHealth Provider Enrollment and Credentialing department at providersupport@mahealth.net or 800-841-2900.

When submitting an invoice for reimbursement for MassHealth-covered medical and provider services, the provider must attach a copy of their Tufts Medicare Preferred HMO explanation of payment (EOP). To receive training or to set up an individual consultation concerning questions about billing from MassHealth services, providers can contact MassHealth at 800-841-2900.

PCP Capitation Report

Tufts Health Plan provides a PCP capitation report that provides member capitation listings for a designated PCP. The report includes the following information:

- Names, addresses, and identification numbers for vendors, PCPs and members
- 100 percent CMS blended payment
- MSF budget cap
- MSF cash cap

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