100.2 - Other Provisions of the MA Contract

(Rev. 79, Issued 02-17-06, Effective Date 02-17-06)

Provisions Necessary to Implement MA Program - The MA organization agrees that a provision will be included in its contract with CMS that specifies such other terms and conditions as CMS may find necessary and appropriate in order to implement requirements of the MA program.

Severability of Contracts - The MA contract will provide that, upon CMS's request:

- The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and
- A separate contract will be deemed to be in place for any such organization or entity that is removed from its former MA contract when such a request is made.

Electronic Communication - An MA organization must have the capacity to communicate with CMS electronically which includes notifying CMS of appropriate e-mail addresses for contact individuals within the organization (and receiving and sending e-mail), accessing the Internet to receive instructions and communications, and sending individual or batch information to CMS or its contractors such as encounter and enrollment/disenrollment information;

Prompt Payment - The MA organization must comply with the following prompt payment of claims provisions for claims that have been submitted by providers for services and supplies rendered to Medicare enrollees when these services and supplies are furnished by non-contracted providers:

- The contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider;
- The MA organization must pay interest on clean claims that are not paid within 30 days; and
- All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request for payment.

If a Medicare Advantage organization chooses to use non-contracting providers to provide services "in lieu of" executing contracts with providers to provide such services, the Medicare Advantage organization must pay the provider the amount it would have received under original Medicare for the services.

In the case of "unforeseen" services furnished by a provider that Medicare pays under a prospective payment system (PPS), e.g., emergency or urgently needed care or certain post-stabilization care service(s) - a Medicare Advantage organization must pay the lesser

of the hospital's billed charges or the PPS rate, but no more than would have been paid under original Medicare.

If CMS determines that the MA organization fails to make payments promptly to non-contracting providers and suppliers, CMS may, following an opportunity for a hearing:

- Provide for direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and
- Provide for appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

Agreements with Federally Qualified Health Centers

Under the contract, if an MA enrollee receives a service from a Federally Qualified Health Center (FQHC) that has a written agreement with the MA organization:

- The MA organization must pay a FQHC a similar amount to what it pays other providers for similar service;
- The FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect; and
- Financial incentives, such as risk pool payments or bonuses, and financial withholdings are not considered in determining the payments by CMS under 42 CFR 422.316(a) (requirements for the MA program).