Health Net

2009 PEARL PLAN NATIONAL PRIVATE FEE-FOR-SERVICE REINBURSEMENT GRID

Health Net®
MEDICARE PROGRAMS

Type of Service	Fee-For-Service Medicare Payment Methodology	Rate Health Net Will Pay Providers for PFFS
Acute Care Hospital – Inpatient Services	These hospitals are paid a diagnosis-related group (DRG) amount using the Medicare prospective payment system (PPS) in all states except Maryland. Software called the Pricer is used to determine much of the payment for each discharge, and these payments vary by hospital. DRG-based payments paid for a discharge consist of operating and capital costs, which include indirect medical education (IME), disproportionate share hospital (DSH), outliers, and the new technology add-on. An amount for hemophilia clotting factors is also included. Submitted charges are used for the calculation of outlier payments only. Otherwise, original Medicare pays the PPS amount even if the submitted charge is lower. The "pass-throughs," which are reflected in the Pricer but paid bi-weekly by original Medicare include: 1 Direct graduate medical education (DGME). 2 Capital for the first 2 years of a new hospital (generally 85 percent of Medicare-allowed capital costs). 3 Organ acquisition costs (excludes bone marrow transplants). 4 Certified registered nurse anesthetists (CRNAs) for small rural hospitals. 5 Nursing and allied health education costs. Bad debt is not in the Pricer, and is paid bi-weekly. OUTLIERS: Payment is 80 percent of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The threshold amount changes each year. The cost of an admission is generally determined by multiplying the hospital's cost-to-charge ratio (CCR) by its charge. TRANSFERS FROM AN ACUTE CARE HOSPITAL TO ANOTHER ACUTE CARE HOSPITAL: For most DRGs, the first hospital is paid a per diem rate equal to the DRG amount divided by the average length of stay for that DRG. However, on the first day, twice the per diem is paid. A maximum of the full DRG is paid to the first hospital. The second hospital is paid the full DRG. Certain DRGs have different policies for transfers. WRAP AROUND PAYMENTS: Medicare makes extra payments on behalf of members of regional PPOs when treated in certain acute care hospitals that qualify as "essential hospitals." All essential hospitals are, by definition, non-network. There are several conditions that must be met for the hospital to receive this extra payment. PAYMENT INFORMATION FOR MA PLANS: Since operating IME and DGME for inpatients are paid by fiscal intermediaries (FIs) on behalf of Medicare Advantage (MA) members, they do not have to be paid by MA plans. However, capital IME does have to be paid by MA plans since it is part of the capital payment, not the IME cost. MA plans do not need to pay the organ acquisition cost pass-through; but could instead pay the full cost for an organ acquisition for one of their own members. Note that if one runs the Pricer with HMO, the organ acquisition cost pass-throughs as well as the graduate medical education costs are omitted. There are two nursing and allied health (NAH) education payments reflected on the hospital cost reports: 1 Cost-based NAH amount – MA plans must pay to non-contracting hospitals. 2 Balanced budget refinement act (BBRA) NAH add-on taken from DGME payments – MA plans do not have to pay to non-contracting hospitals. This is paid by FIs on behalf of MA members. These rules only apply to PPS hospitals, not cost hospitals such as critical access hospitals. Item 1 is included on the cost reports on WS E, Part A, lines 14 and 15. Item 2 is on line 11.01, Nursing and Allied Health Managed Care. It is in effect, a redistribution of the DGME payment on line 11. The DRGs are determined using the Pricer program. Hospital-specific data is contained on the Provider Specific Files. The Pricers on the Internet already contain the provider-specific files and are located at www.cms.hhs.gov/PCPricer/.	100% of Medicare allowable

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Acute Care Hospital – Inpatient Services (continued)	Hospital payment details are online at www.cms.hhs.gov/AcuteInpatientPPS/. Hospital Cost Report Master File (HCRIS): The hospital cost report file is updated quarterly and is located online at www.cms.hhs.gov/CostReports/. Capital payments are calculated on worksheet L of the Medicare cost report. The IME add-on is reported on line 4.03 and the DSH add-on is reported on line 5.04. These line items are then added to the hospital's capital payment based on the federal rate to get the total capital payment on line 6. For the DSH formula, the provider-specific file has the supplemental security income (SSI) ratio in file position 111-114, and the Medicaid fraction in file position: 115-118.	100% of Medicare allowable
Hospital Outpatient Services	Services subject to outpatient PPS are paid by the ambulatory payment classification (APC) methodology. Other services, such as lab, are usually paid on a fee schedule. Physician fees are paid on the physician fee schedule. Hospitals exempt from outpatient PPS include those in Maryland, Indian Health Service, and critical access hospitals. The PPS services are priced using the outpatient code editor, and the outpatient Pricer. As is the case with inpatient services, APC-based payments are made even if the submitted charges for these facility costs are lower. However, the submitted facility charges are used for the calculation of outlier payments. **TOPS:** Transitional outpatient payments (TOPs) are made to those hospitals that are paid less under PPS than they would have been paid under the old cost system. These "hold-harmless" payments are called TOPs payments and were payable through the end of 2003 for most hospitals. Certain small hospitals (including small rural and small sole community hospitals) continue to be eligible for TOPs. **OUTLIER PAYMENTS:** If the cost of a visit exceeds a threshold amount, the hospital outpatient department (OPD) is paid an outlier payment. The threshold amounts are subject to change each year. **OPD MEDICATION:** See Medication section. **PASS-THROUGHS:** The Centers for Medicare and Medicaid Services' (CMS') Internet site has files showing payment amounts for those medications and devices that are paid as a pass-through. They are paid in addition to the APC payment. **COINSURANCE:** Coinsurance amounts vary for each APC of each provider. Providers are allowed to waive coinsurance in excess of 20 percent for any given APC. **PAYMENT INFORMATION FOR MA PLANS:** OPD details are online at www.cms.hhs.gov/HospitalOutpatientPPS/. The Addendum A and Addendum B updates link in the left-hand margin shows APC and procedure codes.	100% of Medicare allowable
Home Health Services	Payments are made on a PPS basis. The payment groups are called Home Health Resource Groups (HHRGs). These payments cover episodes of care up to 60 days. Adjustments are made for short stays and for outliers. Durable medical equipment (DME) is excluded from PPS and is instead paid on a fee schedule. For more information, the CMS home health Web page is www.cms.hhs.gov/center/hha.asp. This page has links to detailed information on how home health payments are determined. The health insurance prospective payment system (HIPPS) groups used in home health bills are explained online at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp#TopOfPage. Master Cost Report File: refer to the Internet at www.cms.hhs.gov/CostReports/. PPS payments are made even if they are greater than the submitted charge. **PAYMENT INFORMATION FOR MA PLANS:** MA organizations may only make low utilization payment adjustment (LUPA) payments in situations similar to those in which original Medicare does. That is, in the case of an episode with four or fewer visits, LUPA applies. Otherwise, payments must be computed using the HIPPS system based on HHRGs and 60-day episodes of care.	100% of Medicare Fee Schedule

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Skilled Nursing Facilities (SNFs)	SNFs are paid on PPS. A case-mix adjusted payment for varying numbers of days of SNF care is made using one of roughly 50 or so Resource Utilization Groups (RUG), Version III (RUG-III). The RUG is identified in the first three positions of the HIPPS code. There may be an add-on for AIDS patients. PAYMENT INFORMATION FOR MA PLANS: For more information, the SNF Web page is www.cms.hhs.gov/SNFPPS/. This page also has a link to the quarterly Pricer. Further information is online at www.cms.hhs.gov/snfconsolidatedbilling. PPS payments may be payable even if they are greater than the submitted charge. Clarification on SNF no payment and MA claims billing procedures are online at www.cms.hhs.gov/transmittals/downloads/R1394CP.pdf.	100% of Medicare allowable
Swing Beds	Swing beds are paid at the SNF PPS. Critical access hospital (CAH) swing beds are exempt from PPS and are paid 101 percent of reasonable costs.	100% of Medicare allowable
Critical Access Hospitals	These are certain small hospitals with limited lengths of stay for acute patients. The inpatient and outpatient services, as well as swing beds, for these hospitals are paid on a reasonable cost basis. Ambulance is also paid if it is the only supplier within a certain number of miles. CAHs are generally paid 101 percent of costs. If a physician elects to reassign his or her claims to the CAH (election of method II), the CAH is paid an extra 15 percent of Medicare's portion of the physician fee schedule amount. This election can only be made for hospital outpatient physician services. The MA plan must also pay 115 percent of the Medicare physician fee schedule for physicians who have reassigned outpatient hospital claims under method II. In this case, the hospital bills the physician services on the same bill as the hospital services. The MA plan then does what the FIs do; it pays the facility part of the bill to the hospital based on 101 percent of costs; and it pays 115 percent of the physician fee schedule to the hospital. The plan does not make payments directly to the physician if payments for a given service were paid directly to the hospital under method II. Please note that the health professional shortage area (HPSA) and physician scarcity area (PSA) physician fee schedule bonuses apply under both method I (direct billing from the physician for outpatient services in a CAH) and method II. In other words, under method II, billing the HPSA and PSA bonuses are applied to the higher consolidated billing amount. PAYMENT INFORMATION FOR MA PLANS: FIs determine the interim payment amounts for each hospital based on their costs. For outpatient services, the payment amount is calculated by the FIs by multiplying the billed charges by the CCR for each hospital. Inpatient services are paid a per diem cost. The MA plan may ask the billing hospital to submit a copy of their most recent interim rate letter from their Medicare FI. For more information, the CAH Web site is www.cms.hhs.gov/center/cah.asp. To access frequently asked questions, select Resources. Please note that as is the case with other hospitals, plans are not required to cost-settle with CAHs.	100% of Medicare allowable
Physician Services	Physicians are paid using the lesser of billed charges, or the Medicare physician fee schedule (MFS). A 10 percent bonus is paid if these services are furnished in a HPSA. An additional 5 percent PSA bonus is payable through at least June 30, 2008, in areas designated by CMS as PSA. More details, including qualifying ZIP codes, are online at www.cms.hhs.gov/HPSAPSAPhysicianBonuses/ and www.cms.hhs.gov/MLNMattersArticles/downloads/MM5698.pdf. The fee schedule for physicians that do not participate in Medicare is 95 percent of the participating fee schedule. Medicare pays 80 percent of the fee schedule payment after the Part B deductible is met, and the beneficiary coinsurance is 20 percent. Certain vaccines and a small number of other services may not be subject to either the deductible, the coinsurance or both. Psychotherapy, unless the patient is an inpatient in a hospital, has 50 percent coinsurance. Medicare calculates its payment as 80 percent of 62.5 percent of the allowed charge. Anesthesiologists have a unique payment under the MFS, and payment depends on base and time units as well as the participation of CRNAs. Payments for physical therapy, speech, language, and occupational therapy have different rules, and some years are	Health Net will pay providers 102% of Medicare Allowable

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Physician Services (continued)	subject to annual payment limits per beneficiary. For example, so far in 2008, mostly for non-hospital settings, there are limits for physical therapy (PT) and speech/language therapy combined; and a separate limit for occupational therapy (OT). However, patients may qualify for exceptions to these limits, at least until June 30, 2008, depending on medical necessity. Medicare usually pays as follows for non-physician practitioner independent billings: • Physician assistant: 85 percent MFS • Nurse practitioner: 85 percent MFS • Clinical nurse specialist: 85 percent MFS • Registered dietitian: 85 percent MFS • Clinical psychologist: 100 percent MFS • Clinical social worker: 75 percent MFS • Audiologist, chiropractor, podiatrist, optometrist, and dentist: 100 percent MFS • Assistant at surgery: If a physician is the assistant, payment is 16 percent MFS. If a physician assistant (PA) is the assistant, payment is 85 percent times 16 percent MFS • Co-surgery: MFS increased by 25 percent; then split between two physicians. Each is then paid 62.5 percent MFS • Nurse midwife: 65 percent MFS Physicians and other qualified professionals are eligible to receive lump sum transitional bonus incentive payments in 2008 that are contingent on the reporting of quality measures on claims incurred in the six months ending December 31, 2007. This is called the physician quality reporting initiative (PQRI) bonus, and is limited to 1.5 percent of all physician fee schedule payments to a particular physician or qualified professional for covered professional services provided during the six-month period. The actual payments to a specific provider; however, are further limited by a cap that is determined using national data. This cap is based on 300 percent of national costs per measure and are not known until 2008. Bonus payments for claims incurred in a given year are payable the following year in a lump sum. Therefore, for example, bonuses earned for claims incurred in 2008 are payable early in 2009. More information on the PQRI bonus payment is available online at www.cms.hhs.gov/PQRI/. PAYMENT INFORMATION FOR MA PLANS: The physician fee schedule details are online at www.cs.hhs.gov/center/physician.asp. Further information on Healthcare common procedure coding system (HCPCS) codes is online at www.cms.hhs.gov/apps/pfslookup/. Plans must also provide the Welcome to Medicare benefit, if applicable, under the same circumstances as original Medicare. Note that the HPSA and PSA bonuses are payable only on 80 percent (original Medicare's portion) of the qualifying physician fee schedule payments. Plans should use CMS resources (see above) to identify Health Manpower Shortage Area (HMSA) and PSA areas by ZIP code and cannot require providers to use modifiers to the extent they are available and not required by original Medicare. A physician who would be eligible to receive the 1.5 percent PQRI bonus for services furnished to a beneficiary not enrolled in an MA plan is entitled to this amount for services furnished to an MA plan enrollee if the physician is entitled to collect the amount that Medicare would pay for the service. If the physician indicates that he or she is participating in the voluntary reporting, an MA organization can decide to pay an extra 1.5 percent on all physician fee schedule claims as they are incurred. Remember that the 1.5 percent PQRI bonus is subject only to claims paid on the Medicare physician fee schedule, and is paid on 100 percent of the fee schedule amount, not just the plan's portion of the payment. Alternatively, because it is not known in advance whether a physician is entitled to the higher amount, and it is subject to a cap, an MA organization may wait until 2008 (or the year after the year for which a bonus payment is due) to pay the bonus. Each physician would need to let the organization know what percentage (capped at 1.5 percent) that particular physician earned for physician fee schedule services. The plan would then make a lump-sum payment to each physician based on that percentage. This percentage would range from 0 to 1.5 percent. In 2007, CMS had initially announced a proposed cut to the physician fee schedule of 10.1 percent beginning January 1, 2008. Section 101 of the Medicare, Medicaid	**Health Net will pay providers 102% of Medicare Allowable**

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Physician Services (continued)	and SCHIP Extension Act of 2007 (enacted December 29, 2007), established an update of 0.5 percent for claims with dates of service January 1, 2008, to June 30, 2008. Original Medicare contractors were able to process claims for services at this new, higher rate beginning January 7, 2008. All claims for dates of service January 1, 2008, and later, were paid by original Medicare at the new rate. New fee schedules were posted on contractors' Web sites on January 11, 2008. Therefore, MA plans must also pay this higher rate to all non-contracting physicians and non-physician practitioners for all claims with dates of service January 1, 2008, through June 30, 2008.	102% of Medicare Fee Schedule
Ambulance	These services are paid on the ambulance fee schedule. Extra payments are made for ground transportation exceeding 50 miles, and for providers in certain rural areas. Ambulances are paid the lesser of the fee schedule, or the submitted charge. PAYMENT INFORMATION FOR MA PLANS: The ambulance fee schedule and other detailed information is online at www.cms.hhs.gov/AmbulanceFeeSchedule/.	100% of Medicare Fee Schedule
Ambulatory Surgical Centers (ACSs)	ASCs are paid on a fee schedule comprised of wage-adjusted payment groups. PAYMENT INFORMATION FOR MA PLANS: The ASC fee schedule, including geographic adjustments and other detailed information, is online at www.cms.hhs.gov/ASCPayment/.	100% of Medicare allowable
End Stage Renal Disease (ESRD) Facilities	ESRD facilities are paid, for routine services, an amount called a composite rate. Composite rates are geographically adjusted. They also vary depending on whether a facility is hospital-based or independent. Non-routine services may be billed separately. A medication add-on, the percentage of which is subject to change each year, is applied to the composite rate. Epoetin has different payments depending on whether or not it is billed by an ESRD facility. Some facilities receive additional payments to their ESRD composite rates that are called "exception" payments. Beginning April 1, 2005, a new case-mix-adjusted PPS payment system was established. PAYMENT INFORMATION FOR MA PLANS: The composite rates are on the Internet. Payments are described in Chapter 8 of the Medicare Claims Processing Manual. Detailed information on ESRD is online at: www.cms.hhs.gov/home/medicare.asp. On that page, there are four hyperlinks on ESRD under the heading End Stage Renal Disease. The ESRD calculator is online at www.cms.hhs.gov/PCPricer/01a_ESRDCalculator.asp#TopOfPage. Master Cost Report File – The renal facility cost report file is online under Renal Facility at www.cms.hhs.gov/CostReports/.	100% of Medicare allowable
Durable Medical Equipment	Medicare payment for DME, prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), surgical dressings, and therapeutic shoes and inserts is based on the lower of either the actual charge for the item or the fee schedule amount calculated for the item. PAYMENT INFORMATION FOR MA PLANS: Payment details are online at www.cms.hhs.gov/DMEPOSFeeSched/.	100% of Medicare allowable
Clinical Lab	Payments are generally based on the lab fee schedule. Certain small hospitals are paid a higher rate, or based on their costs instead of the fee schedule. PAYMENT INFORMATION FOR MA PLANS: The lab payment details are online at www.cms.hhs.gov/ClinicalLabFeeSched/.	100% of Medicare Fee Schedule

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Part B Medications	Most, but not all, medications for PPS hospital inpatients are not billable since they are assumed to be included in the DRG payments. When the outpatient department of a hospital bills for medications, the cost is generally included in the APC payment. However, an extra payment for certain new medications is payable for the first two or three years. Also, during the transition to APCs, other medications may have extra payments. **PAYMENT INFORMATION FOR MA PLANS:** The medication fee schedule, and other details on Part B medication payments, are online at www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.	**100% of Medicare allowable**
Federally Qualified Health Centers (FQHCs)	The FQHC allowed charge is the lesser of an "all-inclusive rate" or a national per-visit limit. The all-inclusive rate is determined for each center based on historical costs. There is a separate national limit for urban and for rural facilities, and these limits are subject to change each year. Medicare pays FQHCs 80 percent of the above, and the beneficiary pays 20 percent of the actual charge. Coinsurance of 20 percent of charges, not the all-inclusive payment, applies to FQHCs as well as rural health clinics (RHCs). FQHC services are not subject the to Part B deductible. The all-inclusive methodology, as well as the Part B deductible exemption, applies only to FQHC services, not to other services preformed at an FQHC. See section 1861 [aa] of the Social Security Act for covered FQHC/Medicare Part B Services. **WRAP-AROUND PAYMENTS:** Medicare makes extra payments to certain FQHCs that have written contracts with MA plans for rates below the lesser of the FQHCs all-inclusive rate or national per visit limit. However, certain conditions must be met, such as requiring that contracting rates are not less than rates for similar services provided outside of an FQHC setting. These extra payments only apply to services of an FQHC that qualify as FQHC services. **PAYMENT INFORMATION FOR MA PLANS:** The MA plan must pay 80 percent of the allowed charge, plus 20 percent of the actual charge, minus the plan's copayment. The plan may request the FI approved rate from the billing FQHC. For more information, the Web site is www.cms.hhs.gov/center/fqhc.asp. **MORE DETAILED INFORMATION FOR PRIVATE FEE-FOR-SERVICE PLANS:** PFFS plans that use a non-network model: These plans must pay providers the same way other types of MA plans pay their out-of-network providers. Therefore, when reimbursing FQHCs by a non-network PFFS plan, the MA plan must pay rates equal to what the provider would have received under original Medicare, except that like all MA plans, they are not required to cost settle with out-of-network providers. MA plans pay 80 percent of the lesser of the all-inclusive rate or the national limit, plus 20 percent of the FQHC's actual charge, minus the plan member's copayment. There is no wrap-around payment due from CMS. Medicare services not covered under the FQHC all-inclusive rate are to be paid at the same rate that the FQHC would receive under original Medicare. **FOR OUT-OF-NETWORK PROVIDERS:** Any out-of-network FQHC providing services to an enrollee of a PFFS plan is not entitled to an FQHC supplemental payment. Federal law requires a written agreement between the plan and FQHC in order for the supplemental wrap-around payment to come into play – see 42 CFR 422.316. However, if the FQHC becomes part of the network through an executed, written contract with the MA organization sponsoring the PFFS plan, then the FQHC could be eligible for wrap-around payments from CMS for services provided to PFFS plan enrollees receiving services on dates on or after the date the written contract is executed.	**100% - 102% of Medicare Fee Schedule**

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Rural Health Clinics	RHCs are paid the lesser of the provider-specific all-inclusive rate or a national per-visit limit. The all-inclusive rate is determined for each center based on historical costs. If an RHC is part of a hospital with less than 50 beds, the limit does not apply. It also does not apply for certain rural sole community hospital-based RHCs, which may have more than 50 beds, but have a low volume of services. Coinsurance of 20 percent of charges, not the all-inclusive payment, applies to FQHCs as well as RHCs. The national per-visit limit is subject to change each year. RHC services are subject to the Part B deductible, which is based on billed charges. The all-inclusive methodology applies only to RHC services, not to other services performed at an RHC, such as lab, the technical components of diagnostic tests, etc. The method of payment for these non-RHC services would be the same as for other similar services processed by the Part B carrier in the case of freestanding RHCs, or the Part A fiscal intermediary in the case of hospital-based RHCs. PAYMENT INFORMATION FOR MA PLANS: The plan may request the FI or carrier-approved rates from the billing RHC. The MA plan must pay 80 percent of the allowed charge, plus 20 percent of the actual charge, minus the plan's copayment. For more information, the Web site is www.cms.hhs.gov/center/rural.asp.	100% - 102% of Medicare Fee Schedule
Long Term Care Hospitals	These hospitals used to be paid reasonable costs for inpatient services, but were put on a DRG-type system a few years ago. There was a four-year blend to the new payments. They are now past the blending period and are paid 100 percent PPS. OUTLIERS FOR INPATIENT SERVICES: The outlier payment is a certain percentage of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The threshold amount is subject to change each year. There are also outlier adjustments for certain short stays. OPD has different outlier rules. For more information, the Web site is www.cms.hhs.gov/LongTermCareHospitalPPS/01_overview.asp. Additional information, including an updated list of all long term care hospitals, is online at www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage. The Pricer is online at www.cms.hhs.gov/PCPricer/07_LTCH.asp#TopOfPage.	100% of Medicare allowable
Inpatient Rehabilitation Hospitals	These hospitals are paid using the inpatient rehabilitation facility prospective payment system (IRF PPS). A case-mix adjusted payment is made using case mix groups (CMGs) for varying numbers of days of IRF care. For more information, the IRF Web site is www.cms.hhs.gov/InpatientRehabFacPPS/. The Pricer is also online at www.cms.hhs.gov/PCPricer/06_IRF.asp#TopOfPage.	100% of Medicare allowable

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Psychiatric Hospitals	There is a new PPS for both freestanding psychiatric hospitals and certified psychiatric units of general acute care hospitals. This system is called the inpatient psychiatric facility prospective payment system (IPFPPS), also referred to as Inpatient Psychiatric Facility PPS. **OLD SYSTEM – TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)** The reasonable cost is defined in TEFRA as a base-year cost per discharge for each hospital increased to the payment year using legislated increase factors. This is also referred to as the hospital's target. Bonuses or relief payments may also be payable if the actual costs for the year are less than or greater than the target respectively. There are plans to eventually implement a new PPS for psychiatric hospitals. **NEW SYSTEM – INPATIENT PSYCHIATRIC FACILITY PPS** For hospital fiscal years beginning after January 1, 2005, the payments are a blend of 75 percent of the old TEFRA payment and 25 percent of the new PPS payment. The first PPS payment period for all hospitals extends to June 30, 2006, after which all PPS updates are for the 12-month periods beginning July 1st. The second payment period uses a blend of 50 percent TEFRA and 50 percent PPS, and the third and last transition year uses 25 percent TEFRA and 75 percent PPS. There is a stop-loss adjustment, which sets the PPS payment to no less than 70 percent of the TEFRA amount for this three-year transition period. The new PPS uses a federal per diem base amount, which is then adjusted for DRGs, comorbidities, age, rural add-on, teaching add-on, outlier payments, wage index, the presence of an emergency department, and electroconvulsive therapy (ECT) treatment. There is also an extra payment, which tapers down during the first 21 days of an admission. There are further rules concerning readmissions. **OUTLIER PAYMENTS** Outlier payments are effective after a per-stay loss of a threshold amount that is subject to change each year (adjusted for the wage index, rural, teaching, etc). Different rules are used for Community Mental Health Centers. Detailed information on payments for psychiatric hospitals is online at www.cms.hhs.gov/InpatientPsychFacilPPS/01_overview.asp.	100% of Medicare allowable
Medicare Dependent Hospitals	These are hospitals that are located in a rural area and: 1 Have no more than 100 beds. 2 At least 60 percent of their patients are on Medicare. 3 Are not classified as a sole community hospital. These hospitals are paid PPS. In addition, if for any given full year the hospital-specific rate (cost-based target rate) is greater than the federal rate, or PPS, the hospital is paid a certain percentage of the difference, which may change over time. The Pricer compares the PPS rate to the hospital-specific rate for each service, but the final settlement compares the PPS payments to the hospital-specific rate for the entire year. In addition, in some years, these hospitals may or may not have a cap on their DSH payments. The DRA extended the Medicare Dependent Hospital program through the year 2011.	100% of Medicare allowable
Sole Community Hospitals (SCHs)	These hospitals are generally paid the greater of PPS or the hospital-specific rate for a full year. As is the case with Medicare-dependent hospitals, Pricer calculates the greater of the two for a given service. For OPD services, Medicare makes an add-on payment for some services of certain qualifying rural SCHs.	100% of Medicare Allowable
Low Volume Hospitals	If a hospital has less than 800 discharges per year, and is more than 25 miles from the closest acute care hospital, CMS makes an additional payment not to exceed 25 percent.	100% of Medicare allowable

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Cancer Hospitals	These hospitals are paid based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Routine costs are generally reimbursed on an interim basis using a per-diem amount, but with limits. Ancillary costs are reimbursed using a payment to charge ratio. Cancer hospitals are also eligible for outlier payments. For OPD services, these hospitals have a different reimbursement methodology, which is more cost-based than regular acute care hospitals. PAYMENT INFORMATION FOR MA PLANS: The FI rate letters show the interim per diems for inpatient, and the cost-to-charge ratios for outpatient. A listing of Medicare PPS, excluding cancer hospitals, are online at www.cms.hhs.gov/AcuteInpatientPPS/10_PPS_Exc_Cancer_Hosp.asp.	100% of Medicare allowable
Children's Hospitals	Same basic methodology as for cancer hospitals.	100% of Medicare allowable
Clinical Trials	Medicare pays for qualified clinical trials. These claims are coded using a QV modifier, and/or a diagnostic code of V70.7. There are a couple of other modifiers for clinical trials used in certain situations. Clinical trial links: detailed information on clinical trials is online at www.cms.hhs.gov/ClinicalTrialPolicies/. PAYMENT INFORMATION FOR MA PLANS: FIs reimburse qualifying clinical trial claims on behalf of MA members. Providers need to submit the bills to the carriers and intermediaries using the proper modifiers and ICD-9 codes.	100% of Medicare allowable
Bad Debts	Most hospitals are paid 70 percent of bad debt by Medicare. Certain other hospitals and facilities receive 100 percent bad debt reimbursement from Medicare, including SNFs, RHCs, FQHCs, and community mental health clinics. ESRD facility bad debt payments are capped so that their Medicare reimbursement does not exceed their costs. Bad debts only include coinsurance for which a beneficiary is directly responsible to pay. For example, it does not include payments due from a Medigap policy. The collection efforts for Medicare patients generally have to match the collection efforts for non-Medicare patients. The general bad-debt policy is set forth in regulations at Sec. 413.80 and the Provider Reimbursement Manual (PRM) (CMS Pub. 1501), Part 1, Chapter 3). Bad-debt policy for ESRD facilities is set forth in a separate regulation at Sec. 413.178 and is further discussed below. For ESRD: At the end of the year, Medicare recognizes a facility's Medicare bad debts. However, under current regulations, bad debt payments are capped so that total Medicare reimbursement (composite rate plus bad debt payments) does not exceed the total cost to serve Medicare patients. PAYMENT INFORMATION FOR MA PLANS: CMS policy is that MA plans are not required to pay their members' unpaid cost sharing. In any case, FIs do not reimburse providers for bad debt payments incurred by MA members.	Health Net reimburses for bad debt

Type of Service	Fee-For-Service Medicare Payment Methodology	Rate Health Net Will Pay Providers for PFFS
Balance Billing	Medicare allows physicians to balance bill up to 15 percent of the non-participating MFS if they do not participate and do not accept assignment. Participating physicians cannot balance bill. The non-participating MFS is 95 percent of the participating MFS. Therefore the balance billing limit is an extra 9.25 percent of the participating MFS. Medicare pays 80 percent of the non-participating MFS. The beneficiary is responsible for 20 percent of the non-participating MFS plus 100 percent of the balance billing amount. Balance billing is allowed for DME and has no set limit. Medicare pays 80 percent of the MFS and the beneficiary is responsible for the other 20 percent plus 100 percent of the balance billing amount. Under Medicare, balance billing is not allowed for most other services, including hospital, SNF, home health, and lab. However, the OPD coinsurance percentage can vary by procedure and be more than 20 percent. PAYMENT INFORMATION FOR MA PLANS: PFFS plans can choose in their terms and conditions whether or not to allow balance billing. They can choose to allow all types of providers to balance bill up to 15 percent. Therefore, their balance billing can be more than that of Medicare.	Health Net will not allow balance billing
Medicare Coverage Database	The Medicare coverage database is online at www.cms.hhs.gov/mcd/overview.asp. This site lists all national and local coverage determinations. Plans must abide by the national determinations in all geographic areas, and the local determinations in affect in the locality of the provider.	Health Net abides by the national determinations in all geographic areas, and the local determinations in affect in the locality of the provider
Special Rules for Services of Veterans Affairs (VA) and Military Providers	If a member who is not eligible for veterans or other military-related benefits receives treatment in a non-network military facility, such as VA or Department of Defense (DOD) hospital, the hospital must accept as payment in full the amount it would normally get paid from original Medicare. The member would be responsible only for the plan's out-of-network or emergency/post-stabilization care copayments, and the plan would be responsible for the remainder. This is the same situation that applies to all non-network hospitals. However, Medicare payments to military treatment facilities are determined differently than payments to other facilities. Inpatient rates are on the DOD Web site, by fiscal year, at www.dod.mil\comptroller\rates\index.html. Those rates are multiplied by the weighting factor that are on the TRICARE Web site at www.tricare.osd.mil\drgrates\.	100% of Medicare allowable
Special Rules for Services of Non-Contracting Providers	FACILITY SERVICES NOT ARRANGED BY THE MA PLAN: Notwithstanding the above, CMS regulations state that if a non-network facility, such as a hospital, SNF or home health agency (HHA), renders services that were not arranged by the plan, a non-PFFS MA plan may pay the lesser of the original Medicare amount or the billed amount. For more information, refer to the last section of the following link online at www.cms.hhs.gov/manuals/downloads/mc86c06.pdf. Note that a PFFS plan must always pay a non-contracting provider the original Medicare amount, even if a lesser amount is billed.	100% of Medicare allowable
Plan Contact Information	Providers may use the following links to obtain contact and mailing information for medical claims related to MA plan members. General MA directory with addresses and telephone numbers: www.cms.hhs.gov/HealthPlansGenInfo/. Mailing addresses for the MA claims processing contacts: www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage.	Health Net makes this information available to providers

Health Net Pearl PFFS terms and conditions can be accessed through the Health Net provider portal at www.healthnet.com/pffs_terms.pdf.


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