Today's Options® PFFS

A WellCare Company

Payment for Covered Services

Today's Options® PFFS reimburses deemed (non-contracted) providers at 100% of the current Medicare-approved amount for all Medicare-covered services, less any member cost-sharing amounts (copayments or coinsurances), according to the Centers for Medicare & Medicaid Services (CMS) guidelines. If a provider is contracted with Today's Options® Network PFFS, the provider will be reimbursed according to the provider's agreement. The following proxy payment grid explains payment methodology for covered services:

PROVIDER TYPE	MEDICARE-BASED REIMBURSEMENT METHODOLOGY SUMMARY
Ambulance Services	Reimbursement is based on the Medicare Ambulance Fee Schedule unless otherwise specified by CMS. *www.cms.hhs.gov/AmbulanceFeeSchedule/*
Ambulatory Surgery Center (ASC)	Reimbursement is based on the Medicare Ambulatory Surgical Center (ASC) Payment System unless otherwise specified By CMS. The ASC Payment System is a fee schedule comprised of wage-adjusted payment groups. *www.cms.hhs.gov/ASCPayment/*
Hospital Outpatient Services	Reimbursement is based on the Outpatient Prospective Payment System (OPPS), under Ambulatory Payment Classifications (APC) methodology unless otherwise specified by CMS. *www.cms.hhs.gov/HospitalOutpatientPPS/*
Clinical Laboratory	Reimbursement is based on the Medicare Clinical Laboratory Fee Schedule unless otherwise specified by CMS. Outpatient clinical laboratory services are paid based on a fee schedule in accordance with Section 1833(h) of the Social Security Act. Payment is the lesser of the amount billed, the local fee for a geographic area, or a national limit. *www.cms.hhs.gov/ClinicallabFeeSched/*
Durable Medical Equipment (DME), Prosthetics, Orthotics, Parenteral and Enteral Nutrition (PEN), Surgical Dressings, Therapeutic Shoes and Supplies (DMEPOS)	Reimbursement is based on the Medicare Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule unless otherwise specified by CMS. Payment is the lesser of the amount billed or the fee schedule amount calculated for the item. *www.cms.hhs.gov/DMEPOSFeeSched/*
End-Stage Renal Disease (ESRD) Center	Reimbursement is based on an ESRD bundled Prospective Payment System (PPS) in accordance with Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA). The base rate for adult patients will be adjusted to reflect differences in wage levels among the areas in which ESRD facilities are located, by patient-level adjustments for case-mix, an outlier adjustment (if applicable), facility-level adjustments, a training add-on (if applicable), adjustments specific to pediatric patients (dialysis patients who are under the age of 18), and a budget neutrality adjustment during the transition period.

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End-Stage Renal Disease (ESRD) Center *(Continued)*	Included in the case-mix adjusters are those variables that are currently used in the basic case-mix adjusted composite payment system (age, Body Surface Area (BSA), and low Body Mass Index (BMI). In addition to those adjusters, the ESRD PPS will also incorporate adjustments for six comorbidity categories and an adjustment for the onset of renal dialysis. The ESRD PPS will provide facilities a four-year phase-in (transition) period under which they will receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS. CMS will update the basic case-mix payment each Calendar Year for purposes of determining the composite rate portion of the blended payment amount. Today's Options PFFS covers all Medicare-covered dialysis services and nutrition therapy for renal disease. ESRD facilities may elect to be reimbursed 100% by ESRD PPS no later than November 1st of each Calendar Year. Facilities that do not elect to be reimbursed **100%** by the ESRD PPS will be reimbursed by a blended payment rate that is composed of the current basic case-mix adjusted composite rate payment system and the new ESRD PPS. *www.cms.hhs.gov/center/esrd.asp*
Federally Qualified Health Centers (FQHC)	Reimbursement for Federally Qualified Health Centers (FQHCs) is based on **80%** of the lower of the provider-specific rate or the per-visit payment limit, plus **20%** of the FQHC's actual charges unless otherwise specified by CMS. *www.cms.hhs.gov/center/fqhc.asp*
Home Health Care	Payments are made on a PPS basis. The payment groups are called HHRGs. These payments cover episodes of care up to 60 days. Adjustments are made for short stays and for outliers. Durable medical equipment is excluded from PPS and is instead paid on a fee schedule. *http://www.cms.hhs.gov/center/hha.asp*

INPATIENT HOSPITAL SERVICES

http://www.cms.hhs.gov/center/hospital.aspw

PROVIDER TYPE	MEDICARE-BASED REIMBURSEMENT METHODOLOGY SUMMARY
Acute Inpatient Services	Reimbursement is based on the Inpatient Prospective Payment System (IPPS), under Diagnosis-Related Groups (DRGs) and effective for discharges after October 1, 2007 Medicare Severity DRGs (MS-DRGs) methodology, unless otherwise specified by CMS. Operating IME and DGME for inpatients are paid by Fiscal Intermediaries (MACs/FIs) on behalf of Medicare Advantage members. Operating IME and DGME are not paid by Today's Options PFFS. However, "capital IME" is paid by Today's Options PFFS since it is part of the capital payment, not the IME cost. *www.cms.hhs.gov/AcuteInpatientPPS*
Critical Access Hospitals	Reimbursement for Critical Access Hospitals (CAHs) for the facility service and the professional service is as follows: Facility: Today's Options PFFS reimbursement to Critical Access Hospitals (CAHs) is not based on the CMS Inpatient Prospective Payment System (IPPS) reimbursement methodology. Rather, each CAH is reimbursed on a reasonable cost basis that is specific for each CAH. Inpatient services rendered by a CAH are paid at an interim rate, based on the rate letter provided by its CMS Fiscal Intermediary. Outpatient services are paid in the same manner. Today's Options PFFS will request from the CAH a copy of its most recent rate letter and pay the CAH based on that amount. If a facility is identified as a CAH but no rate letter is on file, claims will be denied, with a request for a copy of the rate letter. Outpatient services are handled in a similar manner. Professional Reimbursement: For physician professional services to include providers who accept assignment and those who do not accept assignment, **115%** of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule (MPFS). Payment for non-physician practitioner professional services are **115%** of the amount that otherwise would be paid for the practitioner's professional services under the MPFS. *www.cms.hhs.gov/center/cah.asp*
Inpatient Rehabilitation Facility (IRF)	Reimbursement is based on the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS) unless otherwise specified by CMS. *www.cms.hhs.gov/InpatientRehabFacPPS*

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Inpatient Psychiatric Facility (IPF)	Reimbursement is based on the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for both freestanding psychiatric hospitals and certified psychiatric units of general acute care hospitals, unless specified otherwise by CMS. *www.cms.hhs.gov/InpatientPsychFacilPPS/*
Long-Term Care Hospitals	Reimbursement is based on the Long-Term Care Hospital Prospective Payment System (LTCHPPS), under Long-Term Care Diagnosis Related Groups (LTC-DRGs/ MS-LTC-DRGs). *www.cms.hhs.gov/LongTermCareHospitalPPS/*
Skilled Nursing Facilities (SNFs)	Reimbursement is based on the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) unless otherwise specified by CMS. The PPS payment rate utilizes Resource Utilization Groups (RUG III) and is adjusted for case mix and geographic variation in wages and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs). w*ww.cms.hhs.gov/SNFPPS/*
Cancer Hospitals	Reimbursement is based on Fiscal Intermediary (FI) rate letters, which show the interim per diems for inpatient and the cost-to-charge ratios for outpatient. A listing of Medicare PPS-excluded cancer hospitals is available at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.html*

OTHER PROVIDERS AND SERVICES

PROVIDER TYPE	MEDICARE-BASED REIMBURSEMENT METHODOLOGY SUMMARY
Part B Drugs	For Part B drugs that are not applicable to PPS inpatient DRGs and APC outpatient payment groups, reimbursement is based on Average Sales Price (ASP) methodology unless otherwise specified by CMS. *www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*
Physicians and other Healthcare Professionals	Reimbursement is based on the lesser of the charge or the Medicare Physician Fee Schedule (MPFS), unless otherwise specified by CMS. The MPFS is updated as often as CMS releases new revisions to the MPFS. In addition, for those physicians who provide services in areas designated as primary care geographic Health Professional Shortage Areas (HPSAs) by the Health Resources and Services Administration (HRSA), reimbursements include the appropriate regulatory incremental bonus payment. Reimbursement for non-physician practitioner independent billings: • Physician Assistant: **85%** MPFS • Nurse Practitioner: **85%** MPFS • Clinical Nurse Specialist: 85% MPFS • Registered Dietician: **85%** MPFS • Clinical Psychologist: **100%** MPFS • Clinical Social Worker: **75%** MPFS • Audiologist, Chiropractor, Podiatrist, Optometrist, and Dentist: **100%** MPFS • Assistant at surgery: If a physician is the assistant, payment is **16%** MPFS. If a physician assistant is the assistant, payment is **85%** times **16%** MPFS. • Co-surgery: MFS increased by **25%**; then split between 2 doctors. Each then paid **62.5%** MPFS. • Nurse midwife: **100%** MPFS *https://www.cms.gov/apps/physician-fee-schedule/*
Anesthesia	Reimbursement for personally performed, medically directed, and medically supervised services is calculated based on the following formula unless otherwise specified by CMS: Anesthesia conversion factor by locality x (sum of uniform base units + time units) x percentage based on anesthesia modifier. *www.cms.hhs.gov/center/anesth.asp*
Rural Health Clinics	Reimbursement for Rural Health Clinics (RHCs) is based on **80%** of the lower of the provider-specific rate or the per-visit payment limit, plus **20%** of the RHC's actual charges unless otherwise specified by CMS. Note: Per-visit limits do not apply to RHCs owned by rural hospitals with fewer than 50 beds and are paid on a Cost basis. *www.cms.hhs.gov/center/rural.asp*

PROVIDER TYPE	MEDICARE-BASED REIMBURSEMENT METHODOLOGY SUMMARY
Rehabilitation Occupational, Physical and Speech Therapy	Reimbursement for outpatient rehabilitation services, including CORF services is the lesser of the charge or the allowed Medicare Physician Fee Schedule (MPFS) amount. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law on April 16, 2015, extended the therapy cap exception process through December 31, 2017. The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is **$2,010** for 2018, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also **$2,010** for 2018. This is an annual per-beneficiary therapy cap amount determined for each calendar year, as they are established and released by CMS. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. Per beneficiary, services above **$3,000** for PT and SLP services combined and/or **$3,000** for OT services are subject to manual medical review. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate. The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1st, each Calendar Year. These caps do not apply to services billed in hospitals.

Special Circumstances

For certain Medicare-approved providers, Today's Options PFFS pays as follows:

- Eligible hospitals are reimbursed according to CMS IPPS DRG reimbursement methodology, including Capital Indirect Medical Education Expense (IME) payments. Hospitals receive the same IPPS DRG reimbursements, including add-on payments, that they would receive under original Medicare based on rates published on the CMS website (*www.CMS.gov*). The payment is added to the Inpatient Prospective Payment System (IPPS). However, because Fiscal Intermediaries are responsible for operating IME and DGME, Today's Options PFFS does not reimburse those components of the DRG.
- Today's Options PFFS reimburses qualifying Disproportionate Share Hospitals the same capital exception payments and add-on payments for operating DSH that they would have received under original Medicare. The payment is added to the Prospective Payment System (PPS) rate. Today's Options PFFS reimburses DSH payments on a claim-by-claim basis in the same manner as CMS.
- Today's Options PFFS does not reimburse facilities for bad debt incurred as a result of members not paying their cost-sharing amounts, unless specified in a provider's contract with Today's Options Network PFFS.
- Today's Options PFFS does not enter into the annual cost settlement process with providers, contracted or non-contracted. Providers who have treated Today's Options PFFS members should contact Medicare or their Fiscal Intermediary regarding their cost settlements. This provision does not include Today's Options PFFS' obligation to non-contracted providers who qualify for PQRI and/or e-Prescribing incentives.

Billing for Non-Covered Services

Providers may not bill a member if Today's Options PFFS denies payment because the service was not covered, unless:

- The provider has informed the member in advance that the services may not be covered, and
- The member has agreed, in writing, to pay for the services.

Balance Billing Provisions

A provider may collect only applicable plan cost-sharing amounts from Today's Options PFFS members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Today's Options PFFS members.

Today's Options® PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options® PFFS depends on contract renewal.