

Appendix Q

Louisiana Bayou Health Program

Requirements for Managed Care Organization (MCO) Physician Incentive Plans

The Physician Incentive Plan (herein referred to as Plan) rules apply to Medicaid MCOs subject to section 1903(m) of the Social Security Act, *i.e.*, requirements for federal financial participation in contract costs, including both federally qualified MCOs and State Plan defined MCOs.

The MCO may operate a Plan only if - (1) no specific payment is made directly or indirectly under the physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey, and disclosure requirements in this appendix are met.

The MCO must maintain adequate information specified in the Plan regulations and make available to DHH, if requested, in order that DHH may adequately monitor the MCO's Plan if applicable. The disclosure must contain the following information in detail sufficient to enable DHH to determine whether the incentive plan complies with the Plan requirements:

1. Whether services not furnished by the physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.
2. The type of incentive arrangement; for example, withhold, bonus, capitation.
3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.
4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.
5. The panel size and, if patients are pooled, the approved method used.
6. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent calendar year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example home health agency) services.
7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results (which must be provided in a timely manner to Medicaid recipients upon request)

The disclosure requirements numbers 1 through 5 must be provided prior to Contract approval and upon the effective date of its renewal. Disclosure requirement number 6 must be provided for the previous calendar year by April 1 of each year.

The MCO must disclose this information to DHH when requested. The MCO must provide the capitation data required no later than three (3) months after the end of the calendar year. The MCO will provide to the beneficiary upon request whether the prepaid plan uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement,

whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

Disclosure Requirements Related to Subcontracting Arrangements

An MCO that contracts with a physician group that places the individual physician members at substantial financial risk for services they do not furnish must do the following:

- Disclose to DHH, upon request, any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid recipients. The disclosure must include the required information and be made at the times specified.
- Provide adequate stop-loss protection to the individual physicians.
- Conduct enrollee surveys.

An MCO that contracts with an intermediate entity (e.g., an individual practice association, or physician hospital organization) and which bases compensation to its contracting physicians or physician groups on the use or cost of referral services furnished to Medicaid/CHIP recipients must comply with requirements above.

Recipient Survey

42 CFR 417.479(g)(1) requires that organizations that operate incentive plans that place physicians or physician groups at Substantial Financial Risk (SFR) must conduct surveys of enrollees. Surveys must include either all current Medicaid/CHIP members in the MCO's plan and those that have disenrolled other than because of loss of eligibility or relocation, or choose to conduct a valid statistical sample.

According to 42 CFR 417.479(g)(iv), enrollee surveys must be conducted no later than one year after the effective date of the Contract and at least annually thereafter. As long as physicians or physician groups are placed at SFR for referral services, surveys must be conducted **annually**. The survey must address enrollees/disenrollees satisfaction with the quality of services, and their degree of access to the services. DHH has the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. MCOs, upon completion of approved survey tool, will be expected to compile, analyze and summarize survey data within 120 days and submit the results to the DHH.

Note: If disenrollment information is obtained at the time of disenrollment from all recipients, or a survey instrument is administered to a sample of disenrollees, that method will meet the disenrollee survey requirements for the Contract year.

Sanctions

Section 1903(m) of the Act specifies requirements that must be met for states to receive FFP for contracts with MCOs, (42 CFR 434.70(a)(2002, as amended) and sets the conditions for Federal Financial Participation (FFP). Federal funds will be available to Medicaid for payments to MCOs only for the periods that the MCOs comply with the Plan requirements in 42 CFR 417.479(d)-(g), (h)(1), (h)(3), and 417.479(l) requirements related to subcontractors. These regulations cover: 1) the prohibition of physician payments as an inducement to reduce or limit covered medically necessary services furnished to an individual enrollee, 2) proper computation of substantial financial risk, 3) physician stop-loss protection, 4) enrollee survey requirements, and 5) disclosure requirements.

42 CFR 434.70(b) provides that CMS may withhold FFP for any period during which the State fails to meet the State plan requirements of this part.

Intermediate Sanctions and/or Civil Money Penalties

42 CFR 438.700(a) states that intermediate sanctions (42 CFR 438.702, types of intermediate sanctions) may be imposed on an MCO with a risk comprehensive contract which fails to comply with any of the requirements of 417.479(d) - (g), or fails to submit to DHH its physician incentive plans as required or requested in 42 CFR 422.208 and 422.210.

In accordance with 42 CFR 1003.103(f)(1)(vi), the OIG may impose a Civil Monetary Penalty of up to \$25,000 for each determination by CMS that a contracting organization has failed to comply with 417.479(d) - (g) and 434.70. Civil Monetary Penalties may be imposed on the organization in addition to, or in place of the imposed sanctions.

Definitions for Physician Incentive Plan Requirements

Physicians Incentive Plan - Any compensation arrangement between a Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid recipients enrolled in the MCO.

Physician Group - A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Intermediate Entity - Entities which contract between an MCO or one of its contractors and a physician or physician group. An Individual Practice Association (IPA) is considered an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

Substantial Financial Risk - An incentive arrangement based on referral services that place the physician or physician group at risk for amounts beyond the risk threshold. The risk threshold is 25 percent.

Bonus - A payment that a physician or entity receives beyond any salary, fee-for service payment, capitation, or returned withhold. Quality bonuses and other compensation that are not based on referral levels (such as bonuses based solely on care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk, but may be revisited at a later date.

Capitation - A set dollar payment per patient per unit of time (usually per month) that is paid 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.

Payments - The amount an MCO pays physicians or physician group for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this subpart.

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

Risk Threshold - 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. The risk threshold is 25 percent.

Withhold - A percentage of payments or set dollar amount that an organization deducts for a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on the specific predetermined factors.