BOLDER Healthcare Solutions™

Legal Issues: Medicare Advantage and Section 1557

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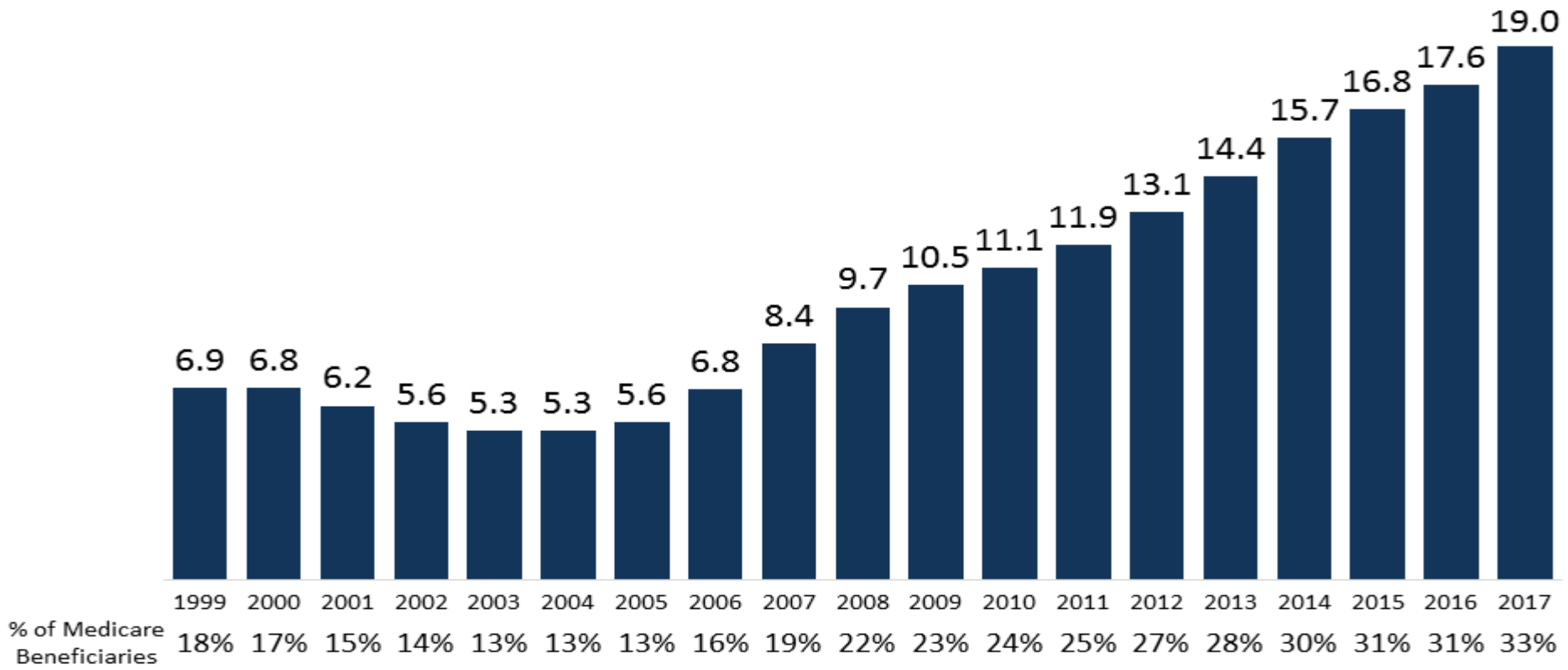
What is Medicare Advantage?

- Medicare beneficiaries were first given the option to receive their Medicare benefits through private health plans in the 1970's
- Balanced Budget Act of 1997 named these plans Medicare+Choice
- Medicare Modernization Act of 2003 renamed these plans Medicare Advantage
- Authorized by Part C of Title XVIII of the Social Security Act and administered by CMS
- Often referred to as Medicare Part C

Who is enrolled?

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2017



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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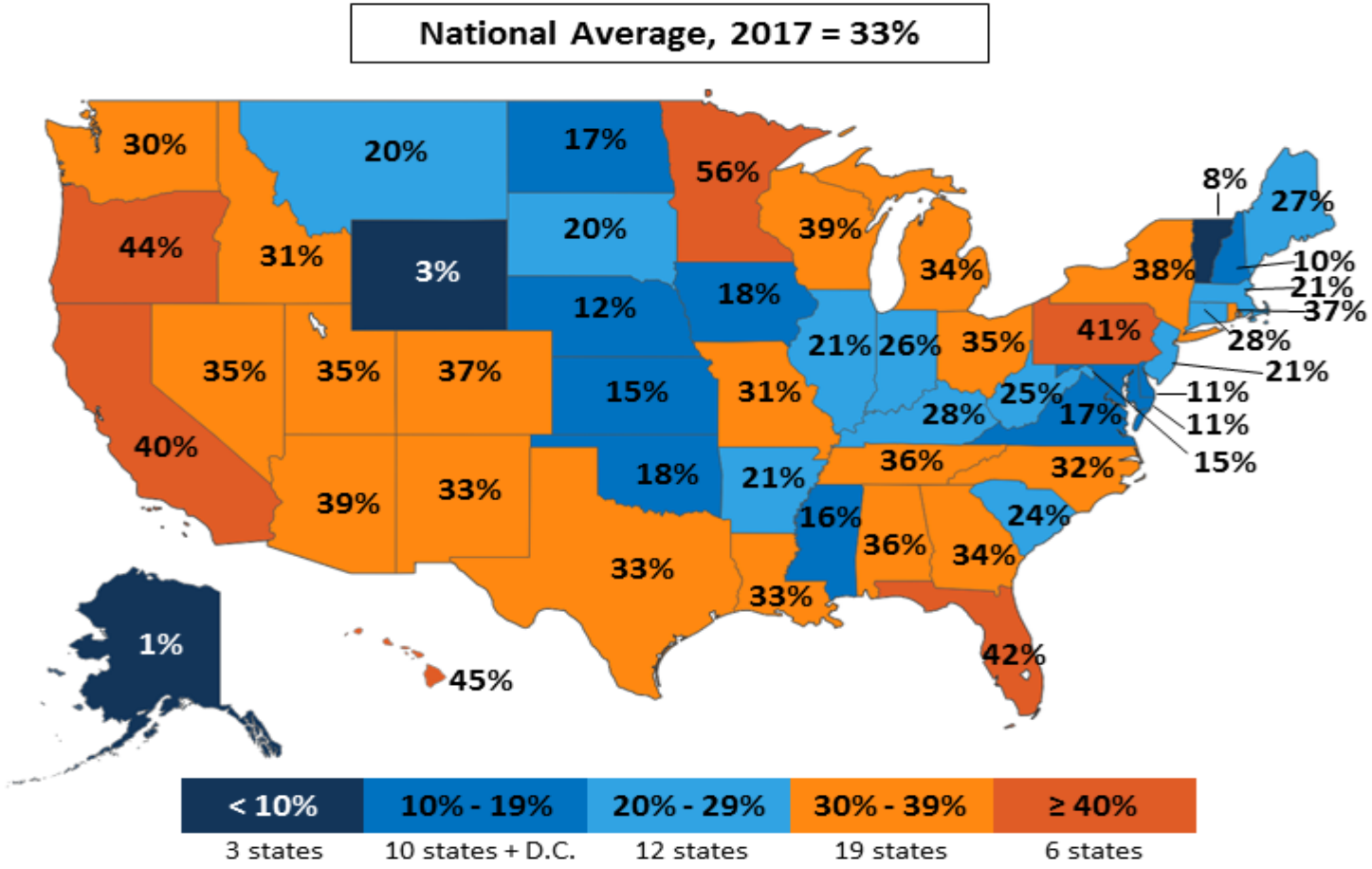
Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2017



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2017.

Change to Medicare Advantage under PPACA

- Reduces payments to the plans over time, in order to bring them closer to the average cost of care under traditional Medicare.
- Provides for bonus payments to plans based on quality ratings
- Beginning in 2014, plans must maintain a Medical Loss ratio of at least 85%, reducing the share of premiums used for administrative costs and profit.

Types of Plans

Private Fee for Service- Closest to Traditional Medicare

- Enrollment in this type of plan has declined significantly
- In 2017, estimated to account for only 1% of Medicare Advantage enrollment

HMO/PPOs- Contract with Provider Networks to Deliver Medicare Benefits

- HMO's account for 63% of the MA enrollment in 2017
- PPO's account for 26% of the MA enrollment in 2017

Other plans include:

- Regional PPO's (7%)
- Other Private Plans (3%)
- Special Needs Plans

Governing Law

- Medicare Advantage contractors administer their plans and benefits under their contracts with the Federal Government and under Federal Law.
- The State is only involved in licensing the plans and to some extent monitoring solvency. Therefore, State Law does not apply.
- The relevant claims arise under the Medicare Act
- Medicare Advantage Plans are not private insurers offering private insurance. They are government contractors, administering government benefits.

Is it an Insurance Policy?

- The short answer is no
- The beneficiaries are not purchasing or applying for a policy. They are electing a way to receive their Medicare benefits through a statutory framework.
- Therefore, they have no contractual policy rights. All disputes must be handled through the Medicare appeals process, just as with traditional Medicare benefit determination appeals.
- Providers also likely must exhaust the Medicare Appeals process prior to engaging in litigation

Contracted vs. Non-Contracted Plans

- Fee for Service plans follow all traditional Medicare Rules and Regulations and payment schedules
- HMO and PPO plans may include some additional contractual requirements on providers and/or clarify or add to traditional Medicare requirements and fee schedules
- All Medicare Advantage plans are to provide basic services and make payment to all contracted and non-contracted providers in a timely manner and in accordance with Medicare law.

Deemed Provider

- Applies only to MA Private Fee for Service Plans
- 2 criteria:
  - The provider is aware in advance of furnishing services, that the patient is enrolled in a PFFS plan.
  - The provider has reasonable access to the plan's terms and conditions of payment.
    - Reasonable access exists if you can call, fax, email, mail, or view a website.
- The provider does not have to accept a PFFS patient (except in emergency situations). However, once the service is provided, if the provider had advanced knowledge, they will be deemed contracted provider.

What do they pay?

- What you agreed to in your contract OR no less than the Medicare Rate
- Medicare coverage and payment is contingent upon a determination that:
  - A service is in a covered benefit category;
  - A service is not specifically excluded from Medicare coverage by the Act; and
  - The item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member, or is a covered preventive service.
- MA plans need not follow Original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

Medical Necessity

- MA plan must have policies and procedures- coverage rules, practice guidelines, payment policies, utilization management, for medical necessity determination.
  - Therefore, they should provide it or be able to direct it to you, if you ask.
- All fully or partially adverse medical necessity decisions are to be reviewed by a licensed physician or healthcare professional, before being issued.
  - Ask for proof of review
- Medicare Program Integrity Manual- If the plan approved the furnishing of services through an adverse determination of coverage, it may not later deny for lack of medical necessity.

Does the Provider have to accept Medicare Rate from a non-contracted MA plan?

- The short answer is yes, in most situations, if you accept the patient, provide the service, and bill the MA plan.
  - The only way around this is to explicitly tell the patient you do not accept the coverage before treatment and not bill the plan.
- CFR 422.214 (b)
  - Non contracted provider must accept as Payment in Full the amounts it could collect if the beneficiary was enrolled in traditional Medicare

Assignee

- Assignee: A non-contract physician or other non-contract provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.
- A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal. Completing that waiver makes the provider an assignee.

What is Section 1557?

- Created by Affordable Care Act in 2010
- Prohibits discrimination in any health program or activity
- Adds on to the existing Civil Rights law
- Intended to advance equality and reduce health disparities to populations most vulnerable to discrimination in the Health context
- First Federal Civil Rights law to prohibit discrimination on the basis of sex in all health programs and activities receiving Federal financial assistance
- Final Rules were issued in May 2016, effective July 18, 2016 (or policy year 2017 for health plans)
  - ***currently enjoined by Federal Court as of December 31, 2016***

To whom does it apply?

- Entities receiving Federal financial assistance through their participation in Medicare or Medicaid;

- Any health program that HHS itself administers;

- Health Insurance Marketplaces and the insurers that participate in those Marketplaces.

Federal Financial Assistance

- Includes grants, loans, subsidies, contract of insurance, and other types of assistance

- Other types of assistance includes premium tax credits, advance payments of premium tax credits and cost-sharing reductions for health insurance coverage purchased through the Health Insurance Marketplace

Sex Discrimination

- Final Rule requires woman to be treated equally with men in the healthcare they receive
- Prohibits the denial of healthcare or health coverage based on sex, including specifically, discrimination based on pregnancy, gender identity, and sex stereotyping
- Requires covered health programs to treat individuals consistent with their gender identity

Disability

- Covered Entity must make all programs and activities provided through electronic and information technology accessible
- Ensure physical accessibility to newly constructed or altered facilities
- Provide appropriate auxiliary aids and services to individuals with disabilities
- Covered Entities are prohibited from using marketing practices or benefit designs that discriminate on the basis of disability
- Take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities

Language and Religion

- Covered Entities must take reasonable steps to provide meaningful access to each individual with limited English proficiency, eligible to be served, or likely to be encountered, in their health programs and activities
- Covered Entities should develop and implement a language access plan
- Section 1557 does not have a religion exemption. However, the final rule does not limit the existing protections for religious freedom.

Procedural Requirements

- Covered Entities with 15 or more employees are required to have a grievance procedure and compliance coordinator
- Covered Entities must post notices of nondiscrimination, including taglines that notify individuals of translations available
- Taglines must be in the top 15 non-English languages spoken in the State (exception for small communications - 2 languages)
- All Section 1557 regulations also apply to a Covered Entity's employee health benefit plan

Enforcement

- Handled by the HHS OCR
- Using existing civil rights enforcement mechanisms including: compliance reviews and reports, compliance investigation, and providing technical support and guidance.
- Where noncompliance cannot be corrected via informal means, available enforcement includes suspension of, termination of, or refusal to continue to grant Federal assistance. Additionally, the OCR may refer to the Justice Department.
- The final regulations state that a civil action may be brought under section 1557.

Grievance Procedure

- Must incorporate appropriate due process standards and allow for prompt and equitable resolution of complaints
- However, an individual does not have to exhaust a Covered Entity's grievance procedure before filing a Section 1557 complaint
- Covered Entities with existing disability discrimination grievance policies can continue to use those and extend them to all other categories
- HHS included a sample grievance procedure in Appendix C of the Final Rule

Notice

- Covered Entity must take appropriate initial and continuing steps to notify the public of their rights under Section 1557 and the nondiscrimination obligations
- The notice must include the following statements:
  - The Covered Entity does not discriminate on the basis of race, color, national origin, sex, age, or disability
  - The Covered Entity provides appropriate auxiliary aids and services, free of charge and in a timely manner, to individuals with disabilities
  - The Covered Entity provides language assistance services, free of charge, and in a timely manner, to individuals with limited English proficiency
  - How an individual can access such aids and services referenced above
  - The contact information for the responsible employee coordination compliance with Section 1557
  - The availability of a grievance procedure, and how to file a grievance
  - How an individual can file a discrimination claim with HHS

Notice

- Must be posted in significant publications and communications, in conspicuous physical locations, and on the website
- Can be combined with other required notices
- Encouraged to post in English and one other language

Significant Publications

- Covered Entities are in the best position to determine, within reason, which of their communications are significant in the context of their own health programs and activities.
- Examples: Application to participate or receive benefits from a Covered Entity's health program or activity; written correspondence regarding an individual's rights; entities outreach or education material

Non-Significant Publications

- Radio and TV ads
- ID cards
- Appointment cards
- Business cards
- Banners
- Envelopes
- Billboards

Sex Stereotyping

- OCR relies on *Price Waterhouse v. Hopkins* to include sex stereotyping
  - 1989 case which held gender stereotyping as actionable
  - Hopkins sued her employer for not promoting her to partner because she did not look or act like a woman
- Sexual stereotypes can be based on expectations of gender roles

Sexual Orientation

- "Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes."
- OCR will investigate for discrimination, but the OCR does not have the authority to include sexual orientation in the definition of discrimination based on sex.
  - No Court decisions…..yet

Gender Identity

- Covered Entities must treat individuals consistent with their gender identity
- OCR defines gender identity as an individual's internal sense of gender, which may be different than the sex assigned at birth.
- Individuals may be male, female, neither, or a combination of male and female.
- Gender Identity also encompasses gender expression and transgender.

Discrimination in Healthcare

- A study referenced in a 2015 Health and Social Work article cited 42% of female-to-male transgender adults reported verbal harassment, physical assault, or denial of equal treatment in a doctor‘s office or hospital.
- One of the major complaints was “no way to identify yourself”
- The study cites previous research finding that medical schools only spend an average of five hours on lesbian, gay, bi-sexual, and transgender issues.

Gender Question

(1) “What is your current gender identity?” Answers could be:

- Male
- Female
- Female-to-male (FTM)/Transgender Male/Trans Man
- Male-to-Female (MTF)/Transgender Female/Trans Woman
- Genderqueer, neither exclusively male nor female
- Additional Gender Category/(or Other _____)
- Decline to answer

(2) The second question is “What sex were you assigned at birth on your original birth certificate?” Patients are to select one: male, female or decline to answer.

** Recommended by LAMBDA and ACLU**

Gender Categories

- Gender Identity - A person's internal sense of being male, female, both or neither
- Gender Expression - The way a person acts, dresses, speaks, and behaves in order to show their gender as feminine, masculine, both, or neither
- Transgender - People whose gender identity is not the same as the sex they were assigned at birth
- Gender Non-conforming - People who express their gender differently than what is culturally expected of them
- Sexual Orientation - How people identify their physical and emotional attraction to others. It is not related to Gender Identity.
- Transsexual - A transgender individual who has transitioned to the opposite sex
- Female to Male (FTM) or Transgender Man - A person born with female genitalia at birth who identifies as a male and lives as a male
- Male to Female (MTF) or Transgender Female - A person born with male genitalia at birth who identifies as a female and lives as a female
- Genderqueer - a term for individuals who do not identify as either male or female, or identify as both genders

Gender Coding

- Occurs when an individuals gender does not align with gender of the person who would typically receive the service
  - Male receiving Ovarian Cyst Removal
  - Female receiving Prostate Exam
- Can also occur when a transgender male seeks coverage for a broken arm, however the individual's gender does not align with the gender loaded in the insurance system
- Covered Entities should consider using a unique billing modifier, which would alert insurer to override sex specific billing codes
- Medicare Part A Condition Code 45/ Medicare B KX modifier
- The flagging of the claim is not in itself a violation, however, delay or denial, due to flagging , is

Franciscan Alliance, Inc. v. Burwell

- US District Court Northern Texas
- 8 States and Religiously affiliated organizations sued the US Government
- Plaintiffs allege Section 1557 requires them to perform abortions and transgender surgeries leading to Religious Discrimination
  - Doctors and Hospitals would be forced to perform services “contrary to religious beliefs or medical judgement”
  - Plaintiffs cite differing medical studies on Transgender procedures
- Plaintiffs’ Motion for Preliminary Relief granted, enjoining HHS from enforcing the Law
- Case is still pending in Court

President Trumps' Executive Order effecting Provisions of ACA

"Take all actions consistent with the law to minimize unwarranted economic and regulatory burdens of the law"

Gives Federal agencies wide latitude to change, delay, or waive provisions of the Law

President Trump's Education Memo

- On February 2017, the Trump Administration sent letters to the nation's public schools advising them to disregard the Obama administration's previous direction on the transgender issue.
- Those Obama Administration memos said that prohibiting transgender students from using facilities, that align with their gender identity, violates federal anti-discrimination laws.
- The Trump memo give no new guidance on the issue, and instead point to the fact that the Obama memos were not legally analyzed or publicly vetted.

Grimm Case

- Transgender Teen in Virginia suing to access Boy's Bathroom
- Supreme Court was set to have arguments on March 2017, however, sent back to lower court to review, after President Trump rescinded federal guidance to school boards on the matter.
    - This Fall the ACLU dismissed the immediate injunction request at the local level, so that the Federal Claim could proceed
- Grimm's claim is that Title 9 prohibits sexual discrimination based on gender identity
- Most believe the case will make it back to the Supreme Court again
- May 2018 School's Motion to Dismiss lawsuit denied
    - Sexual discrimination by way of sexual stereotyping
    - School is appealing this decision

Masterpiece Cakeshop

- Colorado case where religious baker refused to sell wedding cake to same-sex couple
- Case had many problems:
  - Is a cake for a private event really speech or the exercise of religion?
  - Was the cake actually refused or just the messaging?
  - At the time the cake was requested, the action was still “illegal”
- Holding basically inconclusive- Colorado has failed to give Baker’s religious exemption claim consideration

Action Items

- Grievance Procedure
- Notifications
  - Significant Documents
  - Signage
  - Website
- Admissions Paperwork
  - Gender Questions
  - Pronoun selection
  - Legal Name vs. Preferred Name
- Plan/Procedure for Patients to Change Gender Identity
- Scripting for Registration
- Modifiers
- Training for all Staff
- Clinical Procedures for Gender Identity issues
  - Room Share
  - Nursing Supervision
- Single Occupancy Bathrooms

Contact Information

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