Keeping Up with New Payment Models: "Cost Plus" or "Medicare Plus"

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Providers across the country are experiencing a new "reality" in payment models where patients are presenting **"Medicare PLUS"** or **"Cost PLUS"** insurance cards, the latest tactic of self-funded, commercial employee benefit plans. Under these plans, the employer is interpreting a Provider's assignment of benefits acceptance as a contractual agreement to accept a reduced, non-negotiated payment for services determined to be "reasonable", typically Medicare "plus" a percentage.

In effect, these plans extend an alternative reimbursement arrangement via the member's ID Card, which the Provider authorizes by accepting assignment, and the process then circumvents any **existing** contractual arrangements. Although it is not a new concept, the rapid growth of these programs is creating an administrative nightmare for the patient registration staff as well as the billing department and the patients themselves.

Because there is no contract, Providers are **NOT** required to provide non-emergent services to these members. Identifying these programs on the front end is complicated by their inclusion of legitimate PPO network logos for physician or pharmacy services, extremely small print, and few if any details about the program's limitations.

Technically, these individuals do have insurance coverage however, if they are not identified until after the service has been provided, there are differing legal opinions on your options and whether or not the patient can be balanced billed.

We've seen reimbursement levels range from 110% to 140% of Medicare, but the method used to calculate the payment amount can vary significantly. Some pay at a percentage of the Medicare IPPS/APC rate for specific services while others simply apply a percentage to the facility's published cost to charge ratio.

Given their growing popularity, Providers need to be proactive in understanding and managing these types of programs. Although each organization's response should be individualized and based on current policies and local market dynamics, we have provided a few general suggestions to get things started:

- Establish a clear policy on how your organization wants to handle "PLUS" patients both on the front end and back end. Options include turning away the patient, treating as self-pay or pursue balance billing and/or legal action after the service.
- Post signs clearly stating your policy and inform the patients of their potential financial responsibilities, before services are provided.
- Inform registrars about the issue and track/monitor volume and employer specific information.
- Separate balance billing policies may need to be established for those patients that were not identified prior to services performed.
- Once identified, contact the employer and/or TPA to discuss your concerns and explore the possibility of a direct arrangement that benefits all parties, but most importantly the patient.

We all understand an employer's need to control healthcare costs. However, providers deserve the opportunity to be part of the discussion that identifies a solution … not tricked into playing a game that appears to have no rules.

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