

MEDICARE ADVANTAGE PLANS — REGULATORY QUIRKS

By Jeanine Freeman, JD

Medicare Advantage (MA) plans are commercial carriers that contract with the federal government to provide health benefits to Medicare beneficiaries who elect coverage with them in lieu of traditional Medicare. At the close of 2007, approximately 11% of Iowa's Medicare beneficiaries were enrolled in MA plans, lower than the national average of 19%. The Commonwealth Fund estimates that in 2008, MA plans will be paid at a rate of 12.4% higher than traditional fee-for-service Medicare, amounting to a total of \$8.5 billion in additional dollars for an average of \$986 more per enrollee. For some commercial carriers, MA enrollment is their primary source of recent market growth.

For Iowa doctors, MA plans sometimes have meant additional burdens, little guidance, confusion for their patients and office staff, and minimal-to-no identifiable payment advantages over traditional Medicare. CMS is trying to do better and its 2009 Call Letter directs MA plans to engage in active provider outreach and education.

Essential for doctor's practices are the MA plans' documents. If you have a contract with a commercial plan for MA purposes, the contract is binding. If the physician provides services to a Medicare patient known to be enrolled in an MA Private Fee for Service (PFFS) plan, the physician is "deemed" participating and bound by the PFFS plan's terms and conditions so long as they are available; the physician is not required to accept additional PFFS Medicare patients. A September 12, 2008 CMS directive requires MA PFFS plans to adopt model terms and conditions by January 1, 2009. PFFS member ID cards must include the plan's Web link to its terms and conditions and a phone number for providers to call.

To what extent are Medicare's billing and payment rules and medical policies applicable to MA plans? IMS recently asked CMS that question and, with the help of the AMA Washington office, received this response. Unless an MA plan contract signed by the physician specifies otherwise, claims submitted to MA plans should follow the requirements of fee-for-service Medicare, including local and national coverage determinations and requirements for coding.

Medical record requests by PFFS plans for risk adjustment purposes are a source of tension for Iowa medical practices. CMS' Call Letter clarifies that the nature of the request is important. By law, medical practice cooperation is required if the requested records are needed for a verification audit conducted by CMS on the plan. For other requests, medical practices may be required to cooperate either by contract, if the physician has one with the PFFS plan, or by the plan's terms and conditions if the physician is "deemed." CMS says, however, that the PFFS plan can ask only for records belonging to patients enrolled in the PFFS plan and requests must be reasonable and not excessive. CMS gives plans the option of paying providers for producing requested records and suggests language for doing so in its model terms and conditions. CMS' Physicians' Regulatory Issues Team (PRIT) invites contact from medical practices asked by a PFFS plan to provide an unreasonable number of records; similarly, IMS encourages contact with the CMS Region VII office.

IMS serves on a working committee of the AMA to examine MA plans and practices and ways that physicians can most effectively work with the MA program. Let us know of your MA practice challenges so we can better represent you.

For links to additional resources, visit: www.iowamedical.org/LER



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