Eli's Rehab Report

Managed Care: Put These Medicare Advantage Changes on Your Radar

MIPPA legislation insists on contracts for certain private fee-for-services plans.

The recent Medicare Improvements for Patients and Providers Act (MIPPA) set some strict standards for Medicare Advantage (MA) plans, and the outcomes could work both for -- and against -- your rehab business.

MIPPA Cracks Down on MA Marketing Practices

If you're used to being schmoozed by MA plans with free lunches, non-related health products and the like, that's about to change. According to Section 103 of MIPPA, effective for the 2010 plan year, MA plans will have limits on these types of sales activities, as well as on co-branding and commissions. In addition, MIPPA holds MA plans accountable to state appointment laws affecting agents and brokers.

The good news: For rehab providers, especially home health agencies that get more than their share of plan salesperson visits, relief will be welcome. Although some MA plans pay fair rates, the new requirements will help address bad plans and overly aggressive salespeople who provide dishonest marketing, points out **Bob Wardwell**, vice president of regulatory and public affairs for the Visiting Nurse Associations of America.

Congress' decision to "go after" MA plans also helped finance the Medicare Physician Fee Schedule payment fix, adds **William Dombi,** vice president of law for National Association for Home Care & Hospice.

The bad news: You may see an impact on the negotiation of payment rates between the MA (Medicare Advantage) plans and the providers, Dombi notes. "If plans are getting less money, they may be willing to pay less money -- but that's going to be up to the home care agencies [or other rehab provider types] to decide the stance they'll take in negotiations and when to say no to a particular contract."

PFFS Plans Say Goodbye to Solo Days

If Private Fee-For-Service (PFFS) plans still want to participate in Medicare Advantage, they'll have to play by some new rules. Beginning in 2011, these plans will have to measure and report on their providers' quality of care. But the kicker is that they'll also have to form provider networks with contracts.

Details: In counties where there are two or more non-PFFS plans, PFFS plans will no longer be able to simply "deem" providers into the plan without a contract. Under current law, PFFS plans don't have to prove they can meet access standards if they allow any willing qualified Medicare provider to participate, and they pay as traditional Medicare would pay.

One argument is that the network requirement would provide better access to care because there would be contracts between the providers of services and the plan. On the other hand, "private FFS plans may limit the number of providers who are eligible to participate," creating poorer access to care, Dombi says. And don't forget that some provider types may not even be willing to participate, he adds.

Other downsides: From the beneficiary's view, the networking requirement could restrict free choice of providers, Wardwell points out.

All that said, the networking requirement could also discourage poor MA plans from entering the field purely for high profits, Wardwell says, and that's a good thing.

Don't miss: Any time you're dealing with a Medicare HMO, be aware of the possibility of "silent PPOs," says **Barry**

Inglett, PT, CHT, Cert. MDT, with Mailly & Inglett Consulting in Wayne, N.J. "Know every patient that comes in your door and exactly what their benefits are." And when staff calls to verify insurance information, document the conversation and who you spoke with, he says.