

August 23, 2007

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn:
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Advantage program administrative improvements

Dear Deputy Administrator Kuhn:

As you and your colleagues consider important reforms to the Medicare Advantage program, the Medical Group Management Association (MGMA) maintains that the variations in the Medicare Advantage program subject medical practices to extraneous administrative burdens, already an immense burden to efficient patient care. MGMA urges the Centers for Medicare & Medicaid Services (CMS) to eliminate unnecessary administrative burdens, exacerbated by Medicare Advantage, which add to the cost of treating Medicare beneficiaries.

MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA's nearly 21,000 members manage and lead some 12,500 organizations, in which almost 270,000 physicians practice. MGMA's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them.

In recent research, MGMA members expressed clear concern regarding the Medicare Advantage program. Notably, respondents made clear that they could not effectively identify Medicare Advantage patients. Over 56 percent of respondents said they could not accurately identify Medicare Advantage patients, with 90 percent of respondents indicating that patient insurance cards provided ineffective insurance coverage identification.

MGMA members overwhelmingly believe (91 percent), that a majority of Medicare Advantage patients do not understand their coverage options. Members also strongly believe (89 percent) that Medicare Advantage enrollees do not understand that they are no longer traditional Medicare patients. This contributes to widespread confusion, leading to the research findings that over 90 percent of MGMA practice respondents had some of their Medicare Advantage patients switch out of a Medicare Advantage plan and back to traditional Medicare over the last year.

Standardization of Medicare Advantage patient identification cards

Standardized patient identification cards for Medicare Advantage enrollees would allow medical providers to more easily identify the specific type of beneficiary health coverage (e.g., traditional Medicare; Medicare Advantage health maintenance organizations; Medicare Advantage private fee-for-service plans; etc.). Identification card standardization already exists for traditional

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Medicare patients, and should be extended to Medicare Advantage. By standardizing Medicare Advantage patient identification cards, providers can correctly deliver the appropriate medical services entitled to their patients and patients can better understand their insurance carrier. **MGMA recommends that all Medicare Advantage products be mandated to adhere to a governmental standard for patient identification cards.**

The card should bear a CMS-approved Medicare Advantage logo, the Medicare Rx logo (if Part D coverage applies) and clearly state the Medicare Advantage plan sponsor, type of Medicare Advantage product, coinsurance amounts (if any) and claim submission address and phone number. Additionally, the card should prominently state “Providers: Do not bill Medicare. Submit claims directly to [name of plan].” MGMA encourages CMS to use the Workgroup for Electronic Data Interchange endorsed American National Standard (INCITS 284:1997) for all Medicare patient identification cards.

Elimination of the Medicare Advantage “Deeming Provision”

MGMA member respondents to our Medicare Advantage study also report widespread confusion caused by Medicare Advantage private fee-for-service plans. These plans are not required to have a provider network and providers may be “deemed” to be in-network.

The deeming provision is a section of the Medicare regulation found at 42 CFR 422.216(f). The regulatory requirement only applies to Medicare Advantage private fee-for-service plans and is not applicable to emergency and urgent care services. In effect, the section requires that non-participating providers seeing a Medicare Advantage private fee-for-service patient are treated as though they have a contract with the sponsoring plan.

Sixty-five percent of respondents to our member research noted that they have been deemed in-network by one or more Medicare Advantage plans. Practices showed widespread inconsistent deeming policy application, as respondents were split on whether they were deemed per patient (34 percent), per visit (21 percent) or both per patient/per visit (34 percent).

While the Medicare regulations stipulate that a provider is only deemed if they knew or were “given a reasonable opportunity to obtain information” that they are treating a Medicare Advantage private fee-for-service patient, plans do not pro-actively ask providers whether they knew that the patient was indeed enrolled in a private fee-for-service plan. The regulations state that a provider is deemed if the provider knew or should have known that the individual was enrolled in the plan and understood the terms and conditions of payment. The regulations go on to state that this information must be provided in a manner that is designed to “effect informed agreement”, such as a patient identification card. This requirement underscores the importance of the standardized Medicare Advantage patient identification card.

No other insurance product enables plans to create networks without contracts with providers. Medicare Advantage should be held to the same contracting standards as the rest of the industry. MGMA recommends that the deeming provision be eliminated in its entirety.

Fair contracting for Medicare Advantage providers

Furthermore, fair contracting increases transparency of the Medicare Advantage program, improving patient and provider relations. Many fair contracting practices have already been agreed to by several Medicare Advantage plan sponsors in the Multi-District Litigation settlements and mandated by several states.

All products clauses in provider-private payer contracts result in a practice being classified as a network participant with a Medicare Advantage sponsor without the practice’s affirmative acceptance of a Medicare Advantage plan, regardless of product type. All products clauses typically require a provider to submit to the same terms as if they had originally signed a separate contract to provide services for a

specific insurance plan. According to MGMA members that participated in our Medicare Advantage research, 41 percent of respondents were considered part of Medicare Advantage networks through all-products clauses. Thus, all products clauses are a significant component of Medicare Advantage provider network creation.

Several named payers in the Multi-District Litigation settlements are restricted from requiring physicians to participate in products without affirmative agreement for each product. Notably, Aetna, CIGNA, Anthem/Wellpoint and HealthNet are required to specifically exclude all products clauses from their contracts.

Moreover, the Colorado legislature enacted in early 2007 legislation creating guidance for contracts regarding providers and payer plans. Senate Bill 79 prohibits all product clauses for state-regulated insurance products, among other provisions. Several other states have passed similar prohibitions. These states include: Alaska, District of Columbia, Kentucky, Maryland, Minnesota, Nevada and Virginia.

Therefore, MGMA recommends that CMS mandate fair contracting practices. Specifically, MGMA recommends that CMS prohibit the establishment of Medicare Advantage networks through private contract all products clauses and require affirmative acceptance of plan sponsor and products for Medicare Advantage networks.

Medicare Advantage prompt payment of providers and transparency

Plans participating in Medicare Advantage should be compliant with CMS' payment policies regarding contracts and timely payments made to providers. Medicare regulations already require prompt payment requirements for non-network providers seeing Medicare Advantage private fee-for-service patients, but these logical provisions are not extended to network providers. The Medicare guidelines define prompt payment as contractors issuing payment for 95 percent of all clean claims within 13 days for electronic claims and 26 days for all paper claims. **MGMA recommends that CMS mandate Medicare timely processing guidelines, found at 42 USC 1395h(c)(3)(B), for all claims submitted by providers to Medicare Advantage plans as part of the plan's contracting requirements to the Medicare program.**

Similarly, standardized claims processing edits must be extended to the Medicare Advantage program to streamline the program and eliminate unnecessary administrative burdens. The Correct Coding Initiative (CCI) is a Medicare project aimed at limiting improper payments under Medicare Part B that arise from inappropriate coding. The CCI contains more than 280,000 pairs of codes that are scanned and scrubbed electronically for disallowed code pairs, which are then automatically denied. Implemented in January 1996, CMS uses the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices and a review of current coding practices in addition to provider input to update the system each quarter. In an effort to decrease administrative burdens on medical providers, and foster transparency in the Medicare Advantage program, **MGMA recommends that CMS limit the use of claims processing edits to only approved CCI edit pairs for all Medicare Advantage claims.**

We appreciate your attention to these important issues, which when enacted will greatly enhance the provision of quality services performed by medical providers to beneficiaries enrolled in the Medicare Advantage program. If you should have any questions, please contact Jennifer Searfoss Miller in the Government Affairs Department at 202.293.3450.

Sincerely,



William F. Jessee, MD, FACMPE
President and Chief Executive Officer