

Medicare Improvements for Patients and Providers Act: Key Changes to Medicare Advantage Plans

Special Needs Plans

- MIPPA extends Special Needs Plans (SNPs) through December 31, 2010. The moratorium on new plans remains in effect through 2010.
- MIPPA also creates statutory definitions of each type of SNP. Effective January 1, 2010, each plan can only enroll individuals who meet the statutory definitions.
 - *Institutional SNPs*: Institutional SNPs that want to enroll individuals living in the community, but requiring an institutional level of care, must use a state assessment tool to determine the need for institutional care; the assessment must be performed by an entity other than the organization offering the plan.
 - *Dual SNPs*: Dual SNPs must provide “each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format) that describes the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program” and an explanation of which benefits and cost-sharing protections are available under the SNP.¹ Also effective January 1, 2010, dual SNPs must have a contract with the State Medicaid agency to provide, or arrange for the provision of, benefits to which the individual is entitled under Medicaid.² Those that do not have such a contract may continue to operate, but cannot expand their service areas during the period of January 1, 2010 through December 31, 2010.³
 - *Severe or Disabling Chronic Condition SNPs*: The definition for persons eligible for the services of such SNPs includes those “who have or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care.”⁴

¹ [H.R. 6331](#), Section 164 (p. 217)

² These benefits may, but are not required to, include long-term care services that are consistent with those offered by the state Medicaid plan.

³ Under MIPPA, resources must be provided to assist state Medicaid agencies that are inquiring about coordination with Special Needs Plans, but States are not required to enter into contracts with SNPs.

⁴ [H.R. 6331](#), Section 164 (p. 221)

- All SNPs must meet new requirements for care management including:
 - having an evidence-based model of care with appropriate networks of providers and specialists;
 - conducting an initial assessment and annual reassessment of each individual's physical, psychosocial and functional needs;
 - developing a plan, in consultation with the individual, as feasible, that identifies goals and objectives and specific services and benefits; and
 - using an interdisciplinary team to manage the care.⁵

Private Fee-for-Service Plans

- As of January 1, 2011, PFFS plans must meet the access to care requirement, even if there are two or more network-based MA plans in the plan service area. This means that in many regions, PFFS plans must have written contracts with providers, and will no longer be able to deem providers into plans.
- Effective January 1, 2011, all employer MA PFFS plans must use contracts with providers, and can no longer deem providers into plans.

Marketing

MIPPA places prohibitions and limitations on certain sales and marketing activities by Medicare Advantage (MA) plans and Prescription Drug Plans (PDPs).

- Provisions that become effective no later than November 15, 2008 include:
 - limiting the scope of any marketing appointment with an agent or broker to topics and products that the beneficiary and agent or broker have agreed upon in advance (if the appointment is in-person, such an agreement shall be in writing);
 - limiting co-branding of a name or logo with the MA plan or PDP;
 - limiting the value of gifts and promotional items, other than those of nominal value, offered to potential enrollees;
 - limiting agent and broker compensation; and
 - requiring initial training and testing of agents and brokers, as well as annual training and testing.
- Effective January 1, 2009, MA plans and PDPs may not engage in certain activities, including: cold-calling and door-to-door solicitation without the potential enrollee initiating contact; cross-selling of non-health related products

⁵ [H.R. 6331](#), Section 164 (p. 220)

such as life insurance or annuities; providing meals at promotional and sales activities; or holding sales and marketing activities in health care settings other than at educational events.⁶

- Provisions designed to address fraudulent or inappropriate marketing practices by MA plans and PDPs are effective on January 1, 2009 and include:
 - plans can only use agents and brokers licensed under state law;
 - plans must report agent termination, including the reason for termination, to the applicable state; and
 - plans must comply with state information requests regarding the performance of a licensed agent or broker as part of an investigation by the State.⁷
- Effective January 1, 2010, MA plans and PDPs must include the plan type in the plan name using standard terminology.

Other Changes

Effective January 1, 2010, MIPPA places limits on the amount of cost-sharing imposed on dual eligible beneficiaries, including Qualified Medicare Beneficiaries (QMBs), enrolled in Dual SNPs.

- Cost-sharing amounts cannot exceed the amounts that a dual eligible beneficiary would incur under the State Medicaid program if s/he were not enrolled in a Dual SNP.

Information in part provided by the Center for Medicare Advocacy

⁶ [H.R. 6331](#), Section 164 (p. 13-14)

⁷ [H.R. 6331](#), Section 164 (p. 18-19)