

## General Medicare Advantage FAQ's

### 1. What is the Medicare Modernization Act (MMA)?

The Centers for Medicare & Medicaid Services (CMS) has been working to implement the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), passed in 2004. This law brings dramatic and innovative changes to the Medicare program and as a result we have Medicare Advantage. The program brings more affordable health care, prescription drug coverage to all people with Medicare, expanded health options, improved health access for rural Americans, and preventive care services, such as flu shots and mammograms.

### 2. What is Medicare Advantage?

A Medicare program established by the MMA that gives Medicare beneficiaries more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans replaced what used to be called Medicare + Choice Plans.

**Medicare + Choice** was an alternative to the Original Medicare Plan. It was a Medicare program that offered more choices among health plans. Medicare + Choice is now Medicare Advantage.

**Medicare Part A** is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

**Medicare Part B** is Medicare medical insurance that helps pay for doctors, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

### 3. Is Medicare Advantage taking the place of Medicare?

No, Medicare Advantage does not replace Medicare and is not a supplement. A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement. A doctor or hospital must agree to accept the plans Terms and Conditions of Plan Payment prior to providing healthcare services to a member with the exception of emergencies. If a doctor or hospital does not agree to accept the plans Terms and Conditions of Plan Payment, they may not provide healthcare services to a member, except in emergencies.

### 4. What are the health plan options under Medicare Advantage Program?

The Medicare Modernization Act, passed in 2004, authorized private carriers to offer benefits to Medicare beneficiaries, permitting them to opt out of traditional Medicare. In these arrangements, the private carrier is at risk. The Act allows private carriers to offer:

- Local Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point Of Service (POS) and Private Fee-For-Service (PFFS) products
- Stand alone Medicare Prescription Drug Program (Part D) Pharmacy products
- Regional and National Part D pharmacy products
- Regional and National PPO products

**Preferred Provider Organization (PPO) Plan** is a type of Medicare Advantage Plan in which beneficiaries use doctors, hospitals, and providers that belong to the network. Beneficiaries can use doctors, hospitals, and providers outside of the network but will incur additional cost.

**Private Fee For Service (PFFS) Plan** is a type of Medicare Advantage plan in which beneficiaries may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what beneficiaries pay for the services received. Beneficiaries may pay more or less for Medicare-covered benefits. Beneficiaries may have additional benefits such as, preventive care, annual physical exams, some dental services, vision and hearing benefits that Original Medicare Plan doesn't cover.

**Point Of Service (POS) Plan** is a type of Medicare managed care plan option that allows beneficiaries to use doctors and hospitals outside the network for an additional cost. POS is an additional, mandatory supplemental, or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network.

**Health Maintenance Organization (HMO) Plan** is a type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. Beneficiaries usually are covered for care only provided by the providers in the plan

## **5. What are other BlueCross BlueShield Plan's offering?**

In 2005 some Blue Plans began offering local HMO and PPO Medicare Advantage products. Tennessee providers may see out-of-state members residing/visiting Tennessee with a BlueCross BlueShield Medicare Advantage ID card. (See FAQ #7 for sample Medicare Advantage PPO ID card). Tennessee providers are not considered participating providers unless they have entered directly into an agreement with another Blue plan (i.e. contiguous counties).

## **6. Who should I contact if I think a member is covered by a Medicare Advantage product?**

If you think a member is covered by a Medicare Advantage product, you may verify this by calling BlueCard Eligibility at 1-800-676-Blue (2583) and

providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply. For additional information, you may also call the customer service number listed on the back of the member's ID card.

## 7. How do I identify a BlueCross BlueShield member with Medicare Advantage?

Ask for the member ID card. Members will not have a standard Medicare card. A Blue Cross and/or Blue Shield logo will be visible on the ID card. Beginning June 1, 2005, Medicare Advantage and the product type (PPO, HMO, POS, or PFFS) will appear on Medicare Advantage ID cards as they are issued or reissued.

Verify eligibility by contacting 1-800-676-Blue (2583) and provide the alpha prefix. Be sure to ask if Medicare Advantage benefits apply. For additional information, you may also call the customer service numbers listed on the back of the member's ID card or check the Blue Plan's Web site.

**The ID card below is an example of a Medicare Advantage PPO ID card.**



### Unique Identifier

Effective June 2005, all Blue Plans that offer a Blue Medicare Advantage product are required to include a Medicare Advantage unique identifier and Medicare-specific language on all Medicare Advantage PPO, HMO, POS, and PFFS ID cards as they are issued or reissued.

## 8. Where do I submit out-of-state Medicare Advantage claims?

- Tennessee providers should submit claims to BlueCross BlueShield of Tennessee. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment is made directly by a Blue Plan. For out-of-state BlueCard issues, contact the BlueCard service unit at 1-800-705-0391.
- Based upon CMS regulations, if you are a provider who accepts Medicare assignment and renders service to Medicare Advantage members from other Blue Plans, you will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than your charge amount. CMS regulations state that the Medicare allowable amount is considered payment in full.
- Other than the applicable member cost sharing amounts, reimbursement is made directly by the Blue Plan. You may collect only the applicable cost sharing (i.e. co-payment) amounts from the member

at the time of service, and may not otherwise charge or balance bill the member.

### **9. Does BlueCard® apply to Medicare Advantage?**

It is important to note Medicare Advantage products are a part of the BlueCard® program. You can contact BlueCard Services at 1-800-705-0391.

### **10. Do Medical Management rules apply to Medicare Advantage?**

Medical Management rules regarding referrals may apply. Providers are encouraged to obtain an Advance Determination for select services outlined by the MA Organization. Advance Determinations are performed to render coverage, medical necessity and appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that were not reviewed prospectively will be reviewed retrospectively for Medical Appropriateness to determine coverage and reimbursement. It is important to contact the number on the back of the member's ID card to determine these requirements prior to rendering non-emergency services and as soon as the member is stabilized for emergency service.

### **11. How does this impact Medicare Secondary?**

A Medicare beneficiary may choose to purchase an Original Medicare and a Medicare Supplement policy or Medicare Advantage. There are no changes to the way Medicare and Medicare Supplemental claims are filed.

### **12. What are the member requirements to join a Medicare Advantage Plan?**

To join a Medicare Advantage Plan, members must have Medicare Part A and Part B. In addition, members might have to pay a monthly premium to the Medicare Advantage Plan for the additional benefits such as preventive care, annual physical exams, some dental services, and vision and hearing benefits that the plan offers.

### **13. Should a provider ask a member for an ID Card?**

Due to the changes caused by the Medicare Modernization Act, we encourage providers to ask their Medicare patients whether they have changed insurance each time they visit. If a member presents both a Medicare Advantage ID Card and an Original Medicare ID Card, the provider should confirm Medicare Advantage eligibility and then disregard the original Medicare ID card.