Medicare Advantage Plans and CAHs: Friends or Foes?

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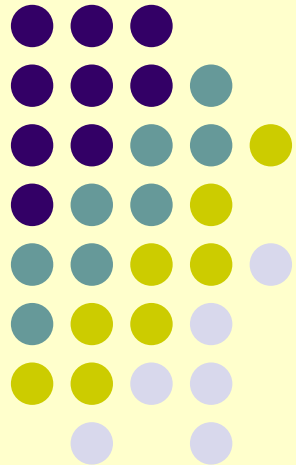
South Dakota Association of Healthcare Organizations
Critical Access Hospital Update



Who cares?

- Congress: 1997 and 2003
- CMS: Norwalk latest statement on CBS News
- Companies themselves: spread into market in all counties
- Beneficiaries: they are enrolling

Does it matter?

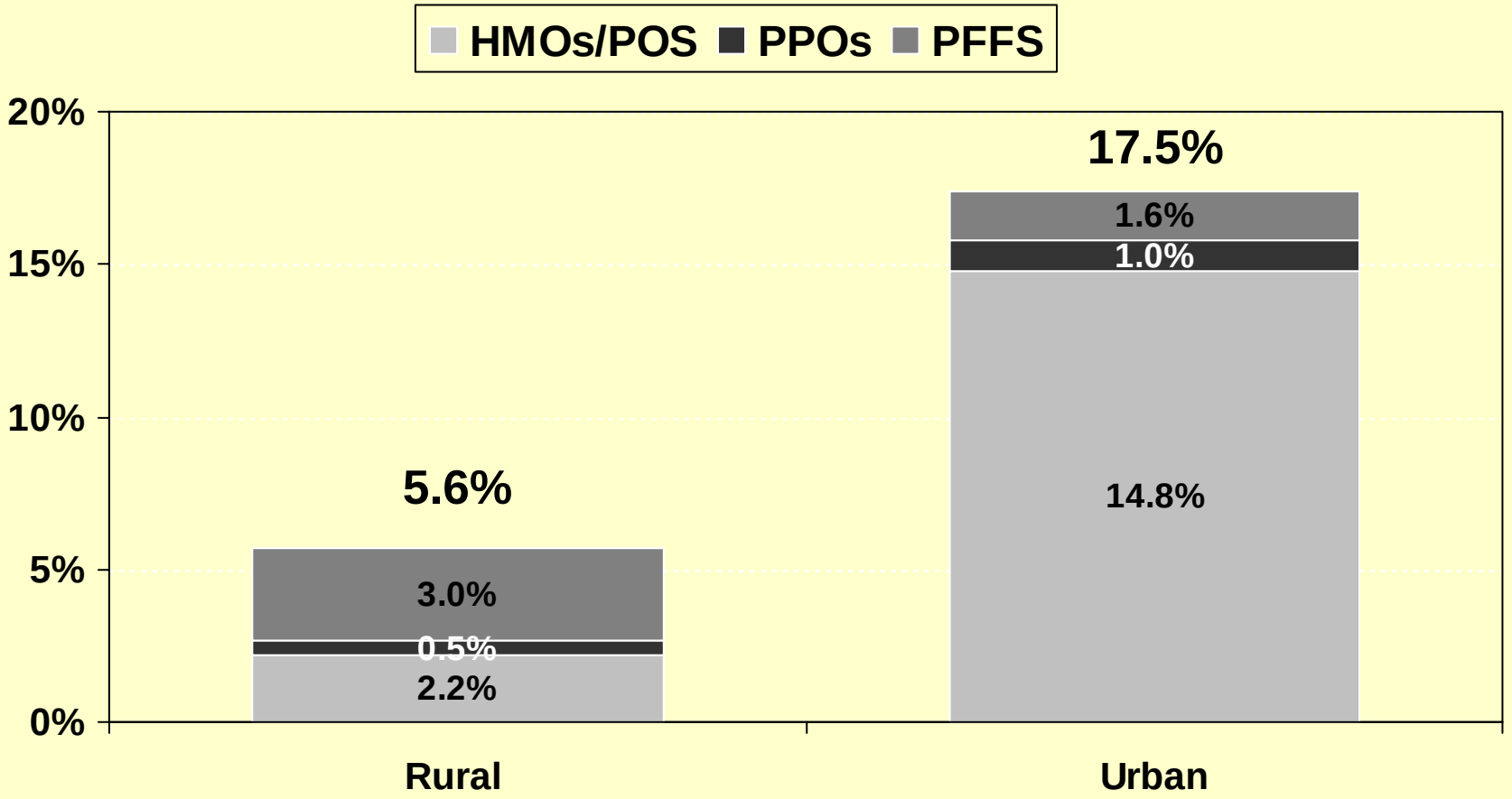
- M+C disappeared, so wait it out?
- Enrollment now exceeds M+C at its peak
- But there is an attack on the expenditures for Medicare Advantage (MA)
- So far, not successful
- And enrollment climbs

Concentration of MA Plans in Rural Areas, by Percent Rural Medicare Beneficiaries Enrolled, June 2007

	Name of Organization	Type of Plan	Number of Counties	Number of Benficiaries Enrolled	Cumulative Percent of Rural MA Beneficiaries Enrolled
	Total number of rural Medicare beneficiaries in MA Plans			864,118	
1	Humana Insurance Company	PFFS	2,049	207,432	24.0%
2	Unicare Life Insurance Company	PFFS	2,049	46,795	29.4%
3	Pyramid Life Insurance Company	PFFS	2,049	40,509	34.1%
4	First Health Life and Health Insurance Company	PFFS	2,049	40,410	38.8%
5	Blue Cross and Blue Shield of Michigan	PFFS	2,049	40,189	43.4%
6	Sterling Life Insurance Company	PFFS	2,049	28,754	46.8%
7	United Mine Workers of America	Cost	636	23,948	49.5%
8	Pacificare Life and Health Insurance Company	PFFS	2,049	21,022	52.0%
9	Geisinger Health Plan	HMO	26	20,594	54.4%
10	Keystone Health Plan West, Inc.	HMO	55	18,474	56.5%

Source: RUPRI Center for Rural Health Policy Analysis

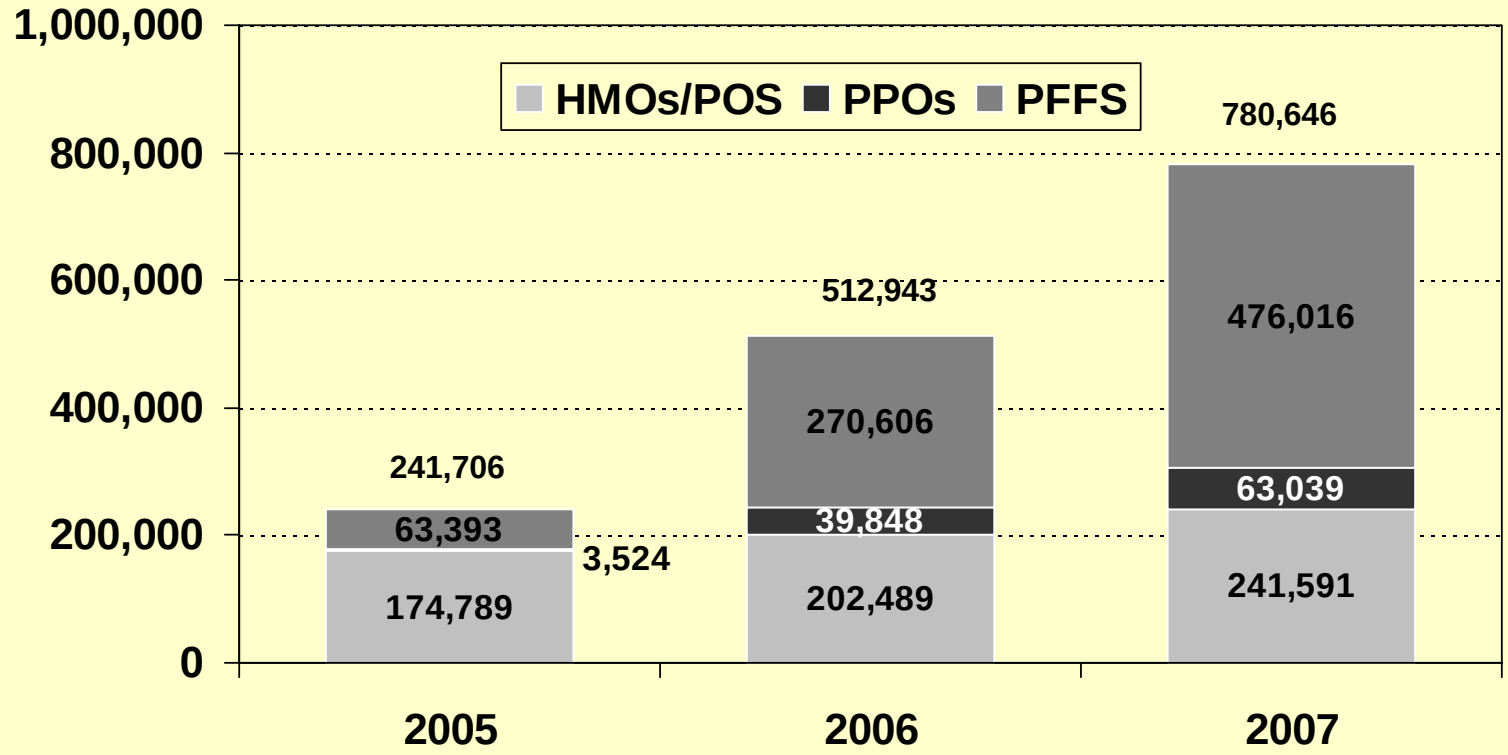
Medicare Advantage Enrollment, by Area of Residence, November 2006



SOURCE: RUPRI Center for Rural Health Policy Analysis.

MA Enrollment in Rural Areas, 2005-2007

- Almost all growth in MA has been in PFFS plans



Source: RUPRI Center for Rural Health Policy Analysis

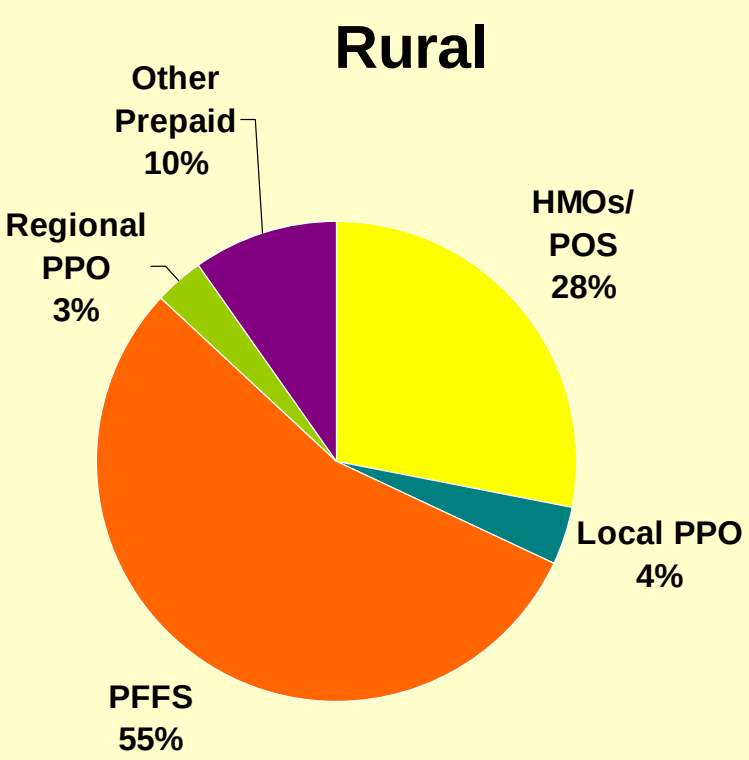
Percent of RURAL Medicare Population Enrolled in Medicare Advantage or Other Prepaid Plans, by State, June 2007

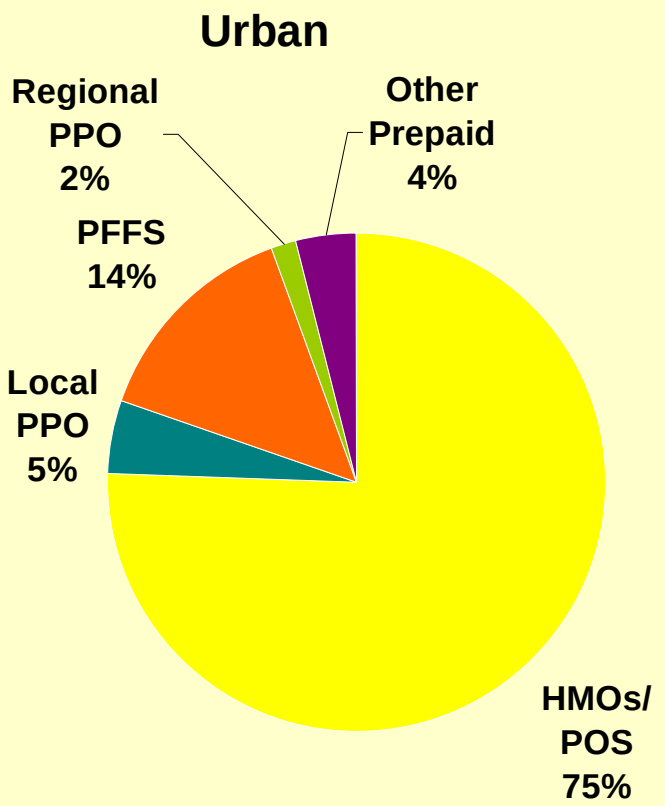
	Percent of Total Medicare Population										
	Medicare Advantage Plans										
State	**TOTAL Enrolled in MA**	PFFS	HMO/POS	Regional PPO	Local PPO	Other MA Plans	Other Prepaid[a]	Percent Enrolled in MA or Prepaid	TOTAL Enrolled in MA or Prepaid	Total RURAL Medicare Population	Exhibit: Percent of Urban Persons Enrolled in MA or Prepaid
TOTAL U.S.	**8.6%**	**5.2%**	**2.5%**	**0.3%**	**0.4%**	**0.2%**	**0.9%**	**9.5%**	**864,118**	**9,078,551**	**22.6%**
MN	**19.2%**	11.2%	1.0%	1.7%		5.3%	3.5%	22.7%	60,333	266,355	33.3%
PA	**18.9%**	3.1%	14.2%		1.6%		0.6%	19.5%	74,762	383,649	34.9%
WI	**18.7%**	12.4%	5.4%	0.1%	0.9%	0.1%	1.2%	19.9%	56,171	281,635	19.2%
NV	**16.6%**	1.1%	2.7%	3.0%		9.8%	0.1%	16.8%	6,990	41,659	32.3%
OR	**16.1%**	5.4%	8.3%		2.4%	0.0%	6.4%	22.4%	38,043	169,693	46.3%
AZ	**15.6%**	5.5%	8.8%	1.0%	0.2%	0.0%	0.1%	15.7%	18,345	116,584	38.3%
HI	**15.0%**	1.3%	11.2%	2.4%			20.2%	35.2%	18,417	52,354	35.8%
NY	**14.4%**	3.9%	7.9%	0.2%	2.3%		0.1%	14.5%	40,354	279,042	24.4%
UT	**14.0%**	13.3%	0.3%		0.4%		1.1%	15.2%	5,667	37,383	23.2%
MI	**13.3%**	13.0%	0.3%	0.0%				13.3%	46,991	352,471	14.8%
ID	**11.4%**	9.9%	1.5%		0.1%		1.5%	12.9%	9,919	76,616	25.5%
WA	**10.2%**	5.9%	4.2%		0.1%		0.1%	10.3%	14,783	144,190	21.4%
MT	**10.0%**	9.2%		0.2%	0.6%		0.0%	10.0%	10,115	101,305	14.6%
NC	**9.9%**	6.6%	3.2%	0.0%	0.1%		0.0%	9.9%	47,990	484,988	16.0%
TN	**9.8%**	3.9%	5.9%		0.0%		0.1%	9.9%	31,380	317,307	20.9%
VA	**9.5%**	8.5%	1.0%		0.0%		1.3%	10.8%	24,558	228,111	9.0%
FL	**8.6%**	2.3%	3.5%	2.2%	0.6%		0.0%	8.6%	19,287	224,383	29.2%
IN	**8.2%**	7.9%		0.2%	0.2%		0.8%	9.0%	21,526	238,303	9.4%
AR	**7.7%**	6.3%	0.6%	0.7%			0.1%	7.8%	18,160	233,958	10.0%
GA	**7.6%**	6.6%	0.0%	0.8%	0.1%			7.6%	21,958	290,252	10.7%
OH	**7.2%**	4.2%	2.4%	0.3%	0.3%		0.2%	7.4%	27,820	376,505	19.8%
SC	**7.1%**	6.0%	0.0%	1.1%	0.0%			7.1%	13,519	189,428	10.2%
AL	**6.6%**	2.8%	3.5%		0.3%		0.0%	6.6%	17,191	260,225	18.5%
KY	**6.5%**	5.9%	0.5%	0.2%	0.0%		1.3%	7.8%	27,335	349,705	13.6%
MO	**6.4%**	4.7%	1.6%	0.1%	0.0%		0.2%	6.6%	20,077	305,813	20.3%
NM	**6.3%**	3.0%	0.2%		3.0%		0.3%	6.5%	7,065	108,036	31.0%
LA	**5.9%**	4.6%	1.2%	0.1%				6.0%	11,389	190,073	21.2%
IA	**5.7%**	5.0%	0.1%	0.5%			1.3%	7.0%	18,612	266,817	15.3%
MS	**5.6%**	5.5%	0.1%	0.0%				5.6%	16,384	291,576	8.7%
IL	**5.3%**	3.9%	0.5%		0.9%		1.0%	6.3%	20,313	323,114	8.2%
NE	**5.2%**	4.6%	0.1%	0.5%			0.7%	5.9%	8,548	143,769	12.5%
CA	**5.2%**	0.8%	3.3%	1.1%			0.2%	5.4%	8,288	154,077	34.0%
ND	**4.8%**	4.8%				0.0%	0.9%	5.8%	3,662	63,461	6.6%
SD	**4.7%**	2.2%	2.0%	0.5%				4.7%	3,225	68,742	7.5%
TX	**4.2%**	3.0%	0.8%	0.4%	0.0%		1.0%	5.3%	26,990	512,868	16.7%
CT	**3.7%**	0.4%	3.3%		0.0%			3.7%	1,807	48,373	10.6%
CO	**3.7%**	3.5%	0.2%				7.8%	11.5%	10,706	93,013	34.6%
OK	**3.4%**	2.9%	0.4%		0.1%		0.1%	3.4%	8,252	241,715	18.1%
WV	**3.0%**	1.6%	0.4%	0.0%	1.0%		6.1%	9.1%	16,398	181,071	11.8%
WY	**2.5%**	2.5%					0.7%	3.2%	1,636	50,641	5.0%
KS	**2.1%**	2.1%			0.0%		0.4%	2.5%	4,209	170,375	11.0%
ME	**1.7%**	1.4%	0.0%		0.3%			1.7%	1,843	106,993	2.5%
DE	**1.6%**	0.9%	0.0%	0.5%	0.2%		0.0%	1.7%	657	38,990	2.7%
VT	**1.4%**	1.4%						1.4%	1,039	73,839	0.6%
NH	**1.1%**	1.1%						1.1%	979	86,413	2.7%
MD	**0.7%**	0.5%	0.1%	0.1%	0.0%		0.1%	0.8%	410	51,293	6.0%
AK	**0.2%**	0.2%						0.2%	15	7,472	0.1%

Source: RUPRI Center for Rural Health Policy Analysis

Enrollment in MA and Other Prepaid Plans, by Rural and Urban, and by Type of Plan, June 2007

- Rural PFFS enrollment is 55%; in urban areas, HMP/POS plans are 75% of enrollment

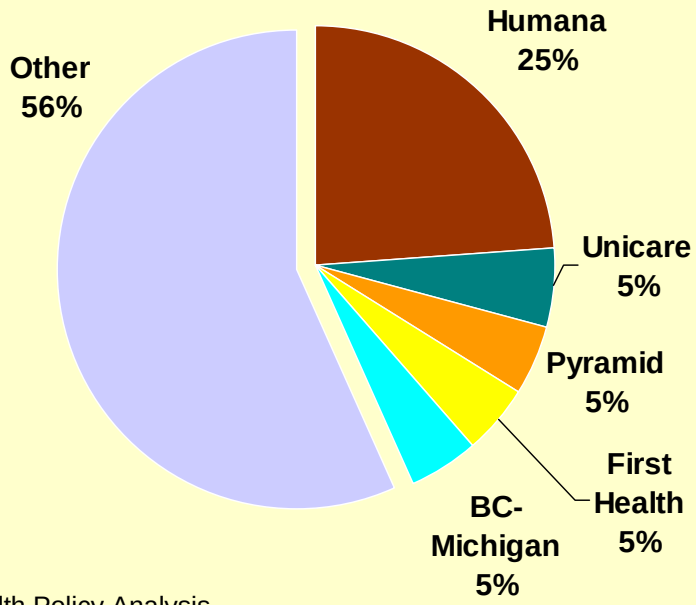




Source: RUPRI Center for Rural Health Policy Analysis

Concentration of MA Enrollment in Rural Areas, June 2007

- About half of rural MA enrollees are in five contracts, including 25% in one contract—Humana
- The top five contracts in rural areas are PFFS contracts and account for about 45% of the enrollment
- Eight of the top ten contracts are PFFS contracts



Source: RUPRI Center for Rural Health Policy Analysis

Think PFFS

- Around since 1997/1998
- Product design seems to fit rural
- Including how providers are paid
  - Fee-for-service
  - No network necessary
- But potentially evolving to network-based plans

Concerns from NRHA

- Web access to policy brief:

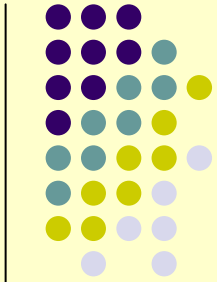
  http://www.nrharural.org/advocacy/sub/policybriefs/0407MA.pdf

- Private plan determinations
  - Access
  - Payment
- Beneficiary confusion

Concerns from NRHA (cont.)

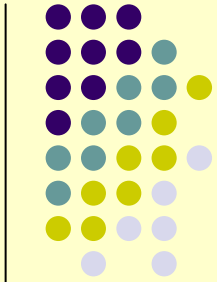
- Interpretation of access standards
- Potential to destabilize safety net
- Equity of benefits across space

What is happening to beneficiaries?



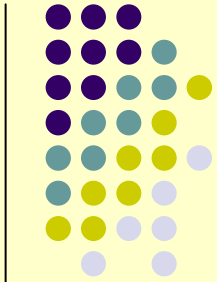
- Enrollment by default?
  - Dual eligibles
  - Come in for drug benefit
- Without full knowledge of benefit design and cost
- Perplexed when can’t use same provider, and/or face out-of-pocket costs

What is happening to beneficiaries? (cont.)



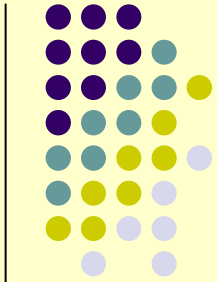
- New low-cost options
- Increased benefits
- Familiar products

What is happening to providers?



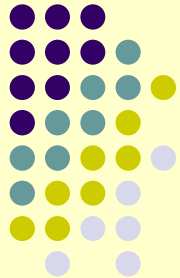
- Complexity of plans and benefits
- Collecting from beneficiaries
- Billing and collecting from insurers
- Negotiating contracts

Results of Current Survey Work: Payment Issues



- Establishing interim rate, especially if there is no settlement
- Timeliness of payment
- Initially wanting to pay less than costs

CAH-Identified Beneficiary Issues

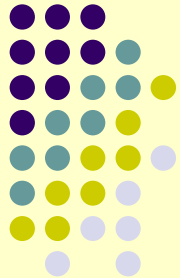


- Knowledge of being on plan
- Awareness of cost-sharing
- Awareness of benefits

Comments from CAHs

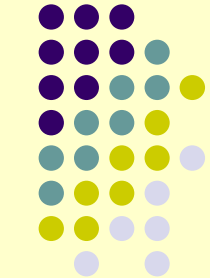
- About HMO/PPO: “Patients don’t understand what they purchased (plan), they don’t understand that payments can be affected.”
- About PFFS: “Payments aren’t updated quickly enough, and we have no settlement.”
- About the financial impact of HMO/PPO: “Not much of an impact because the system routinely audits what we are being reimbursed, and it is often less than what was contracted, so then we have Humana make the adjustments. If we did not do these audits, it would be a negative impact.”

Comments from CAHs (cont.)



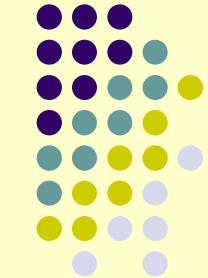
- “We formed a group of CAHs . . . By doing this we have more power in negotiation. It is important to get the same reimbursement CAHs were getting under Medicare, which can be difficult because plans don’t always understand what CAH rates are.”
- “The [hospital assoc] stepped up and assisted with negotiation. If they had not done this, then we would have had more difficulty getting the terms that we did and would be much worse off. Managed care was not designed for small rural; because of this, plans can come in and bully CAHs by offering lower cost.”
- About PFFS payment: “Many times payments are calculated incorrectly. I have to verify every payment and make sure it is correct. The payments are not consistent within the same plan and even for the same patient.”

Recommendations of the National Advisory Committee on Rural Health and Human Services



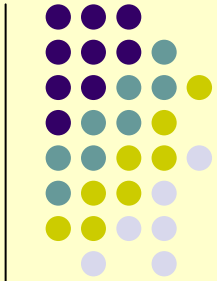
- Link: http://ruralcommittee.hrsa.gov/nacpubs.htm
- Secretary should charge CMS with providing enhanced information to beneficiaries
- Secretary should mandate that CMS solicit input from rural health care experts in determining and enforcing adequate rural community access standards

Recommendations of the National Advisory Committee on Rural Health and Human Services (cont.)



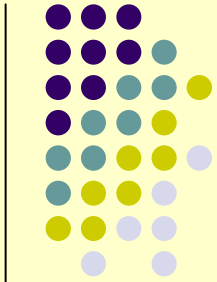
- Secretary should provide access to MA plan applications through the CMS web site
- Secretary should charge CMS with establishing a web site where providers can instantly verify beneficiaries' current plan enrollment
- Secretary should ensure efficient administration of PFFS plan payments to non-contracted providers

Recommendations of the National Rural Health Association



- Legislation to ensure CAHs paid equivalent to or no less than traditional Medicare
- CMS engage rural health experts regarding rural community access standards consistent with individual communities' historic/present patterns of care
- CMS ensure that beneficiaries given adequate and accurate information
- CMS regional offices regain role as access point by providers for definitive MA information and ombudsman for dispute resolution with plans

Recommendations of the National Rural Health Association (cont.)



- Web site for providers to verify beneficiaries' current plan enrollment
- Transparent approval process of MA plans and amendments
- Improve administration of PFFS payments to non-network providers

Strange bedfellows?

- Has definitely started out that way
- But following NACHHS and NRHA recommendations could change
- Until further notice . . . be aware

Thank You

For more information, visit

http://www.unmc.edu/ruprihealth