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

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

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

<table>
<thead>
<tr>
<th>State</th>
<th>TOTAL Enrolled in MA</th>
<th>PFFS</th>
<th>HMO/POS</th>
<th>Regional PPO</th>
<th>Local PPO</th>
<th>Other MA Plans</th>
<th>Other Prepaid</th>
<th>TOTAL Enrolled in MA or Prepaid</th>
<th>Total RURAL Medicare Population</th>
<th>Percent of Total MedicarePopulation</th>
<th>Exhibit: Percent of Urban Persons Enrolled in MA or Prepaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL U.S.</strong></td>
<td>8.6%</td>
<td>5.2%</td>
<td>2.5%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.9%</td>
<td>9.5%</td>
<td>864,118</td>
<td>9,078,551</td>
<td>22.6%</td>
</tr>
</tbody>
</table>

#### 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