POLICY ANALYSIS BRIEF

NORC WALSH CENTER FOR RURAL HEALTH ANALYSIS
RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS

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Critical Access Hospitals' Experiences with Medicare Advantage Plans

Purpose

This report details findings from a survey of 60 critical access hospital (CAH) administrators regarding their experiences with Medicare Advantage (MA) plans. Findings from this research identify concerns of CAH administrators that, as the MA program evolves, may be addressed through technical assistance and changes in regulation or legislation.

Key Findings

- CAHs rejected contracts with MA plans for the following reasons: inadequate reimbursement terms, administrative concerns, or low MA penetration in their area.
- Respondents reported that some MA plan representatives were unfamiliar with CAH reimbursement methods under traditional Medicare.
- Although MA plans, more often than not, reimbursed CAHs at a level equivalent to traditional Medicare, many contracts made no provisions for an annual or year-end cost settlement.
- Most CAHs' experience with non-network, private fee-for-service (PFFS) plans involved outpatient care, and even that experience, at the time of the interviews, was quite limited.
- The impact of MA plans on CAHs' financial performance has been largely negligible, but the impact differed across individual hospitals and was influenced by MA penetration in the area.

Background on the MA Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the MA program to replace the Medicare+Choice program that had been in place since the Balanced Budget Act of 1997. Through the MA program, beneficiaries have the option to receive their Medicare benefits through private health plans that are contracted by the Centers for Medicare and Medicaid Services (CMS). CMS requires that MA plans include nearly all of the benefits encompassed by Parts A and B of traditional Medicare and may add other benefits as well. MA plans may or may not include the prescription drug benefit (Part D)—if they do, they

are referred to as Medicare Advantage prescription drug plans, or MA/PDPs. Overall, there are several types of MA plans:

- Health maintenance organizations (HMOs)
- Provider-sponsored organizations (PSOs)
- Preferred provider organizations (PPOs)
  - ✧ Local PPOs, serving specific counties
  - ✧ Regional PPOs, which must offer the same plan benefits for the same beneficiary premium throughout the region (there are 26 regions defined by statute)
  - ✧ National PPOs
- Special needs plans (SNPs)
- Private fee-for-service (PFFS) plans (network and non-network models)
  - ✧ Local PFFS plans based on county boundaries
  - ✧ National PFFS plans
- Medicare cost plans (grandfathered into the program, these are a limited number of plans Medicare pays based on their costs)
- Medical savings accounts (MSAs)
- Program of All Inclusive Care for the Elderly (PACE) plans

The MA plans of interest in this research are HMOs, PPOs, and PFFS plans. Any of these may offer contracts to providers with terms of payment different from the payment formulas of traditional Medicare. Both HMOs and PPOs must develop networks of providers who participate in these plans, and the networks must meet network access standards established by CMS. In contrast, PFFS plans need not form networks of providers. By statute, however, they are to ensure that payment to providers is at least equivalent to what traditional Medicare would have paid for the same service.

Although only 10.1% of rural Medicare beneficiaries were enrolled in MA as of January 2008—compared to 19.7% of all Medicare beneficiaries—both the availability of MA plans to rural persons and rural enrollment is growing.[1] In 2005, there was at least one MA plan available to Medicare beneficiaries in 78% of rural counties.[2] As of 2007, all Medicare beneficiaries had access to at least one MA plan.[3] As of January 2008, MA plans had enrolled 9.0 million beneficiaries, with rural enrollment reaching 926,381, up from 241,706 in 2005. The growth in rural enrollment has been mostly in PFFS plans, which account for approximately 61% of all rural enrollment and 76% of the two-year growth in rural enrollment from 2005 to 2007.[4,5] As such, the principal effects of the MA program on rural providers, including CAHs, will be from enrollment in PFFS plans, especially those that have not yet developed provider networks.

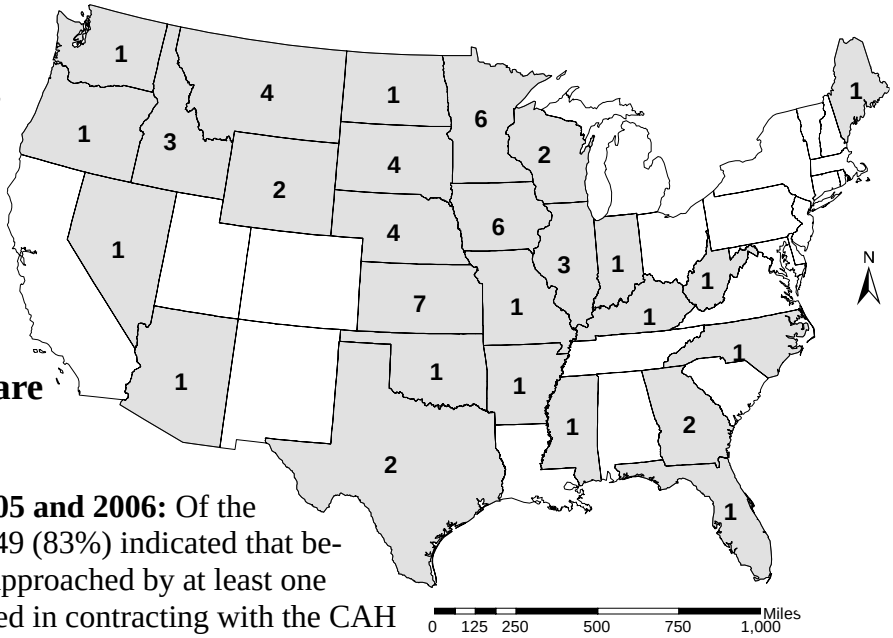
As the name implies, PFFS plans pay providers on a fee-for-service basis after receiving payment from CMS. The plans determine these schedules with one caveat—for non-network providers, the

total payment received by the provider (combination of plan and beneficiary out-of-pocket) must be analogous to Medicare rates, referred to as Medicare-like rates. If a provider signs a contract to be a network provider, however, the payment is set by the contract terms and need not be equivalent to payment under traditional Medicare. CAHs may refuse to accept the terms of payment from any MA plan, including PFFS plans, as long as they do so prior to providing any service. Once services are provided, the CAH is *deemed* a network provider and must accept payment from the plan as long as the following conditions are met: the provider is aware that a particular patient is enrolled in the plan; the provider is aware of the reimbursement terms and conditions; and the provider performs a covered service for the enrollee.[6] PFFS plans are not required to follow the same methodology as traditional Medicare to reimburse providers. For CAHs, this means that three CAH-specific Medicare policies need not be followed: (1) periodic interim payment based on 101% of cost, (2) beneficiary cost-sharing, and (3) cost settlement at the end of the hospital's fiscal year. As seen in the findings that follow in this report, PFFS plans are likely to use variations of those elements in setting payment.

Methods

The information presented in this report was gathered from telephone interviews conducted in the spring and summer of 2007 with 60 randomly selected CAH representatives.[7] Interviewers asked to speak with each hospital's administrator or chief executive officer, or with the individual who was most familiar with the MA plans in the area or the MA plans affiliated with the hospital, regardless of whether the hospital held a contract with these plans. Respondents included a variety of organizational representatives, including chief operating officers, chief financial officers, business managers, chief medical officers, and other hospital administrators. Figure 1 shows the 27 states represented in our interviews and the number of interviews completed in each state.

Figure 1. Number of Interviews by States Represented in Survey



CAH Interactions with Medicare Advantage

MA contracts accepted between 2005 and 2006: Of the 60 CAH administrators interviewed, 49 (83%) indicated that between 2005 and 2006 they had been approached by at least one MA plan that potentially was interested in contracting with the CAH (see Table 1). One respondent was unsure and therefore was excluded from the analysis.

The overwhelming majority of CAHs were offered a contract. Forty-seven CAHs (78%) were *offered* at least one MA contract (the number of contracts offered ranged from 0 to 10, and averaged 3). Of those CAHs offered a contract, 31 (66%) had *accepted* and held at least one contract at the time that they were interviewed.

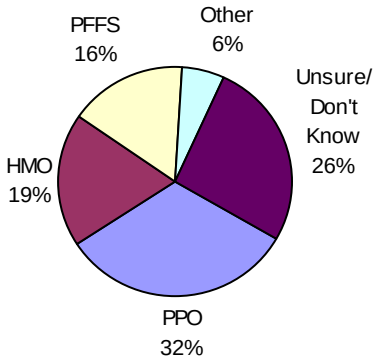
Table 1. CAH Experience with MA Contracts, 2005 to 2006

	N 59*	% 100
Contracts offered	49	83
No contracts offered	12	20
1 contract offered	16	27
2+ contracts offered	31	40
Contracts accepted and rejected	47	100
No contracts accepted	16	34
1 contract accepted	16	34
2+ contracts accepted	15	32

*Does not total 60 since one respondent indicated that he did not know.

Thirty-two percent of respondents indicated that their hospital's largest MA contract, in terms of patient volume, was with a PPO; 19% reported that their hospital's largest contract was with an HMO; and 16% reported that their hospital's largest contract was with a PFFS plan. The remaining respondents indicated that their hospital's largest MA contracts were with other, less common types of MA plans. Twenty-six percent of respondents were unsure which type of plan accounted for the largest number of their hospital's MA patients. These results are shown in Figure 2.

Figure 2. Types of Medicare Advantage Plans Contracting with CAHs



Reasons for rejecting MA contracts: Of the 32 CAH respondents who indicated that they had rejected at least one MA contract, more than one-half (17) indicated that the primary reason for rejecting these agreements was related to unacceptable reimbursement or cost-settlement terms. These respondents reported that they were unwilling to accept a payment rate that was less than that paid by traditional Medicare. Four hospital respondents reported that they had rejected a contract because they believed the MA penetration rate in the region was low and, consequently, the number of new patients that they could expect to treat would be low as well. Other reasons cited for rejecting MA contracts included ambiguous contract terms and "deceptive marketing tactics" used by plans that were enrolling beneficiaries. Finally, one administrator indicated that he rejected a contract because the plan was not authorized to enroll patients in the hospital's county.

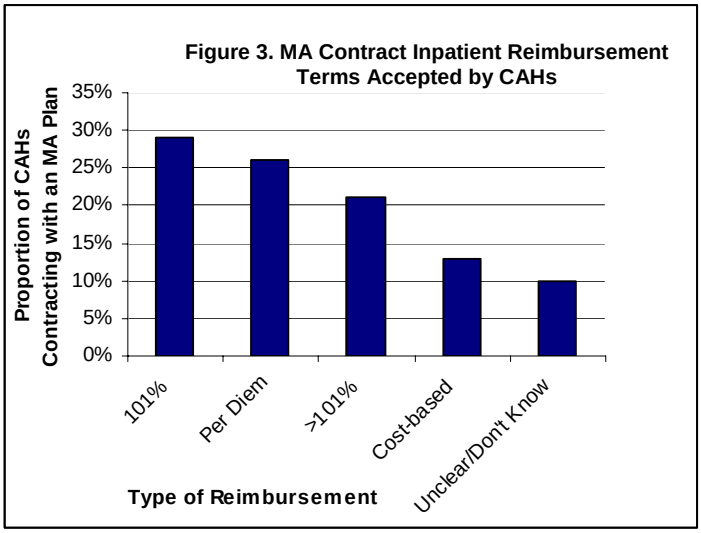
PFFS plans with no contract (non-network PFFS) : Of the 60 CAH administrators interviewed, 33 (55%) reported providing services to beneficiaries of PFFS MA plans with which the CAH was not a contracted network provider. These CAHs were located in 16 of the 27 states sampled. Respondents from these CAHs reported treating patients from 1 to 12 different non-network PFFS plans. Seventeen of these 33 respondents (52%) indicated that their hospital had treated patients from 5 or fewer PFFS MA plans for which they were not network providers. Eleven of these respondents (33%) reported that their hospital had treated patients from 6 or more PFFS plans that have not built networks. Five respondents were unsure of the number of such plans for which their hospital had treated patients.

"We requested two global agreements. One, that they would pay 101% of costs and two, that they would provide a reconciliation opportunity, such as an end-of-year settlement. We've found that most of the plans are happy to give us the 101%, but they're not willing to give us a reconciliation."

Reimbursement Terms

MA contracts: Under traditional Medicare, CAHs are reimbursed at 101% of reasonable and allowable costs. However, under MA, the basis of payment is negotiated between the MA plans and CAHs. MA plans may offer payment rates above, below, or comparable to traditional Medicare rates. As can be seen in Figure 3, of the 31 CAHs that held at least one MA contract, 29% were reimbursed for inpatient services on the basis of cost plus 1%, and 13% were reimbursed on the basis of cost only, i.e., at 100% of costs. About 26% of respondents indicated that their hospital was reimbursed on a per diem basis but did not elaborate as to how these per diem amounts compared to traditional Medicare reimbursement. Approximately 22% of respondents reported reimbursement that was greater than that offered by Medicare; however, only one CAH administrator had negotiated a payment rate substantially higher than that offered by Medicare—this hospital held a contract reimbursing 105% of inpatient costs. Three administrators (10%) were unclear as to how the MA plan covering the largest number of their Medicare beneficiaries reimbursed the hospital for inpatient services.

Among these same 31 hospitals, 10 administrators indicated that their contract included a provision for an annual or year-end cost-settlement; these 10 included all 9 CAHs that reported they were reimbursed at 101% of cost and the one hospital that reported receiving 105% of cost.



Almost one-half (14) of the respondents whose hospital had accepted at least one MA contract indicated that they were reimbursed for outpatient services in the same manner as they were reimbursed for inpatient services. These respondents indicated that outpatient services were reimbursed at 101% of cost. The remaining CAHs were reimbursed either (a) a percentage of charges, (b) a percentage of costs, or (c) another fee-for-service amount. Four CAH administrators were unclear or did not know how their hospital was reimbursed for outpatient services by the MA plan that accounted for their largest patient volume.

Non-network PFFS: CMS requires non-network PFFS plans to reimburse hospitals at Medicare-like rates.[8] Thus, of the 30 respondents who indicated their hospital had provided inpatient services for non-network PFFS enrollees,[9] all should have been reimbursed an amount equivalent to traditional Medicare for CAHs. However, only 23 of these 30 respondents (76%) indicated that these plans reimbursed the hospital the same as traditional Medicare, and four respondents did not know or were uncertain how these plans reimbursed their hospitals for inpatient services. Two respondents reported that they received a per diem payment that turned out to be less than the traditional Medicare payment—most likely because PFFS plans are not required to conduct an annual cost-settlement. One respondent reported receiving 105% from the largest PFFS plan for which it had provided inpatient services to enrollees.

"We've had longer turnaround times in collection…it creates more of a hassle for payment for services at the business office. Our average for MA plans is 90 days; for Medicare, it's 15 days."

Reimbursement rates for outpatient services were the same as traditional Medicare for the majority of respondents (22 of 33); however, three reported receiving less than what they were reimbursed under traditional Medicare (again, most likely because they did not undertake a year-end or annual cost-settlement), and one reported receiving more than traditional Medicare (105%). Seven respondents (21%) did not know or were uncertain of how their hospital was reimbursed for outpatient services by these plans.

Patient Volume

MA contracts: The vast majority of respondents (80%) with an MA contract indicated that the plans with which they contracted had little or no impact on the total number of patients treated by their hospital. Two respondents (6%) indicated that their patient volume increased as a result of contracting with MA plans, and three respondents (10%) did not know or were unsure of the impact on the total number of patients treated by their hospital. One chief executive officer believed the hospital might be losing market share (to other hospitals that had MA contracts) because he refused to contract with MA plans whose reimbursement rate was less than that of traditional Medicare.

Non-network PFFS: Even though PFFS MA plans are available in many rural communities and over one-half of the CAHs in our sample had provided services to patients under these plans, respondents from these hospitals reported that these plans accounted for a low volume of patients. Of the 33 CAH administrators whose hospitals treated Medicare beneficiaries in a non-contracted PFFS plan, 23 (70%) reported that the plan had little to no impact on the number of patients treated. Five respondents (15%) reported an increase in the number of patients treated. Three respondents (9%) perceived a loss of patients to other facilities that they believed were willing to accept payment from the patients' PFFS plans. Two respondents (6%) reported some impact on the hospital's patient volume but were not clear as to the direction of the impact.

Financial Performance

MA contracts: When asked to describe how their largest MA contract affected their hospital's financial performance, the majority of administrators[10] reported that these contracts had either a negligible (52% of respondents) or a negative (30% of respondents) impact on their hospital's financial performance. Only three respondents indicated that these contracts had positively affected the hospital's financial status. Two respondents were unsure of the financial impact.

Administrators reporting a negligible impact noted that their MA patient volume was insufficient to affect financial performance. Respondents who reported that their MA contract(s) adversely affected their hospital's financial performance frequently cited the lack of a cost-settlement and delays in receiving payments as the causes for poor performance. In fact, several respondents indicated that MA plans were slow in processing claims and that it was not unusual for the plans to take three or more times longer than traditional Medicare (which respondents estimated was approximately 15 days) to pay for services rendered by the hospital. These respondents explained that the delay in payment increased the hospital's accounts receivable, hindered cash flow, and in general, imposed an administrative burden. A few hospital representatives indicated that they had to regularly press the plans for payments due.

Non-network PFFS: At the time of the interviews, the impact of PFFS MA plans on hospitals' financial performance was minimal. Twenty-two of 33 respondents reported little to no financial impact as a result of treating patients covered under PFFS MA plans. A small number of respondents (n = 4) reported that these PFFS plans were contributing negatively to financial performance.

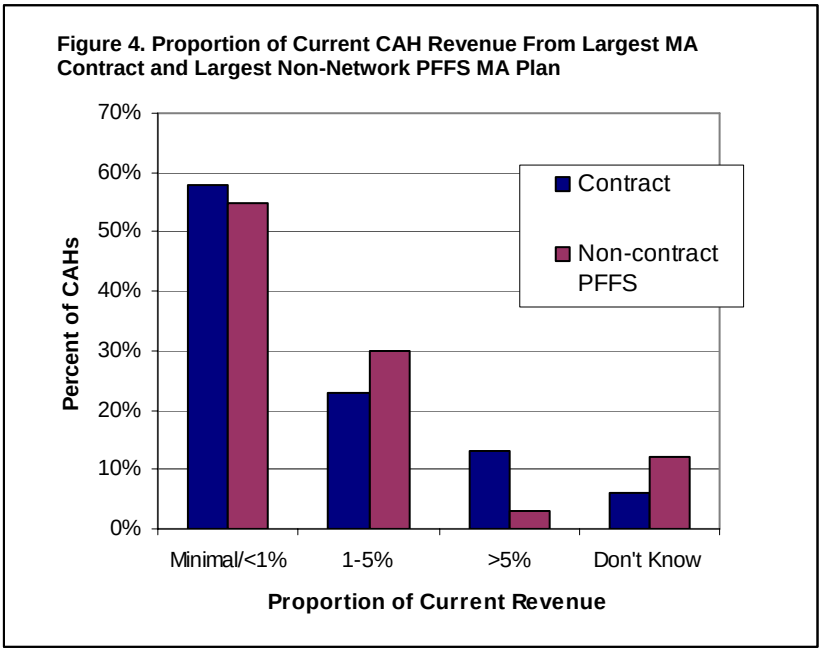
As with contracted MA plans, respondents cited the lack of cost-settlements (which can lead to lower reimbursement), delays in receipt of reimbursement, and loss of patients to facilities willing to treat patients for payment from these non-network PFFS plans as reasons for the negative impact on the hospital's financial performance. Several respondents explained that their CAH had little experience with PFFS plans due to the low volume of patients with this type of coverage. Several administrators indicated that they had not had the opportunity to fairly assess the financial impact of these plans on their hospitals. A few respondents expressed concern that if the volume of non-contracted PFFS patients increased, the hospital's financial performance could be affected negatively.

"[The hospital] gets an interim rate, which [the PFFS plan] has agreed to pay, but they do not understand the settlement at the end of the year and have not agreed to pay it—they did not understand that rate adjustments typically take place."

Revenue

MA contracts: Most CAH administrators reported that their hospital's largest MA contract accounted for only a small proportion of the hospital's current revenue. Eighteen respondents (58%) reported that their largest MA contract accounted for either a "minimal" amount or less than 1% of current revenue (see Figure 4). Seven respondents (23%) indicated that their hospital derived between 1% and 5% of its current revenue from their largest MA contract. Only four respondents (13%) reported receiving more than 5% of current revenue from the hospital's largest MA contract. Finally, two administrators interviewed (6%) did not know how much revenue the hospital derived from the largest MA contract.

Figure 4. Proportion of Current CAH Revenue From Largest MA Contract and Largest Non-Network PFFS MA Plan



Non-Network PFFS: Eighteen respondents (55%) reported that less than 1% of their current revenue was derived from non-network PFFS patients. Ten respondents (30%) reported receiving between 1% and 5% of their current revenue from patients under these plans. One respondent reported that 23% of the CAH's current revenue came from PFFS patients. Four respondents (12%) did not know the percentage of revenue that was generated by patients with PFFS plans.

Relationship with Beneficiaries

MA contracts: Beneficiaries often have difficulties comparing MA plans to traditional Medicare in terms of the different benefit structures, out-of-pocket costs, and premium levels. For this reason, about 30% of hospitals (nine respondents) with an MA contract reported conducting outreach activities to assist enrollees to better understand MA. Respondents reported that they are reaching out to plan members in a number of ways, including distributing informational pamphlets, holding "lunch and learn" sessions that are open to the public, and working directly with an insurance agent network to communicate information to enrollees.

The majority of respondents (71%), however, reported that their hospital did not engage in specific outreach activities targeted toward MA enrollees or those considering enrolling. Most respondents indicated that the number of patients enrolled in MA plans was small, and thus broad-based outreach was not warranted. Rather, several hospitals counseled patients on a one-on-one basis as questions or issues arose.

Non-Network PFFS: One-third of the administrators (11 of 33) who indicated that their patients were covered under non-contracted PFFS plans reported that the plan had a negative impact on their relationship with patients. According to several administrators, some patients were misdirecting their frustrations toward the hospital when their out-of-pocket costs increased or services were not covered under their MA plan.

The majority of respondents (24 of 33) reported that their hospital did not undertake any outreach activities to educate beneficiaries about the different PFFS plans, although many of these hospitals worked with patients individually to help them understand their benefits. Some administrators expressed a need for more resources to further educate their patients. Other respondents were apprehensive about sharing information about these non-network PFFS plans with their patients. Overall, examples of hospitals' attempts to educate their communities included publishing articles in the local newspaper, meeting with Rotary clubs, and holding informational visits at senior citizen centers.

Discussion

As of 2007, all Medicare beneficiaries had at least one MA plan available to them. Although rural enrollment in MA remains relatively low to date—with fewer than one in ten rural Medicare beneficiaries enrolled in MA—rural beneficiaries increasingly are enrolling in MA plans and have been enrolling in PFFS MA plans much more frequently than in other types of MA plans.[2] Thus, while experience with PFFS MA plans was limited for most of the hospitals sampled, our findings represent potential concerns if enrollment in PFFS MA plans continues to grow. Overall, CAH administrators who we interviewed reported that payments for services provided to MA enrollees account for a minimal amount of their hospital's total revenue. Despite this, however, payment issues continue to dominate their thinking about MA plans and may be a source of concern should MA penetration continue to grow in rural areas. For both contract and non-contract MA plans, CAH administrators raised concerns regarding levels of reimbursement, lack of cost-settlements, timeliness of payment, and to a lesser extent, beneficiary relations—mostly in cases where enrollees did not understand their benefits or faced higher out-of-pocket expenses (see Tables 2 and 3 for a summary of findings).

The CAH representatives who we spoke to provided the following recommendations to other CAHs interested in negotiating with MA plans:

- CAHs located within the same region should communicate regularly regarding their experiences with MA plans and, whenever possible, enter into negotiations with MA plans seeking a provider network as a group in order to secure the best reimbursement terms possible.
- When negotiating contract terms with MA plans, CAHs should explain from the outset the concept of a Medicare cost report and how it is used as part of a cost-settlement process to ensure that they receive 101% of their reasonable and allowable costs for treating Medicare beneficiaries.
- CAHs must consider seriously the potential tradeoffs involved in contracting with MA plans, namely, reduced reimbursement versus reduced access to care for MA beneficiaries in the community.

Table 2. Summary of the Impact of Largest MA Contract Held by CAHs

	N	%*
Current CAH revenue from largest CAH contract (n = 31)		
Minimal or <1%	18	58
1%-5%	7	23
>5%	4	13
Don't know/unclear	2	6
MA effect on CAH financial performance (n = 30)		
Little or no impact	17	57
Negative	9	30
Positive	2	7
Don't know/unclear	2	7
MA effect on number of patients treated by CAHs (n = 31)		
Little or no impact	25	80
Increased	2	6
Decreased	1	3
Don't know/unclear	3	10
CAH outreach to MA beneficiaries (n = 31)		
Yes	9	29
No	22	71

Table 3. Summary of the Impact of Largest Non-Network PFFS Plan on CAHs

	N	%*
Current CAH revenue from largest PFFS plan (n = 33)		
Minimal or <1%	18	55
1%-5%	10	30
>5%	1	3
Don't know/unclear	4	12
PFFS effect on CAH financial performance (n = 33)		
Little or no impact	22	67
Negative	4	12
Positive	0	0
Don't know/unclear	7	21
PFFS effect on number of patients treated (n = 33)		
Little or no impact	23	70
Increased	3	9
Decreased	5	15
Don't know/unclear	2	6
CAH outreach to MA beneficiaries (n = 30 CAHs)		
Yes	6	18
No	24	73

*Numbers may not add to 100% due to rounding.

Overall, as a result of the increasing availability of MA plans in rural areas and the increasing rural enrollment in PFFS MA plans, CAHs increasingly must decide whether to (1) contract with HMO and/or PPO MA plans and (2) treat non-network PFFS MA plan enrollees. Their decisions may have significant consequences for the hospital's financial outcomes and for rural residents' access to care, particularly if enrollment continues to grow. While the decisions that rural hospitals made in either instance may have seemed trivial in 2005 when rural MA enrollment was very modest, the consequences have become more significant, especially in the states with higher-than-national-average rural enrollment.

Since CAH experience with MA plans is still limited, the findings in this report should be treated as early signs about issues that may impact CAHs should enrollment of rural beneficiaries in MA plans continue to grow. This could well be the case since at the time of the interviews, the full impact of the increase in PFFS MA plan enrollment that occurred in the second half of 2007 had not yet been felt. Therefore, we suggest that CAH experiences continue to be monitored and that their reactions continue to be shared with the MA plans, CMS, rural decision makers, and policymakers at the state, local, and national level.

References

[1]Data from RUPRI Center for Rural Health Policy Analysis, based on data available from the Centers for Medicare and Medicaid Services, updating McBride TD, Mueller KJ. Update on Rural Enrollment in Medicare Advantage: Growth Continues. RUPRI Center for Rural Health Policy Analysis Rural Policy Brief. 2007 October; 12(7).

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[3]Henry J. Kaiser Family Foundation. Medicare Advantage Overview. <http://kff.org/medicare/upload/7646.pdf> Accessed 1 Feb 2008.

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[6]National Rural Health Association. Medicare Dis-Advantage for Rural America? NRHA Policy Brief. 2007 January.

[7]The list of CAHs from which respondent facilities were randomly selected was the latest list of nationwide CAHs available on the Flex Team Monitoring Web site as of March 2007 <http://www.flexmonitoring.org/index.shtml>.

[8]Merlis M. Medicare Advantage Payment Policy. September 24, 2007. National Health Policy Forum Background Paper.

[9]Three CAHs indicated they had provided only outpatient services for non-network PFFS patients.

[10]Out of 30 valid responses.

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