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Senate Finance Committee
Hearing on Medicare Advantage Private Fee-For-Service Plans
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On behalf of the National Rural Health Association (NRHA) and as administrator of a critical access hospital in Yazoo City, Mississippi, thank you for this opportunity to testify before the committee on the impact of Medicare Advantage (MA) plans, especially Private Fee-for-Service (PFFS) Plans, in rural America. The NRHA is a national, non-profit membership organization whose mission is to improve the health of rural Americans. NRHA provides leadership on rural health issues through advocacy, communications, education and research.

Although my comments will specifically address the impact of MA plans on rural Mississippi, interaction with colleagues across the county support the existence of similar trends in many other markets. In discussing rural MA, we are almost exclusively talking about the rise of PFFS plans as this is where most of the enrollment growth has been over the last two years. Since December 2005, rural America has seen a 362 percent growth in MA enrollment. In December 2005, 18 percent of rural MA enrollees were in PFFS plans, today it is 62 percent (compared to 16% for urban beneficiaries). Rural beneficiaries enrolled in PFFS disproportionately outnumber their urban counterparts and often require greater chronic care. Rural Medicare beneficiaries deserve a Medicare plan that is sensitive to their needs and preserves the fragile rural health care safety net. This testimony focuses on the NRHA's concerns for MA expansion in rural areas across the nation and the NRHA's recommendations to Congress on how to best provide for the needs of our elderly populations in rural America. Our primary concern is payment equity and access to care in the Medicare system, especially in traditional Fee-for-Service and PFFS, where rural beneficiaries are most likely to enroll.

INTRODUCTION

The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet fully understood by either the public or providers. Medicare Advantage (MA) is intended to fulfill the goals of (1) substantially increasing the number of Medicare beneficiaries enrolled in private health insurance, based on the premise believed by many policy makers that competition among these private health plans and between these plans and the traditional fee-for-service Medicare program will reduce federal spending; and (2) creating opportunities for beneficiaries to enroll in richer benefit packages than those available through traditional Medicare

(sometimes with tradeoffs regarding choice of providers and drug formularies, and oftentimes at a higher cost than the cost of care under traditional Medicare fee-for-service). Policy makers may also believe, at least implicitly, that private health plans can be held accountable for healthy outcomes for enrollees, as measured against benchmarks established by the National Committee for Quality Assurance.

The focus of my testimony is to address MA implementation in regard to PFFS issues relevant to rural communities. It assumes that the federal policy of "privatizing" Medicare to create a competitive structure to cut costs will continue. It is left to others to argue the probability of MA taking permanent root in rural America, in a way its predecessor, Medicare+Choice, did not. This is a serious question. As of this month, only 10.1 percent of rural Medicare beneficiaries have joined an MA plan at a significantly higher cost to the federal budget. However, those that join MA plans in rural America are nearly four times more likely to join PFFS plans than their urban counterparts (62% of rural MA enrollees vs. 16% urban). We know from this is that if and as MA plans gain rural market share, the potential consequences to rural health from PFFS are significant, and potentially quite negative.

Rural America cannot wait to fully understand what MA does or does not do. Problems have already been identified and they need to be resolved before the MA program becomes entrenched and less malleable. Congress must assure that MA is implemented and administered in a manner that is sensitive to the needs of rural communities. If not, the devastation to the rural health care infrastructure could take a generation or more to rebuild. Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits.

WHAT IS THE POTENTIAL DOWNSIDE OF MEDICARE ADVANTAGE IN RURAL COMMUNITIES?

With MA, beneficiaries' access to benefits and to local providers is determined by private sector health plan contracts with beneficiaries and with providers and only indirectly by Medicare. The spread of MA fundamentally changes how beneficiaries, providers, private health insurance plans, and the Centers for Medicare and Medicaid Services (CMS) relate to and work with each other. As these relationships change, there is a real and significant risk to beneficiaries' access to local care and to the ability of rural hospitals and doctors to provide local services. Medicare must continue to improve, but the fragility of our seniors and the rural health infrastructure demand something more than the haphazard approach observed to date.

Private Fee-for-Service (PFFS), unlike other MA plans, resemble traditional Medicare in that they do not include a care management component. Presently, PFFS plans are available in 96 percent of rural counties, and they are the most prevalent type of private Medicare plan in rural areas. There are two kinds of PFFS plans that are quite different. The first, the "non-network" model, allows PFFS plans to operate without a contracted network of providers, but these plans must pay all providers at rates that are "comparable to traditional Medicare rates." For providers whose payments are "cost-based" under traditional Medicare, this provision appears to be being interpreted as the provider's interim payment rate (without the usual year-end cost settlement). The second model, still rare, is a PFFS plan with a contracted network. Contracted or deemed providers in these plans may be paid at rates lower than traditional Medicare, if community access standards are met.

Under both PFFS models, providers can be "deemed" (for a particular plan enrollee for a particular visit or admission) to be PFFS plan providers. This means, without knowing it, the provider

may have agreed to accept the plan's terms and conditions, including the rate of payment. Three conditions must be met for a provider to be deemed a PFFS plan provider: (1) the provider must know that the patient is a member of a PFFS plan, (2) the provider must be aware of a PFFS plan's terms and conditions, and (3) the provider must perform a covered service for the patient. As a deemed PFFS plan provider, a provider must accept, as payment in full, whatever rate that particular PFFS plan pays their other contracted providers. Consider the practicality of this in terms of billing. It is not as though we can submit charges to traditional Medicare with a note that says "we didn't know the patient was an MA beneficiary." In addition, emergency room patients are of particular concern since they account for 80 percent of my facility's admissions. This is serious flaw in the system and a grave concern for many rural providers since they are ethically, practically and legally required to provide services prior to determination of ability to pay. This will have the effect of reversing programs established by Congress, such as Critical Access Hospitals and Rural Health Clinics, which have helped to provide adequate payments and ensure access to care in rural communities. In addition, as "non-network" PFFS plans gain market share, it is reasonable to assume these plans will convert to the "network" PFFS model and become aggressive in negotiating rates below traditional Medicare payment rates and below the cost of care in rural communities.

Many rural facilities, especially critical access hospitals in poorer areas of the county, function on a cash basis (i.e. the cash received this week is needed to make payroll or pay accounts payable next week). PFFS MA plans often require literally months of manual follow-up via multiple letters and phone calls to receive accurate payment for services rendered to beneficiaries. Sometimes these delays are due to poorly developed electronic or even manual billing systems in place at PFFS claims processing. Other times these delays appear to be intentional. On several occasions, I have had to personally intervene in these payment delays due to the absolute frustration of my billing staff. And, only after threatening to complain to the state insurance commissioner did we receive payment for services rendered as much as 12 months in arrears. Compare this to traditional Medicare under which my facility may routinely expect payment within 15 days of submission of a clean claim. Whatever the reason for the delays, at my facility, this has contributed to a 30% increase in accounts receivable representing almost $1 million in unrealized cash. This has also required a 20% increase in business office staffing in addition to pulling additional resources from other staff including administration, nursing and case management/social work. It is also not at all uncommon to encounter retrospective denials for Swingbed admissions based on MA plan critera as many of these plans require multiple certifications and recertifications throughout the patient stay as opposed to traditional Medicare which employs no such process.

The experience in my state of Mississippi mirrors the national trends. While, Mississippi lags behind the nation in enrollment in MA plans, 5.7 percent of all rural Medicare beneficiaries (6.8 percent statewide). The vast majority of this population is enrolled in PFFS plans. In fact, as of September, less than 300 people in rural Mississippi were enrolled in any other type of plan. While this population still represents a fraction of the overall Medicare population, the effects of MA plans are already being felt. In my own hospital, we counsel and assist confused and frustrated beneficiaries daily. Often these individuals have no comprehension that they opted out of traditional Medicare and are horrified to learn that the physician who has provided their primary care for most of their lives is not a participant in the PFFS plan they selected. It is not at all uncommon to encounter patients who have no idea that they have joined an MA plan. They simply thought they were singing up for Medicare drug benefits. Other times, beneficiaries are shocked to learn that the "low cost" plan they opted for will actually cost them sometimes twice as much in copays and deductibles as they would have paid for an acute stay under

traditional Medicare. Add to this the fact that none of the physicians who admit to my facility accept Medicare Advantage plans nor do most of the home healthcare agencies to which we often discharge. This contributes to increased lengths of stay and cost to MA beneficiaries, yet often the plans refuse to reimburse for the added days of care.

In addition, last week the sole emergency medical services provider (EMS) to 23 Mississippi counties, in addition to counties in Kansas, Alabama, Georgia, Tennessee, Virginia and Florida, Emergystat, went out of business literally overnight. While there were many contributing factors, one of the points of uncertainty in our state was the lack of cash flow from MA plans. Again, these plans often pay much slower than traditional Medicare and as stated, provide a payment that is uncertain and often inaccurate for rural providers. Rural EMS is difficult to provide nationwide due to the high costs of transportation and training for relatively low volume. To have one company, which provided much of the rural EMS service to our state, go out of business is disastrous to our entire rural healthcare safety net. We must make sure that they are the anomaly and not the proverbial "canary in the coal mine." And, a canary in a coal mine is useless during a cave in.

MA has produced significant beneficiary confusion. Consumer choice is generally understood to be desirable, but too much choice, too much variation and a large number of contingencies make comparison shopping difficult, particularly for the elderly. The potential for confusion extends to the type of private plans and their relative merits in comparison to one other and to traditional Medicare. This leads to a concern regarding potential abuse of the system. Testimony at field hearings by the National Advisory Committee on Rural Health and Human Services cited significant confusion by the elderly, an issue that is not unique to rural beneficiaries. Recently, the HHS Office of the Inspector General announced that the Office is evaluating whether certain health insurers are coercing beneficiaries to enroll in an MA plan that would include prescription drug benefit (MA-PD) versus a stand-alone drug benefit program. Congress and CMS over the last year have spent a great deal of time working to rectify some of these problems so I will not detail them again at great length. In May 2007, then Mississippi Senator Trent Lott advised Mississippi beneficiaries to "stay on traditional Medicare plans." And, MS Deputy Insurance Commissioner, Lee Harrell testified before Congress on June 26, 2007 regarding "Abusive Medicare Advantage Sales Practices."

Enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by MA plans against rural providers. The MA program statutes and regulations require CMS to ensure that plan enrollees have reasonable local access to covered services. How CMS and MA plans interpret what is "reasonable" is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. As stated in the CMS Medicare Managed Care Manual: "Plans must…ensure that services are geographically accessible and consistent with local community patterns of care." It is not yet known how or whether CMS is enforcing this provision with PFFS and RPPO plans. Anecdotal evidence to date indicates enforcement is lax at best.

If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region's rural providers, undermining the rural health infrastructure in the effected communities. Plans could ultimately steer rural beneficiaries away from their local health care providers, forcing beneficiaries to leave their communities

for care that is available locally. This loss of critical volume could lead to the closure of local facilities and loss of access to care for all beneficiaries in the community as well as all other local residents.

MA has the potential to destabilize the existing rural safety net. Whether or not MA plans will honor existing rural add-on payments for safety net providers is not known. All MA plans, except "non-network" model PFFS plans, are permitted to negotiate payment rates with providers at levels below amounts the providers would receive under traditional fee-for-service Medicare. This is a process that seems to favor the MA plans, particularly in rural areas where providers may have little managed care contracting experience and little or no negotiating power such as in less remote areas where MA plans can threaten to steer patients to other contracted providers. In some rural areas, individual providers may be able to force fair negotiations because of isolation from other providers and therefore a position of strength vis-à-vis health plans needing to include them to meet access standards.

Most MA plans base payments on a percentage of the interim Medicare rate for Critical Access Hospitals. Unfortunately, as more beneficiaries move to MA plans, the shift in traditional Medicare percentage ratchets the interim payment rate down which in turn drives the MA payment rate down as well. So, logic dictates that as MA plans grow, and to the extent that MA payment rates are based on the interim rate for traditional Medicare, the downward spiral of payment will ultimately ratchet down to a level significantly below cost and place facilities in jeopardy.

Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. These payments were factored into CMS' benchmarking process described below. Whether the MA plans will recognize these targeted rural special payments that have been part of traditional Medicare payments to rural providers is of concern. If not, the previously referenced Emergystat crisis from my state will not be the last.

The promise of additional benefits to beneficiaries from MA plans is unevenly distributed. The technical specifics of the MA bidding process create inequities in the availability of plans with reduced cost sharing or additional benefits in rural areas. The benchmarks used in the bidding process are based on historical Medicare fee-for-service payments at the county level, incorporating historical geographical variation in Medicare expenditures. In general, urban areas have higher physician-to-patient ratios, higher rates of utilization and consequently higher benchmark rates. The degree to which rural county level payment "floors" mitigate this issue is not known. Opportunities for additional savings and benefits should not be based on a system that primarily rewards areas that historically have excess utilization and provides minimal incentives to maintain reasonable utilization in those places where the amount of care provided is already close to appropriate levels, or in fact too low.

Traditional Medicare is not a safe harbor. If the past is a guide, economic incentives will incent MA plans to expand by attracting healthier, lower-cost beneficiaries from traditional Medicare (based on the experiences of Medicare HMOs in the 1980s and 1990s). This would have a negative effect on the traditional Medicare program, leaving it with a disproportionate number of sicker and older patients. Traditional Medicare would be left burdened with higher costs, increasing the political pressure to reduce traditional Medicare's benefits and provider payments. The actual impact of enrollment in MA plans will be more complex than earlier managed care efforts because of provisions of the 2003 legislations that provided for full implementation of risk adjustment, use of corridors to protect plans from unpredicted risk associated with adverse selection, and enrollment in special needs plans that are marketed specifically for chronically ill beneficiaries (the number of such plans grew in 2006 and again in 2007). Nevertheless,

the possibility remains that the earlier experience of favorable risk enrollment in MA plans could be repeated.

CMS needs to walk the transparency talk. CMS's Hospital Compare web site is based on the concept that it is good to make provider performance available to the public. Similarly, detailed data describing CMS and plan performance must be publicly available. Just one example: enrollment figures for MA plans in rural communities were not made public until almost a year after MA plans began enrolling beneficiaries. How plans are managing the communication with beneficiaries around the key issue of access standards and how CMS is monitoring compliance to these standards is also unknown.

RECOMMENDATIONS of the NRHA

1. Ensure that rural providers receive equitable reimbursements in amounts no less than they would be paid by traditional Medicare. Legislation has been introduced to assure this. The Congress should pass this legislation so that Critical Access Hospitals and Rural Health Clinics among other providers are able to continue to serve rural America.
2. Payments to MA plans should not rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization.
3. Make sure that the rural voice is represented with policy makers and that policy makers work more closely with rural communities.
    - Require CMS to engage with rural health experts regarding how best to determine and enforce rural community access standards consistent with individual communities' historic/present patterns of care. CMS must also engage with rural citizens about these standards by developing more user- friendly web sites, train more call center workers who understand the "older learner" and/or their (mature) children or friends who have questions.
    - Provide the Federal Office of Rural Health Policy, Health Resources and Services Administration, expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in the review of MA contracts.
    - Ensure that the Medicare Payment Advisory Commission, which statute says must have rural-urban "balance" achieves that by mandating proportional representation.
4. Require a much higher level of scrutiny and oversight of MA plans, especially PFFS.
    - CMS must take action to ensure that beneficiaries are given the information and support to allow them to make well-informed decisions, particularly for rural beneficiaries who typically have less experience with managed care.
    - CMS Regional Offices must regain their role as an access point by providers in their regions for definitive information and an ombudsman for dispute resolution with plans.
    - State insurance commissioners' offices should be encouraged to act as state level ombudsmen for rural beneficiaries enrolled with MA plans.

5. Require more transparency on the part of MA plans so that providers, policymakers and beneficiaries understand the choices and changes that have been made.
    - CMS needs to continue providing county or equivalent specific plan enrollment data and in a timely manner (quarterly over time).
    - A web site is needed for providers to verify beneficiaries' current plan enrollments.
    - The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications.

CONCLUSION

Medicare Advantage is still unfolding, with its full impact yet to be realized. The continued privatization of Medicare in rural America, even if only partially accomplished, will certainly transform the rural health landscape. It is imperative that (1) rural beneficiaries are ensured appropriate and ongoing access to local care, (2) rural beneficiaries have access to and receive the benefits equivalent to those offered by MA in urban communities, (3) payment rates are high enough to sustain a viable rural health system, and that (4) the relationship among beneficiaries, providers, plans and CMS be well integrated.

SOURCES

Numbers of enrollees in MA plans both urban and rural come from the RUPRI Center for Rural Health Policy Analysis, based on CMS data. Nationwide data is current as of January 2008 with state-level data current as of September 2007.

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