RURAL HEALTH POLICY BRIEF

Contracting With Medicare Advantage Plans: A Brief for Critical Access Hospital Administrators

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Purpose

This document summarizes the experience of CAH administrators with contracts offered by Medicare Advantage (MA) plans. Telephone surveys were conducted with CAH administrators across the country to learn about their experiences with MA plans. This brief includes information about the contract terms administrators have been offered, their experiences negotiating with MA plans, and their advice for others dealing with this issue.

See p. 6 for CAH administrators' and state informants' perceptions of CAH contracting.

See p. 7 for advice from CAH administrators with MA contract experience.

Key Findings

- At the time of the interview, 43% of administrators surveyed had not been approached by MA plans; another 12% had been approached with initial proposals but had limited or no follow-up from the MA plan.
- Most final contracts (after negotiations) specified that payments from the MA plan were to be cost-based, but there were some notable exceptions across lines of service (inpatient, outpatient, lab, swing beds).
- About two-thirds of signed cost-based contracts included provisions for annual cost settlement, but in some cases administrators had to negotiate to get settlement terms in the final contract.
- Administrators strongly advised examining all details of contracts.
- Administrators voiced concern about the ability to retain local patients if contracts were not accepted.

Medicare Advantage: What You Should Know

Beginning January 1, 2006, Medicare managed care will see some dramatic changes. These changes are mandated by the Medicare Modernization Act (MMA) and are being implemented by the Centers for Medicare & Medicaid Services (CMS). Previously, Medicare managed care was virtually nonexistent in most rural parts of the United States. Under the old rules, Medicare managed care plans (then referred to as Medicare+Choice) were marketed on a county-by-county basis, and Medicare payment created incentives to focus on densely populated urban areas. The new rules will not permit this cherry-picking. In the new Medicare Advantage (MA) program, preferred provider organization (PPO) plans certified as regional plans will be required to offer uniform benefits and identical out-of-pocket costs across entire regions, including rural areas, if they want to market in the urban areas. Consequently, it is expected that rural beneficiaries could be enticed by greater benefits and lower out-of-pocket costs and, therefore, enroll in plans in greater numbers than in the past. It is unknown just how many will enroll, but many believe there will be significantly more enrollment than in the past.

MA plans are insurance plans certified by CMS that provide coverage of Medicare Part A and Part B benefits; some MA plans may offer additional benefits. The MA plans receive a monthly payment from Medicare for each beneficiary enrolled. Beginning in 2006, MA plans will incorporate prescription drug plans that offer the new Part D benefit created by the MMA. There are four types of MA plans: health maintenance organizations (HMOs), PPOs, private fee-for-service (PFFS) plans, and cost plans (these are carried forward from the early days of Medicare managed care, but there will be no new cost plans). These private plans replace Medicare as the insurance carrier for beneficiaries who join them; Medicare's only role is to pay the plans. In the past two years, some type of MA plan has been certified in nearly every county in the United States and in all 26 MA regions that were established to implement the MMA (see Figure 1). In 21 regions, MA PPO plans have been certified as regional plans, meaning they must be offered to all beneficiaries in all counties in the region.

Under MA, payment for Critical Access Hospital (CAH) services provided to MA enrollees will be determined by MA plans, either through contractual arrangements or by a default decision to pay the CAH as an out-of-network provider. The MMA does not require that MA plans pay any certain amount or use any particular method to pay CAHs who participate in their networks. If an MA plan is paying for services rendered by a CAH not in its network, it must pay what Medicare would otherwise pay. However, the beneficiary may face a higher copayment than would be the case if services had been rendered by a network provider, and the CAH would need to collect the out-of-pocket payment from the beneficiary.

MA plans will be competing with traditional Medicare (plus Medigap) and possibly other MA plans for beneficiaries. In seeking to enlist providers such as CAHs, plans may try to lower costs by negotiating with providers to accept lower payments and by reducing administrative expenses, such as the costs of end-of-year settlements and interim payment mechanisms. The financial impact of MA payment on CAHs depends on contract terms and beneficiary enrollment, which is likely to vary across and within the MA regions. Given the uncertainty of payment and collection if a CAH is not in a provider network and the potential for rural beneficiary enrollment, there may be good reason for CAH administrators to consider the terms of contracts offered by MA plans, including specific payment processes that may or may not parallel current Medicare practice (e.g., interim payment and annual settlement).

Sample

This brief contains information learned through interviews with administrators of CAHs. Our sample of administrators was restricted to states that contain five or more CAHs (33 states); Mississippi and Louisiana

were excluded because of Hurricane Katrina. After identifying regions believed to be active with respect to MA plan formation, a sample of 58 CAH administrators from 22 states were interviewed. Results were received by both telephone and e-mail. We obtained detailed information about contracting activities from key informants in regional and statewide organizations in two additional states, bringing the total number of states sampled to 24.

Key Contract Components

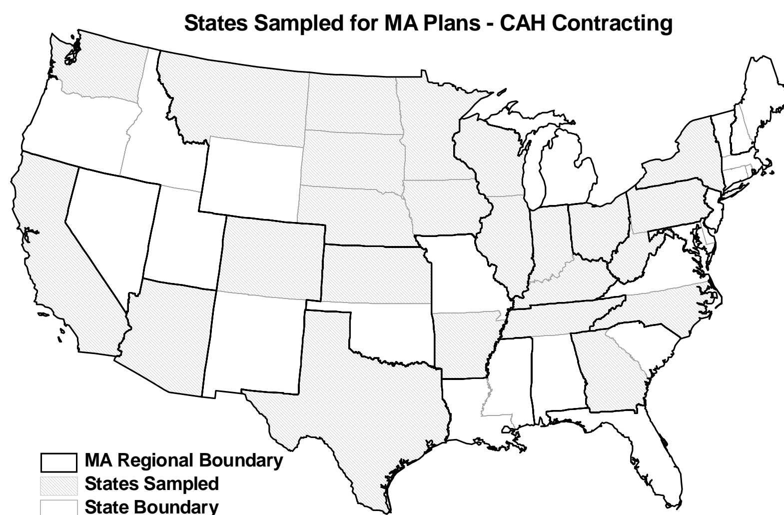
Basis for Payment

The basis of payment for CAH services provided to enrollees is subject to negotiation between MA plans and CAH administrators. Contracts were offered to CAHs using one of the following methodologies:

- Prospective Payment System (PPS);
- Cost-based, as used currently to determine payments for CAHs; and
- Per diem payment rates set by the contract, not necessarily cost-based.

Figure 1.

States Sampled for MA Plans - CAH Contracting



Most final contracts (after negotiations) specifed that the CAH would be paid using a cost-based methodology, at either 100% or 101% of cost. However, some CAH administrators have signed contracts with payment terms based on a lower percentage of cost or Medicare PPS rates. For each individual hospital, contract terms for reimbursement of outpatient services generally were the same as terms for inpatient services.

Of the CAH administrators surveyed who rejected at least one contract, about one-third cited unacceptable payment terms as their primary reason, including per diem rates or 2% to 3% over the cost-to-charge ratio rates. In general, contracts that did not call for cost-based payments were rejected, which is to be expected given that CAHs receive 101% cost-based payments for treating regular Medicare patients.

Definition of Cost

Among the administrators accepting cost-based contracts, half indicated that the contract defined cost explicitly; however, many respondents were unable to provide a clear verbal explanation of their contract's definition. Overwhelmingly, they reported that cost was defined based on the "Medicare definition," described in various terms by these respondents as based on "Medicare cost report reimbursement rules," "Medicare allowable rates," and "Medicare rates."

Settlement

Currently, CAHs are paid by Medicare on a cost basis (101% of cost), with interim payments during a fiscal year based on costs estimated from a prior year's cost report. After a fiscal year ends, CMS reaches a "settlement" with CAHs to align payment to actual costs, which may be higher or lower than projected. If

interim payments were lower than actual costs, CMS pays the CAH the difference; if the payment was higher, the CAH repays CMS.

More than two-thirds of the administrators who accepted cost-based contracts indicated that final contract terms included some basis for settlement. Among these respondents, more than half arrived at settlement terms only after negotiating with the MA plans—for these hospitals, a basis for settlement was not an original contract feature but, rather, evolved only after CAH administrators insisted on such terms. For the most part, it was reported that settlement was based on the Medicare cost reports submitted to MA plans, as one respondent described, "They agree to take our cost report and make us whole."

The exclusion of some basis for settlement from contract terms was a key reason CAH administrators rejected contracts presented by MA plans. One administrator who was offered 101% cost-based payment rates rejected the contract because the MA plan refused to include terms for settlement. Other respondents reported similar experiences, and despite their attempts to negotiate, the MA plans refused to bend, and the contracts fell through accordingly. Overall, about one-third of the CAH administrators who rejected at least one contract cited as their main reason for doing so the exclusion of some basis for settlement.

Interim Payment

Under current Medicare policies, CAHs are paid periodically based on the number of beneficiaries served during that period, as an interim payment until final payment can be determined based on audited cost reports. All but one of the administrators who indicated their MA contract included some basis for settlement also reported receiving some type of interim payment—not one reported contract offered interim payments in the absence of settlement. Comparable to the basis for settlement, hospitals reported that MA plans will deliver interim payments based on hospitals' cost reports.

Other Provisions

Key informants raised other issues about contract provisions. They indicated a need for vigilance and reading all text in contracts:

- The contract being offered by an MA plan to CAHs in one state does not include any provisions to pay for home health services or services provided in a Distinct Part psychiatric unit.
- Timeframes for payment of clean claims may not be defined in contracts.
- Contracts are not addressing payment for Medicare bad debt.
- There is no "spell of illness" concept for inpatient hospitalizations similar to Medicare's. Therefore, a copayment will be charged each time an insured is admitted as an inpatient. This has the potential to create collection problems for the hospital as beneficiaries will not be expecting the second charge and associated copayment.[1]

The Negotiation Process

Just over half of the administrators interviewed had been contacted by an MA plan. The negotiating experiences reported by respondents varied, from how MA plans approached administrators to the extent to which each party pressed the other into accepting their contract terms. Three respondents—all of whom

[1]The insured will pay a copayment ($165 per day for days 1-5, $0 for remaining days) for each admission. The out-of-pocket maximum of $5,000 applies to in-network services for the Kansas and Oklahoma Regional PPO products.

rejected contracts—reported that MA plans in their region approached them informally. For example, one administrator described experiencing a simple "conversation" with an MA plan representative, speculating that the plan was "fishing for information" before offering a formal contract. Another respondent reported receiving a contract from a plan with no follow-up, in which case the respondent "put it in the trash."

When there was negotiation, the majority of administrators accepting contracts reported that negotiating was necessary to obtain the terms they wanted. In particular, they reported negotiating most frequently for some form of settlement and cost-based payment rates and, more often than not, they succeeded in achieving these terms. Likewise, a number of CAH administrators reported rejecting contracts from MA plans offering unacceptable terms. Thus, on the one hand, some respondents were successful at engineering payment terms to their liking. On the other hand, some were unable to change the position of the MA plan. A few signed contracts anyway, citing as their main reason a concern that MA patients in their community would in effect lose access to their facility because of higher out-of-pocket expenses.

From one state, we learned of a process that involved a group of CAHs using a single point of contact with an MA plan to develop a base contract that could then be offered to each CAH for their consideration. This use of the messenger model (hospitals are not sharing pricing information with each other and are not colluding through a single contracting authority) eased the burden of enumerating the details of contract language for individual CAHs. At the same time, the administrative burden otherwise borne by the MA plan was reduced, as use of the basic contract language that reflected reimbursement terms similar to that under historical Medicare payments to CAHs made negotiations with individual CAHs simpler.

Signed Contracts[2]

Payment Terms

The majority of contracts signed included cost-based payment terms similar to Medicare (100% or 101% of cost). However, some CAH administrators signed contracts with payment terms based on a percent of cost below 100% or Medicare PPS rates. In some contracts, payment methodology varied across hospital service lines, including outpatient, lab, and swing beds.

Table 1. Contracts Signed Without Negotiation of Payment Terms

	Example A (5 contracts)	*Example B (2 contracts)*	*Example C (1 contract)*	*Example D (1 contract)*	*Example E (1 contract)*
Inpatient	101% cost	100% cost	101% cost	PPS	PPS
Outpatient	101% cost	100% cost	% charges	58% cost	PPS
Lab	101% cost	100% cost	% charges	58% cost	PPS
Therapy	101% cost	100% cost	n/a	n/a	PPS
Observation Beds	101% cost	100% cost	101% cost	n/a	PPS
Swing Bed	101% cost	100% cost	per diem	58% cost	$450/day
Distinct Part	101% cost	n/a	n/a	n/a	n/a
Home Health	101% cost*	n/a	n/a	n/a	n/a
EMS	101% cost*	100% cost	n/a	n/a	PPS

*Services not applicable for some contracts.

The contracts summarized in Table 1 are examples of contracts acceptable to CAH administrators with no negotiations on payment terms. However, when initially contacted by MA plans, at least one administrator asserted that they would not accept a contract that did not provide payment in the same way as Medicare.

[2]Among the 58 hospitals surveyed, 11 had at least one signed contract with an MA plan. In 2 of these hospitals, 2 contracts had been signed; therefore, we obtained information on a total of 13 agreements.

Two CAH administrators we spoke with had signed MA contracts after successfully negotiating payment terms different from those originally offered. Examples of these contracts are shown in Table 2.

Table 2: Contracts Signed After Negotiation of Payment Terms

	Example A (1 contract)	*Example B (2 contracts)*
Inpatient	PPS → 101% cost	PPS → 101% cost
Outpatient	FFS → % charges	PPS → 101% cost
Lab	FFS → % charges	PPS → 101% cost
Therapy	n/a	PPS → 101% cost
Observation Beds	PPS → 101% cost	PPS → 101% cost
Swing Bed	Per Diem	PPS → 101% cost
Distinct Part	n/a	PPS → 101% cost
Home Health	n/a	PPS → 101% cost
EMS	n/a	PPS → 101% cost

CAH Administrators' and State Informants' Perceptions of CAH Contracting

The following is a summary of general comments made by CAH administrators and state informants during interviews regarding MA plans in their region. Although some respondents felt that the contract terms for a CAH should remain as close as possible to CAH Medicare rates, others believed that the best contract terms ultimately depend on the unique circumstances of the particular hospital and its community.

- Some administrators felt that hospitals should insist on CAH Medicare rates in their MA contracts. However, they took into consideration the possibility of losing their MA patients if they did not commit to an MA plan.
- One administrator wanted cost-based reimbursement only for outpatient care, noting that the CAH "does okay under a PPS," but the insurer would not agree to those terms.
- One state informant noted that the CAH administrators in his state are looking for assurances that they can at least receive cost plus 1%, but few, if any, have received such assurances contractually.
- Another state informant reported that the regional plans in his state all report that they will pay CAHs a cost-based payment, but there is no consistent method for determining how the plan will address cost report settlement issues.
- CAH administrators also found end-of-year settlement was a contentious issue. Some administrators are unsure how the settlement question will be addressed, if it is addressed at all. More than one respondent related that they wanted end-of-year settlement but were unable to get it in a contract. Another respondent simply stated that all plans being considered by a CAH must offer settlement at the end of the year.
- More than one CAH administrator was quick to point out that their hospital operates with a narrow margin, at a high fixed cost with low volume. Because of this, two respondents had no intention of

signing an MA contract in the near future. One believed she would eventually sign but first wanted assurance her hospital would not lose money on MA. The other stated he would always be reluctant to sign but noted that the hospital's ability to serve its community is vital to the survival of that community.

- One respondent stated that the common perception is that hospitals should sign an MA contract if a significant number of their patient population are Medicare Advantage beneficiaries.
- Because they do not have a contractual relationship with PFFS plans, administrators at one CAH chose not to accept patients enrolled in those plans. Their system-level managed care director stated that plans promised seniors lower premiums but did not advise them to determine if their local providers were participating before they enrolled. This director said he has called the PFFS plans and requested they stop marketing in their community.
- Several CAH administrators were unclear about how MA patients should be reported for traditional cost calculations and were concerned about how this might affect reimbursement.
- Some respondents indicated that contract negotiations occurred at the system level; individual CAH administrators would not be negotiating terms on their own.

Advice from CAH Administrators With MA Contract Experience

During interviews, CAH administrators were asked what information concerning their experiences with MA plans they believed would be helpful to pass on to other CAH administrators. The following is what we heard.

Administrators must remember they have the power to negotiate:

- “Stand firm! Don't take anything less than cost-based reimbursement.”
- “Try to negotiate as close as possible to current cost-based reimbursement.”

Administrators need to read contracts carefully and bring in experts who understand payment and contract language:

- “Talk to whoever does the cost reports (for your hospital) and a lawyer who is familiar with this area.”
- “Read everything . . . look at every single detail.”
- “Watch the language used in the contract, (language) such as ‘sole discretion of payer.’ ”

Administrators should be sure the contract states specifically the terms that are required to meet the needs of your hospital.

- “Be clear about time frames for payment and try to get prompt payment for services.”
- “Make sure contract wording includes ability to make rate adjustments based on CAH cost report rules.”
- “Get, or try to get, interim rate updates.”

Interviewing Methodology

The Rural Health Research Centers collaborated to develop the structured protocol used during interviews with respondents. Questions were based on information obtained from informal discussions with CAH administrators and CEOs prior to the start of the study. In advance of contacting potential study respondents, the protocol was pilot tested in the field with a few facilities to ensure it was suitable for collecting the intended information.

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