

## Medicare Advantage

*Medicare has a history of offering alternatives to the traditional Medicare fee-for-service program. However, the latest offering called Medicare Advantage, has the potential to shape the healthcare industry like no other that has come before it. Deciding how to handle the new program is the most immediate issue facing hospital administrators today.*

*So, how do you decide whether Medicare Advantage is truly an advantageous option for your hospital system? The answer is a tricky one, and it requires thoughtful examination of how well your organization can respond to the demands of this managed care program.*

# TO PLAY OR NOT TO PLAY

*Tools and Strategies for  
Determining Whether to  
Sign On With Medicare  
Advantage*

*A QHR  
White Paper*

### Questions to Consider as You Weigh the Pros and Cons

1. What is your current payor mix for Medicare enrollees?
2. What is the current and projected Medicare Advantage enrollment in your area?
3. What is the impact of private fee for service (PFFS) plans?
4. What are the benefits of the program for enrollees?
5. What are the objectives of the program?
6. What are the political implications?
7. What are the considerations whether you choose to play or not to play?

**By:  
Howard Green  
Director  
Managed Care**

**QHR<sup>®</sup>**

## Question #1: What is your current payor mix for Medicare enrollees?

To begin the discussion about whether Medicare Advantage is right for your organization, the first thing you must analyze is your current Medicare payor mix. A typical payor mix is in the 40 – 50 percent range, but this differs depending on the demographics of the area. Because many of the Medicare enrollees will transition to the Medicare Advantage program, it is essential that you retain the business of this important group of patients.

## Question #2: What is the projected Medicare Advantage enrollment in your area?

The national enrollment represents 19 percent of those Medicare eligible. In some areas, we have already seen transition activity much higher. The current number of enrollees is 8.5 million people. The percentage of those who will transition to Medicare Advantage is expected to increase exponentially in the next several years. The Center for Medicare and Medicaid Services (CMS) projects Medicare Advantage will comprise 30 percent of the Medicare mix by 2013 (see Figure 1). Because this is such a popular product with seniors, we believe this number is too conservative, and will in fact, be much higher. To find out what the current enrollment looks like in your area, visit [http://www.cms.hhs.gov/Prescription/DrugCovGenIn/02\\_EnrollmentData.asp](http://www.cms.hhs.gov/Prescription/DrugCovGenIn/02_EnrollmentData.asp).

*The data found at this website will tell you the volume of activity present, whether it is private fee for service and no contract is required, and the key players with licenses in your market. These are critical pieces of data in your research to make the best decision for your organization.*

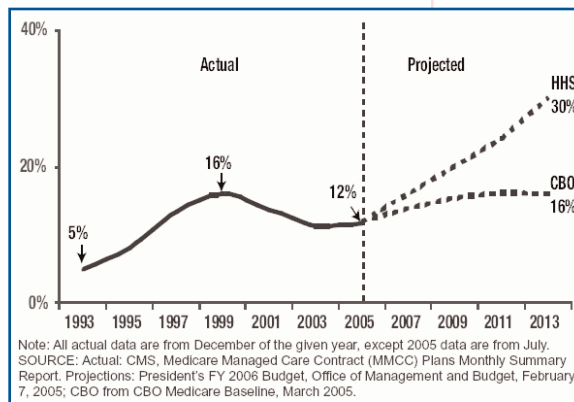
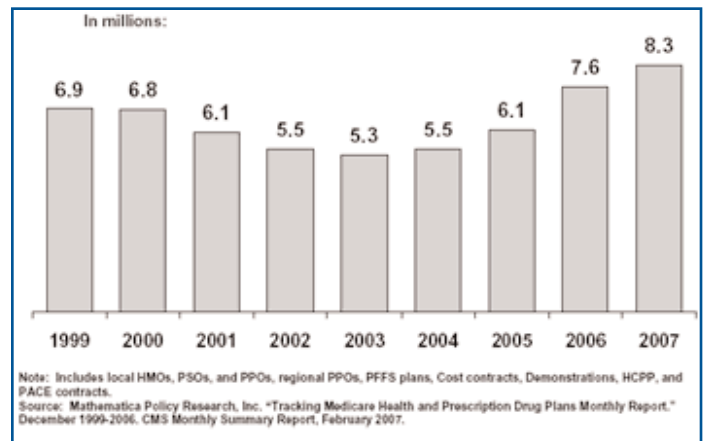


Figure 2  
Total Medicare Private Health Plan Enrollment, 1999-2007



## Question #3: What is the impact of private fee for service (PFFS) plans?

Of the 2.8 million additional covered lives enrolled in Medicare Advantage since 2004, half of that growth is represented by PFFS lives. From a provider perspective, these are lives that the facility may elect to treat, but for which there is no formal agreement. The provider is merely a "deemed provider," and there is no settlement process that occurs with these patients as occurs with regular Medicare lives. However, several national payers have agreed to voluntarily pay the bad debt portion of settlement as an inducement to gain the agreement of the hospital to accept or continue to treat these PFFS patients.

This offer by the payer, while better than no settlement, impacts the financials of all hospitals, but in particular the performance of a critical access facility. Critical access facilities receive large lump sum final settlements reflecting the difference in their interim rates and final settlement rates. In the absence of such a settlement, those providers will not receive payments anywhere near their full 101 percent of costs. Prospective payment hospitals are largely impacted in disproportionate share settlements only.

## **Question #4: What are the benefits of the program for enrollees?**

The reason this program is so popular with seniors is because it offers significant advantages over traditional Medicare. In the traditional Medicare fee for service system, patients must also sign up for Part B and possibly additional supplements to gain additional benefits. With Medicare Advantage, these benefits are built right in. According to the regulations, plans must provide traditional Medicare benefits as a minimum offering. The average savings per individual is \$700 per year and \$2,000 for those with chronic health conditions.

Regional Medicare plans must also provide a single deductible versus two deductibles for traditional Medicare – Parts A and B. The plan must also have catastrophic limits on out-of-pocket expenses for in-network services and the requirement of paying the deductible by the beneficiary can also be waived.

Selection of this PFFS product by the patient does not require that they go to a limited PPO or HMO network; in fact they can go to any acute care or physician provider who is willing to accept regular Medicare payments and is willing to treat them.

## **Question #5: What are the objectives of the program?**

Medicare Advantage is a byproduct of the Medicare Modernization Act (MMA) of 2003 and a successor product to Medicare Choice. Through the MMA and the introduction of Medicare Advantage, the government is attempting to address all stakeholder concerns with the program. CMS believes it will reduce the cost of care for seniors by negotiating price reductions and coordinating a continuum of care. The end goal is to remove the federal government from the operation of programs.

## **Question #6: Are you in an area that could receive essential hospital status?**

An essential piece of the Medicare Advantage puzzle is that it requires hospitals to provide a continuum of care. In areas where hospitals refuse to sign on to the program and there is not a provider hospital, CMS has the ability to designate you as an essential hospital. If this happens, the patient will receive all of the benefits without having to pay the out-of-network differential. This has actually happened on a very limited basis, and it is important to note that critical access facilities cannot be deemed “essential.” In essence, if it is your strategy “not to play,” do not allow the threat of being named “essential” to change your mind.

## **Question #7: What are the political implications?**

While you may have the ability to refuse participation in the program, it is essential to consider not only the financial aspects of your decision, but the political ones as well. How will it be perceived in your community if you refuse to accept the plan carried by 30 percent of the seniors in your area? We recommend discussing the decision with your board of directors and senior executives before you make a decision. You want to make sure everyone is on board with the decision and presents a unanimous front in the event of a potential public relations situation.

## **Question #8: What are the considerations whether you choose to play or not to play?**

If you decide to “play,” it is important to consider the following factors:

- ❖ Loss of control;
- ❖ Future CMS and payer actions;
- ❖ Pressure felt by physicians to participate;
- ❖ Inability to comprehend the program by seniors;
- ❖ Your ability to negotiate the final settlement process.

If you decide “not to play,” weigh the following concerns:

- ❖ Loss of patient base to competitors;
- ❖ Loyal physicians’ loss of access to patients;
- ❖ Potential physician migration to other participating hospitals;
- ❖ Payors are to reimburse interim rates, but out-of-network irregularities will occur;
- ❖ No final settlement process available.

## The Final Decision

Hospitals who are considering participation should gain a clear understanding not only of the total number of lives in their market, but assess who the key payers are and the products they are offering. The same data equips the hospital to assess whether participation in a PFFS product by way of being a deemed provider is in their best interest. In some cases, they may elect to leverage decisions regarding contracting and agreeing to be a deemed provider with PFFS in a fashion to gain the agreement of the payer to provide the greatest level of settlement possible.

In the end, there are two critical factors to consider. The first is whether you are in geographic area that is isolated from competition. If so why sign an agreement? If you are exposed to major out-migration by patients, you should consider participation. You have to protect your access to this essential group of patients. All of these considerations should be weighed by you and your team of executives and board members. You are the only people who can predict what will happen in your community.

*Howard Green is the Director of Managed Care for QHR Consulting Services and is based in Birmingham, Ala. For more information on this topic, e-mail [howard\\_green@qhr.com](mailto:howard_green@qhr.com).*

If you have any questions about this white paper, or would like to speak with QHR about your managed care challenges, please call Howard Green, Director of Managed Care Services, at 1/800-233-1470, ext. 2010. To read more about how QHR has successfully helped clients address hospital issues, go to [www.qhr.com](http://www.qhr.com), and click on the Consulting Services tab.