Some Medicare Marketing on Hold

BY MARY ELLEN SCHNEIDER
New York Bureau

Several Medicare Advantage fee-for-service plan sponsors have agreed to voluntarily suspend marketing of their plans until officials at the Centers for Medicare and Medicaid Services can verify that they are in compliance with certain management controls.

CMS officials announced this temporary marketing moratorium as part of an effort to halt deceptive marketing practices in the private fee-for-service Medicare market.

"It is our strong belief that while most agents and brokers are helpful and responsible in describing and explaining choices to beneficiaries, there are a few bad actors operating in the marketplace that need to be removed from the system," Abby Block, director of the Center for Beneficiary Choices at the CMS, said during a press briefing. "This voluntary agreement demonstrates that the plans are stepping up to ensure that deceptive marketing practices end and that beneficiaries fully understand what they are purchasing."

From last December through April, CMS officials received about 2,700 complaints from beneficiaries regarding Medicare Advantage plans, with many of those complaints relating to private fee-for-service plans. However, Ms. Block pointed out that the 2,700 complaints account for a small fraction of the 1.3 million Medicare beneficiaries who have elected to enroll in such plans.

The problems reported range from agents encouraging the misperception that the private plans are just like traditional Medicare and are accepted by all providers who accept Medicare to more blatant cases of deception in which agents have told beneficiaries they are still enrolled in traditional Medicare and are purchasing a Medigap supplemental insurance policy.

The seven private fee-for-service Medicare plans that recently signed an agreement with the CMS to suspend their marketing efforts are United Healthcare, Humana, WellCare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross Blue Shield of Tennessee. Together, they account for about 90% of enrollment in private fee-for-service plans, according to the CMS. "These are clearly the major players in the industry," Ms. Block said.

The plans were not singled out because of particular problems with their marketing practices, Ms. Block said. The real concern relates to actions by a small number of rogue brokers and agents with whom these and other organizations may contract, she said.

The temporary moratorium does not apply to enrollment among the plans and does not affect the employer market, where CMS has not received complaints of issues with marketing tactics.

The marketing moratorium will be lifted on a plan-by-plan basis when the CMS certifies that the plan has both systems and management controls in place that meet conditions spelled out by the agency in guidance earlier this year.

For example, plan sponsors will have to show that all of their advertising, marketing, and enrollment materials include model disclaimer language provided by the CMS that private fee-for-service Medicare plans are not the same as traditional Medicare or Medigap and that not all providers will accept the plan. All representatives selling products on behalf of a plan sponsor will have to pass a written test demonstrating familiarity with Medicare and fee-for-service plans.

Plans must also agree to provide a list of individuals who are marketing the plan upon request by the CMS or state agencies. The CMS will begin to review plans as soon as they indicate they are in compliance, Ms. Block said. ■

Cigna, Aetna Tops in Payment Performance

BY ALICIA AULT
Associate Editor, Practice Trends

In 2006, Cigna Healthcare moved from fifth place to top ranking among national payers, and Aetna moved from fourth place to second, according to the second annual assessment of overall payment performance conducted by one of the nation's largest physician revenue management companies.

Not surprisingly, state Medicaid programs ranked near the bottom.

The performance rankings were compiled for the second year in a row by AthenaHealth, a Watertown, Mass.–based company that collects about $2 billion a year for medical providers.

AthenaHealth used claims data from 8,000 providers, representing 28 million "charge lines," or line items. The medical services were billed in 33 states. The ranking included national payers that had at least 120,000 charge lines and regional payers with at least 20,000 charge lines.

In 2005, Humana was the top-ranked payer, followed by Medicare. A year later, Medicare held the third position, while Humana dropped to fourth.

Rounding out the top eight national payers were UnitedHealth Group, WellPoint, Coventry Health Care, and CHAMPUS/Tricare.

According to AthenaHealth, there were several trends observed from year to year. In 2006, days in accounts receivable (DAR) dropped by 5%, from 36.2 days to 34.4 days. Blue Cross & Blue Shield of Rhode Island had the lowest DAR at 16.8 days. New York's Medicaid plan had the highest, at 111 days.

Payers are also asking patients to pay more up front, which places a greater collections burden on physicians. Last year, there was a 19% increase in the amount of billed charges transferred to patients, according to AthenaHealth.

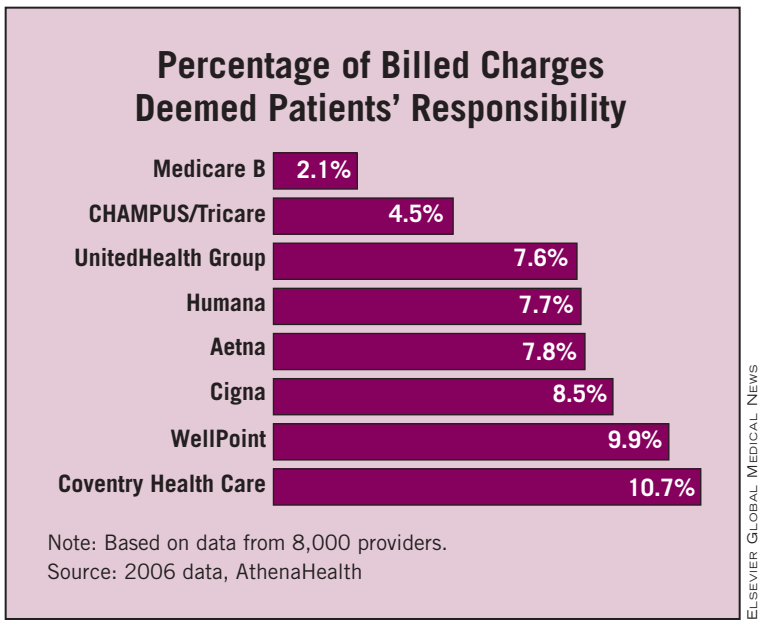
The overall ranking was based on how often claims were resolved on the first pass, the denial rate, denial transparency, percentage noncompliance with national coding standards, and percentage of claims requiring medical documentation.

Denial rates ranged from a low of 4% at Cigna's southern plan to a high of 48% at Louisiana's Medicaid program. The Medicaid programs were laggards on all performance measures. The Illinois Medicaid program paid medical claims on the first attempt only about 30% of the time, and was the second slowest payer overall, with an average 103 days to pay a claim.

"We are seeing disturbing administrative process breakdowns with some state Medicaid plans that are resulting in a growing number of physicians no longer accepting new Medicaid patients, said Jonathan Bush, chairman and CEO of AthenaHealth.

The company said that some states have experimented with managed care as a solution to Medicaid's administrative difficulties. But in Georgia, that may have backfired. A year after patients were moved into managed care, the Medical Association of Georgia "has had to troubleshoot more than 500 complaints from physicians," said Dr. S. William Clark III. ■

The rankings are posted at www.athenapayerview.com.



Elsevier Global Medical News

Hospitals Look To Physicians As Partners

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Hospitals are getting smart instead of angry about competition from physicians.

"A lot of care is moving from the hospital to the ambulatory sector, some of which is still under the auspices of the hospital, but increasingly into doctor's offices, into physician-owned ambulatory surgery centers, imaging centers, testing facilities," Dr. Robert Berenson, a senior fellow at the Washington-based think tank the Urban Institute, said at a press briefing on health care costs sponsored by the Center for Studying Health System Change.

Physicians often set up these centers in part out of frustration with hospital bureaucracy, but also in response to economic pressures, said Adam Feinstein, a managing director at Lehman Brothers where he coordinates the health care facilities research team.

"Physician incomes have been going down. They have been looking to make up for the lost income, and they're competing more aggressively with the hospitals," he said.

Over the past 10 years, the number of ambulatory surgery centers has doubled to approximately 5,000. There are now almost as many surgery centers as there are hospitals in the country. By comparison, there are only about 100 specialty hospitals in the United States, despite all the political attention they get.

Jeff Schaub, who rates acute care hospitals for the international credit rating firm Fitch Ratings, noted that when hospital leadership does not focus on "what their physicians are doing and want to do, we have seen dozens of places have their outpatient surgery volumes cut in half because docs have gone out and put up buildings."

To counteract such trends, "what we have seen over the last 5-8 years is tremendous interest on the part of hospitals and systems to do joint ventures with physicians, figuring that they would rather lose half the business than all of it," he said.

Alternatively, some hospitals have tried to integrate physicians into more of the business decisions, hoping to create a more comfortable environment for them to work, Mr. Schaub said.

"It is really interesting how things come full circle," said Mr. Feinstein. "Hospitals were letting doctors partner with them back in the mid-1990s, there was a lot of scrutiny over this so everyone stopped doing it, and now here we are again and everyone is doing it."

There are similarities, but some important differences this time around, Mr. Schaub said.

"In the 1990s, everybody was buying practices just because everybody else was buying practices. Now what I see is a much more strategic focus, whether it's service line-related or to head off entrepreneurs splitting off or to focus on a particular geography," he said. ■