COMPARISON OF MEDICARE ADVANTAGE PLANS & ORIGINAL MEDICARE FOR HOME HEALTH SERVICE IN DALLAS COUNTY IN TERMS OF PRIOR AUTHORIZATION REQUIREMENTS, NETWORK REQUIREMENTS, AND COPAY/COINSURANCE

PROFESSIONAL REPORT

Presented to the School of Public Health

University of North Texas

Health Science Center at Fort Worth

in Partial Fulfillment of the Requirements

for the Degree of

Master of Public Health

By

Shiney Daniel, MBA, JD

Fort Worth, Texas

December 10, 2008

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Medicare is a health insurance program that is available to most people in the United States who are 65 or older, as well as those under 65 who have certain disabilities or any patient at any age who has End-stage Renal Disease (ESRD), a permanent kidney failure that requires dialysis or kidney transplant as treatment. Medicare, enacted in 1965 was originally comprised of two major sections of coverage: Part A & Part B (Centers for Medicare & Medicaid Services [CMS], 2008c).

Part A, which is also known as Hospital Insurance, covers the patient's inpatient care in hospitals, which includes inpatient rehabilitation facilities as well as skilled nursing facilities. Hospice and home health care services are also covered under Part A services. Part B covers physician services, outpatient care, medical equipment and supplies, and various other services that are not covered under Part A (CMS, 2008c).

Medicare Part C, previously known as Medicare+Choice and established under the Balanced Budget Act of 1997, has since been modified under the Medicare Modernization Act of 2003. Part C is now commonly referred to as Medicare Advantage (Henry Kaiser Family Foundation [KFF], 2007a). Please refer to Appendix I for definition of terms.

Efforts have been made since the implementation of the Balanced Budget Act of 1997 to offer Medicare recipients private insurance options. Under the Medicare Modernization Act of 2003 (MMA), there have been changes made to these private options that have encouraged private insurers to offer a variety of plans, now known as

Medicare Advantage plans (KFF, 2007a). Medicare Advantage plans provide seniors with a variety of options such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service plans (PFFS); medical savings accounts (MSAs); and special needs plans (SNPs). Medicare pays a fixed amount monthly to the Medicare Advantage Plan chosen by the Medicare beneficiary (CMS, 2008a).

Medicare Advantage Plans are required to provide all of the benefits under Part A and Part B and must cover at least all of the medically-necessary services that Original Medicare provides. These plans are allowed to charge different copayments, coinsurances, and deductibles than Medicare. Many of these plans also have extra benefits such as hearing, vision, dental, and prescription drug coverage. Beneficiaries enrolled in Medicare Advantage plans may have to obtain a referral to see specialists. Many of the Medicare Advantage plans also have provider networks. This means that the beneficiary can receive coverage if seen by doctors or other providers who belong to the plan. In addition, beneficiaries enrolled in a Medicare Advantage plan may be limited to certain hospitals or facilities to get covered services. The exception to this would be cases of emergency or urgently needed care or medically-necessary dialysis. In some Medicare Advantage plans, if the enrolled beneficiary is seen by a doctor or other provider who does not contract or participate in the plan, the beneficiary's services may not be covered at all or the beneficiary's out-of-pocket cost may be higher (CMS, 2008a).

Medicare Advantage plans may give benefits in addition to those provided by Original Medicare by reducing the amount of the patient's cost-sharing, providing

benefits that are not covered by Medicare, or by providing a rebate to the patient the patients for all or part of the Part B or Part D premiums (MedPAC, 2007). Part D of Medicare is the Medicare Prescription Drug Benefit.

As per Appendix II, which is a page included in the Medicare handbook, entitled "*Medicare & You 2009*", Medicare recipients may enroll in the Original Medicare Plan, which covers Part A & Part B and then decide whether to add Prescription Drug Coverage under Part D. In addition, Medicare recipients who choose the Original Medicare Plan may also purchase a Medigap policy. Medigap policy refers to a private health insurance policy designed to supplement Original Medicare. Medigap policies cover costs which are not covered under Original Medicare such as copayments, coinsurance, and deductibles. Medicare recipients who elect coverage under a Medicare Advantage Plan, may choose a plan that already has integrated prescription drug coverage or purchase a stand-alone prescription drug coverage plan. However, Medigap policies do not work with Medicare Advantage plans because Medigap policies will not cover Medicare Advantage Plan deductibles, copayments, or coinsurance (CMS, 2008a).

In order for a Medicare beneficiary to enroll in a Medicare Advantage plan, the beneficiary must have both Part A and Part B of Medicare. In addition, the beneficiary must live within the service area of the Medicare Advantage plan. Also, the Medicare beneficiary may not enroll in a Medicare Advantage plan if the beneficiary has End-Stage Renal Disease (ESRD), permanent kidney failure which requires dialysis or a kidney transplant. There are some exceptions to the ESRD exclusion. For instance, if a Medicare beneficiary was already enrolled in a Medicare Advantage plan prior to

developing ESRD, the beneficiary has either an employer or union health plan or other health coverage which is offered by a company that offers Medicare Advantage plans, or the beneficiary has had a successful kidney transplant (CMS, 2008a).

There are additional rules which apply to when a Medicare beneficiary can join, switch, or drop a Medicare Advantage Plan. A Medicare beneficiary may join a Medicare Advantage plan when he or she first becomes eligible for Medicare. This period begins 3 months before the beneficiary becomes 65 year of age and continues until 3 months after the month that the beneficiary turns 65. A Medicare beneficiary who becomes eligible for Medicare as the result of a disability, may join a Medicare Advantage plan during the 3 months preceding or 3 months following the 25th month of disability (CMS, 2008a).

Beneficiaries may also join, switch, or drop a Medicare Advantage plan during the period of November 15-December 31. The new plan, in this case, would become effective January 1 of the following year. Finally, during the period of January 1-March 31 of each year, the beneficiary may also join, switch, or drop a plan. However, the beneficiary may not join or switch to a plan with prescription drug coverage during this period unless the beneficiary already has Medicare prescription drug coverage through Part D. The beneficiary may not drop a Medicare Advantage plan with prescription coverage during the January 1-March 31 period (CMS, 2008a).

Under Original Medicare, home health is a benefit which the Medicare beneficiary may receive if medically necessary. Under the Medicare home health benefit, a home-bound Medicare beneficiary may receive intermittent skilled care, physical

therapy, occupational therapy, or speech therapy delivered in the beneficiary's home. Medical social workers, home health aides, and medical supplies to be used in the home are also covered under the home health benefit (CMS, 2008a).

Skilled nursing care covered under Original Medicare is care provided by a licensed nurse (either licensed practical nurse or registered nurse) which can be performed safely in the Medicare beneficiary's home (Conditions of Participation: Home Health Agencies, 1999). The skilled services provided by the nurse must be "reasonable and necessary" to treat the beneficiary's injury or illness (CMS, 2007; CMS, 2008a). Skilled nursing must be intermittent, which means that the total number of hours of nursing and home health aide services combined must be less than 8 hours a day or less than 28 hours per week (CMS, 2007).

Home health aide services may be provided to the Medicare beneficiary as long as the beneficiary is also receiving skilled services such as nursing or therapy from the home health agency. A home health aide is provided by someone who does not have a nursing license (even though the aide may check the home health patient's blood pressure, temperature, and pulse as a routine part of the home health aide visit). A qualified home health aide must have at least 75 hours of training prior assisting Medicare beneficiaries (Conditions of Participation: Home Health Agencies, 1999). The home health aide services must be services that are provided as part of the care for the Medicare beneficiary's illness or injury (CMS, 1997). Home health aide services are primarily used to assist the Medicare beneficiary with personal care such as bathing, dressing, toileting, skin care, nail care, and foot care. The home health aide also provides services

which are extensions of the skilled care such as range of motion exercises and administration of medications that are normally self-administered. Services provided by the home health aide must be ordered by the beneficiary's physician and supervised at least every two weeks by a registered nurse or therapist if the patient is not receiving nursing (Conditions of Participation: Home Health Agencies, 1999). Other services such as laundry, making the bed, and light housekeeping in the beneficiary's immediate surroundings may be performed in addition to the personal care. Personal care must be part of the home health visit in order for the visit to be qualified for payment under the Original Medicare program (CMS, 2007).

Physical therapy is provided by a licensed therapist or licensed therapy assistant (Conditions of Participation: Home Health Agencies, 1999). Physical therapy is primarily used to improve gross motor skills. Physical therapy may include exercises which are intended to assist the beneficiary to regain strength or movement in an area of the body. Physical therapy may also be used to assist the beneficiary in transferring movements, such as getting in and out of a wheelchair, bathtub, or bed (CMS, 1997).

Occupational therapy must be provided by a licensed occupational therapist or licensed occupational therapy assistant (Conditions of Participation: Home Health Agencies, 1999). Occupational therapy is primary used to instruct the Medicare therapy client on how to perform activities of daily living. Occupational therapists may instruct beneficiaries on new ways to eat, comb hair, and put on clothes and shoes, either with or without adaptive aids to assist in the task. Occupational therapy services may not be the only skilled service that a Medicare beneficiary receives initially when the Medicare

beneficiary is first admitted to home health care. However, occupational therapy may continue the services once the skilled need had previously been established by skilled nursing, physical therapy, or speech therapy (CMS 1997).

Speech therapy, under the Medicare benefit, is only to be provided by a qualified speech pathologist or audiologist (Conditions of Participation: Home Health Agencies, 1999). Unlike physical therapy and occupational therapy, where therapy assistants may be utilized in the provision of care, there are no speech therapy assistants recognized to provide speech therapy under the Original Medicare home health benefit. Speech therapy services provide therapy to help the beneficiary regain and strengthen speaking or swallowing skills. Speech therapy is also used to improve listening, reading and memory skills (CMS, 2007).

In order for a beneficiary to access the home health benefit, a physician must certify the need for the home health service by signing an order for the home health service, and the home health service must be provided by a Medicare-certified home health agency. The Medicare beneficiary must be homebound to receive home health services. A homebound Medicare beneficiary is one who requires a taxing effort to leave the home (CMS, 2008a).

As long as the requirements listed in the preceding paragraph are met, the Medicare beneficiary may receive home health from any Medicare certified home health agency. There are no prior authorizations required from Original Medicare for home health agencies to provide home health services. Also, there are no networks in the structure and delivery of Original Medicare. Thus, a Medicare beneficiary has freedom

of choice to seek home health services from a Medicare home health agency of the beneficiary's choice. There are currently no copays or coinsurance for home health under Original Medicare (MedPAC, 2008a).

Original Medicare pays for home health services in 60-day episodes, provided that the home health provider performs five or more qualified home health visits during the 60 day period. The qualified home health visits may be any combination of skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social worker assistance. If the beneficiary's care is not completed in first 60 day period, Medicare will pay for additional 60 day periods. There are no limits on how many 60 day periods a home health agency may provide services to a Medicare beneficiary, as long as the services are reasonable and necessary to the beneficiary's care. During the years of 2000-2007, home health agencies were paid by Original Medicare for one of 80 possible home health resource groups. Beginning in 2008, Original Medicare has revised home health reimbursement into 153 possible home health resource groups under the home health Prospective Pay System refinements (MedPAC, 2008a).

Medicare beneficiaries in Original Medicare are not limited by network requirements. Medicare beneficiaries in Original Medicare, residing in Dallas County, TX, may choose to receive home health services from any of the 433 Medicare-certified agencies that serve Dallas County (Long Term Care Quality Reporting System, 2008). Medicare beneficiaries who remain with Original Medicare do not have a copay or coinsurance for home health. Furthermore, Original Medicare does not require prior authorization for a beneficiary to receive home health. Original Medicare enrollees may

receive all the home health care that is reasonable and necessary and is ordered by the beneficiary's physician. (CMS, 2008a).

Each of the three cost containment features examined in this professional report (copay/coinsurance, network requirement, and prior authorization) are used by insurance plans in various combinations. Cost containment, in the health insurance context, refers to the methods that are used by a health insurance company to reduce payment for services or reduce costs for providing services to the plan beneficiaries (Mays, 2004). Copay/coinsurance, network requirements, and prior authorization each present a barrier to the Medicare beneficiary in accessing home health care.

Copays, which are not required for home health under Original Medicare, pose a barrier to access to home health for those beneficiaries who have limited or moderate income. Copays refer to a set amount (rather than a percentage) that beneficiaries are required to pay as the beneficiary's share of the cost for the services for a medical service or supply. Examples of copays include paying $10 for a doctor's office visit or prescription (CMS, 2008a)

The network requirement presents a barrier to access to home health to the beneficiary such that, instead of being able to choose from the all of the 433 Medicare-certified home health agencies, the beneficiary must choose from a small number of providers in the network of the health plan that the beneficiary has chosen. Network, in the health delivery context, refers to a group of providers assembled by a health plan who have accepted the contractual terms of the health plan. (KFF, 2007a)

Finally, prior authorization presents a barrier to access to home health to the beneficiary, by limiting the home health care to that which the insurance plan representative authorizes rather than that which the physician orders. Prior authorization refers to the approval by an insurer or third party payor of health care service before the service is provided. This approval is required in order for the insurer to pay the provider for the service (Venes, 2005).

For the purpose of this professional report, "access" refers to the relative ease in navigating the health plan choices to receive all the physician-ordered home health care needed to treat a beneficiary's disease or condition. Any requirement of copay/coinsurance, network requirement, or prior authorization imposes a barrier to the beneficiary's access to home health service of the beneficiary's choice or the quantity ordered by the beneficiary's physician. The geographic region considered for the professional report is Dallas County, Texas.

STATEMENT OF PURPOSE

This professional report will compare the home health options available to Dallas County, Texas Medicare beneficiaries in terms of prior authorization, network requirements, and copay/coinsurance under Original Medicare as well as under Medicare Advantage Plans.

RESEARCH QUESTION

Do Dallas County Texas Medicare beneficiaries have greater access to home health services under Original Medicare or Medicare Advantage plans in terms of prior authorization, network requirements, and copay/coinsurance?

HYPOTHESIS

Dallas County Texas Medicare beneficiaries who elect to remain in Original Medicare will have the same or greater access to home care than those who elect Medicare Advantage coverage in terms of prior authorization, network requirements, and copay/coinsurance.

DELIMITATIONS

The literature for this review was based on available resources in print and electronic form on the topic.

LIMITATIONS

Medicare Advantage plans, in their current form in 2008, have been in place less than five years. There are very few articles published in scholarly journals regarding their performance. However, some limited evaluations of the Medicare Advantage program conducted by the Congressional Budget Office exist, as well as a small number of published reports conducted by private organizations focusing on Medicare Advantage.

ASSUMPTIONS

1) Data published in the articles are accurate.

2) Those reporting on the Medicare alternatives did so focusing on actual facts rather than on political biases.

METHODOLOGY

This professional report is based on a review of the scientific literature using searches conducted through the University of North Texas Health Science Center Journal Finder databases as well as searches of articles and websites through the Internet search engine Google, PubMED, Academic Search Complete, websites of National Association for Home Care, Centers for Medicare & Medicaid Services, Medicare.gov; Kaiser Family Foundation, MedPAC, The CommonWealth Fund; Mathmatica Policy Research; AARP. The following search terms were used: “Medicare Advantage”; “Medicare+Choice”; “Medicare Options Compare”; “Home Health”; “Medicare Advantage Home Health”; “Medicare Advantage” + “Health Affairs”. Only articles from 1997-2008 were evaluated for the purpose of this literature review. Additional articles were retrieved from references in footnotes in the reviewed articles as well as references which were listed at the end of the retrieved articles. Finally, in an effort to obtain relevant databases for this study, personal communication by phone was held with Corina Deems in the Research Department of National Association for Home Care, Customer Service at Palmetto Government Benefits Administrators (home health fiscal intermediary); and Stuaart Guterman at The CommonwealthFund.

In order to secure information on the number of Medicare-certified home health agencies that serve Dallas County, the following steps were taken. First, a Google search was performed on "TX DADS". This led to the result of the home page for the Texas Department of Aging and Disability Services. Next, the link on the left side of the page labeled "Find and Compare Long-term Care Providers" was accessed. Then, "Home Health Agencies for Medicare Services" was selected. The option called "Let me choose a specific County" was chosen. Finally, Dallas County was selected in a drop-down menu. The results were 433 Medicare-certified agencies that are available to patients in Dallas County, TX who receive their benefits through Original Medicare.

Data was also collected from Medicare.gov. This was done by searching the term "Medicare Advantage" on Google. This search yields the section of the Medicare.gov website that is titled "Medicare Advantage Plans". At the bottom of that home page, is a hyperlink labeled "Medicare Options Compare". On the Medicare Options Compare page, is a link labeled "Find & Compare Medicare Health Plans". Then a general plan search was conducted. The zip code "75150", age range of "65-69", and health status "good" were used as search criteria. According to the Medicare.gov website, age and health status do not affect the number of choices available to a beneficiary. "75150" is a zip code in Dallas County and was used to generate options in Dallas County. Original Medicare Plan was the answer given for the question "What type(s) of coverage do you have? Mark all that apply". The answer to the question **"**Did you get a letter from Medicare or the Social Security Administration (SSA) that said you are either eligible for or qualified for extra help paying for your Medicare Prescription drug plan costs?" was

"No". This search was performed on July 9, 2008, and the result yielded 72 health plan options for Medicare beneficiaries in Dallas County.

Details of each of the 72 health plan options were obtained by clicking on the name of the health plan which contained a hyperlink which yielded details of the individual plan. The 10 special needs plans (SNPs) as well as the one demonstration plan were excluded from the comparison because these plans are available only to a limited number of beneficiaries who have certain chronic conditions or are dually eligible for both Medicare and Medicaid. The remaining 61 plans were compared in three cost-containment features which present barriers to access to home health: 1) whether the health plan required the beneficiary to pay a copay or co-insurance; 2) whether the beneficiary was required to seek home health from a provider who was in network; and 3) whether the plan required prior authorization for home health services before the client could utilize the home health service.

Table I

Comparison of 61 Home Care Options for Dallas County (TX) Medicare Recipients Plans listed by Plan Type					
Plan #	**Descriptive Name of Plan**	**Plan Type**	**Copay/ Coinsurance**	**Network Required**	**Prior Authorization**
H0001-001	Original Medicare	Medicare	No	No	No
H0540-010	Unicare-Security Choice Enhanced	PFFS	No	No	No
H0540-032	Unicare-Security Choice Enhanced Plus	PFFS	No	No	No
H0846-004	Advantra Freedom-Freedom 1	PFFS	No	No	No
H0846-005	Advantra Freedom-Freedom 2	PFFS	No	No	No
H1340-004	WellCare-Melody	PFFS	No	No	No
H1804-133	Humana-Gold Choice PFFS (H1804-133)	PFFS	No	No	No
H2762-008	CIGNA-Medicare Access Plane Two	PFFS	No	No	No
H2762-009	CIGNA-Medicare Access Plane Three	PFFS	No	No	No
H1804-237	Humana-Gold Choice PFFS (H1804-237)	PFFS	No	No	No
H5227-001	Advantra Freedom-Freedom 5	PFFS	No	No	No
H5435-001	Secure Horizons Medicare Direct Plan 1	PFFS	No	No	No
H5435-017	Secure Horizons Medicare Direct Plan 1A	PFFS	No	No	No
H5435-020	Secure Horizons Medicare Direct Plan 100	PFFS	No	No	No
H5820-002	Universal Health Care-Any, Any, Any Gold 1	PFFS	No	No	No
H5820-005	Universal Health Care-Any, Any, Any Silver 1	PFFS	No	No	No
H5820-008	Universal Health Care-Any, Any, Any Platinum 1	PFFS	No	No	No
H5996-007	Health Net Pearl Option 7	PFFS	No	No	No
H5996-014	Health Net Pearl Option 14	PFFS	No	No	No
H5996-015	Health Net Pearl Option 14	PFFS	No	No	No
H7845-001	HealthMarkets Care Assured-Premier Plus Plan	PFFS	No	No	No
H7845-002	HealthMarkets Care Assured-Premier Plan	PFFS	No	No	No
H7845-003	HealthMarkets Care Assured-Value Plus Plan	PFFS	No	No	No
H7845-004	HealthMarkets Care Assured-Value Plan	PFFS	No	No	No
H1340-014	WellCare-Concert	PFFS	Yes	No	No
H1340-020	WellCare-Prelude	PFFS	Yes	No	No
H1340-024	WellCare-Sonata	PFFS	Yes	No	No
H0540-020	Unicare-Security Choice Plus	PFFS	Yes	No	No
H0540-001	Unicare-Security Choice Classic	PFFS	Yes	No	No
H2762-007	CIGNA-Medicare Access Plane One	PFFS	Yes	No	No
H5006-010	Sterling Life Insurance Co.-Option II	PFFS	Yes	No	No
H5006-011	Sterling Life Insurance Co.-Option II	PFFS	Yes	No	No
H5006-012	Sterling Life Insurance Co.-Option III	PFFS	Yes	No	No
H5006-013	Sterling Life Insurance Co.-Option IV	PFFS	Yes	No	No
H7357-043	Today's Option Powered by CCRx Premier	PFFS	Yes	No	No
H7357-044	Today's Option Powered by CCRx Value	PFFS	Yes	No	No
H7357-045	Today's Option Powered by CCRx Basic	PFFS	Yes	No	No
H7357-046	Today's Option Powered by CCRx Premier Plus	PFFS	Yes	No	No
H7357-047	Today's Option Powered by CCRx Value Plus	PFFS	Yes	No	No
H7357-048	Today's Option Powered by CCRx Basic Plus	PFFS	Yes	No	No

Table I (Cont.)

Comparison of 61 Home Care Options for Dallas County (TX) Medicare Recipients (continued) Plans listed by Plan Type					
Plan #	**Descriptive Name of Plan**	**Plan Type**	**Copay/ Coinsurance**	**Network Required**	**Prior Authorization**
H5421-106	Universal American-Today's Options Premier	PFFS	Yes	Yes	No
H5421-107	Universal American-Today's Options Value	PFFS	Yes	Yes	No
H5421-108	Universal American-Today's Options Basic	PFFS	Yes	Yes	No
H5421-109	Universal American-Today's Options Premier Plus	PFFS	Yes	Yes	No
H5421-110	Universal American-Today's Options Value Plus	PFFS	Yes	Yes	No
H5421-111	Universal American-Today's Options Basic Plus	PFFS	Yes	Yes	No
H4524-007	Aetna- Golden Choice Value Plan	PPO	Yes	Yes	No
H4524-008	Aetna- Golden Choice Premier Plan	PPO	Yes	Yes	No
H4520-006	Humana Choice PPO	PPO	Yes	Yes	Yes
R5826-012	Humana Choice PPO R5826-012	PPO	Yes	Yes	Yes
R5826-026	Humana Choice PPO R5826-026	PPO	Yes	Yes	Yes
H4523-005	Aetna- Golden Medicare Value Plan	HMO	No	Yes	No
H4590-027	Secure Horizons-AARP Medicare Complete Essential	HMO	No	Yes	Yes
H4590-012	Secure Horizons-AARP Medicare Complete Plan 1	HMO	No	Yes	Yes
H4510-018	Humana Health Plan of TX-Gold Plus	HMO	No	Yes	Yes
H5656-001	TX First Health Plans-TX Plus Powered by CCRx	HMO	No	Yes	Yes
H5656-003	TX First Health Plans-Texan Value	HMO	No	Yes	Yes
H5656-004	TX First Health Plans-Texan Select Powered by CCRx	HMO	No	Yes	Yes
H1264-005	WellCare-Wellcare Value	HMO	Yes	Yes	Yes
H5656-007	TX First Health Plans-Texan Premier	HMO	Yes	Yes	Yes
H5656-008	TX First Health Plans-Texan Premier Powered by CCRx	HMO	Yes	Yes	Yes

Source: Medicare Options Compare (2008).
http://www.medicare.gov/PPF/Include/DataSection/Questions/SearchOptions.asp

Table II

Comparison of Medicare to HMO, PPO, and PFFS plan types Barriers in accessing Home Health in Dallas County, TX				
	0 Barriers	**1 Barrier**	**2 Barriers**	**3 Barriers**
Insurance Type				
Original Medicare	1	0	0	0
PFFS Plans	23	16	6	0
PPO Plans	0	0	2	3
HMO Plans	0	1	6	3
# of Plans	24	17	14	6

Source: Medicare Options Compare (2008).
http://www.medicare.gov/PPF/Include/DataSection/Questions/SearchOptions.asp

IMPORTANCE OF THE STUDY

The conflict of ideologies in terms of the solution to the problem of Medicare insolvency pits those who are for privatization of Medicare against those who are against the concept. The topic of cuts to Medicare Advantage has been hotly debated in both the House of Representatives and Senate during the months of January through July of 2008, specifically because of the impact of the Medicare Advantage program on Medicare spending (KFF, 2007b).

On June 24, 2008, the United States House of Representatives approved H.R. 6331: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which would delay for 18 months payment cuts to physicians but would cost insurers in the Medicare Advantage program $14 billion over the next five years. The US Senate passed the bill in a veto-proof majority of 70 to 26. This bill was in the news specifically because President George W. Bush had threatened to veto the cuts to private insurers under the Medicare Advantage program. The bill was vetoed by President Bush July 15, 2008. The House & Senate overrode the President's veto on July 16, 2008 (Mathews & Zhang, 2008). MIPPA became Public Law No: 110-275 (National Association for Home Care & Hospice, 2008).

As the result of funding cuts to Medicare Advantage, the private plans which are currently viable may follow the path of Medicare managed care plans of the recent past. In the aftermath of the payment restructuring of the Balanced Budget Act of 1997, one senior health plan after another pulled out of the senior managed care market, leaving few choices for Medicare beneficiaries in terms of seeking alternatives to Original Medicare.

As a result of payment cuts under the balanced Budget Act of 1997, enrollment in all private Medicare plans dropped from 7 million in 1999 (18 percent of total beneficiaries) to 5.3 million by the end of 2003 (13% of total beneficiaries) (Berenson, 2004).

There are also questions regarding equity in the distribution of Medicare benefits over the entire Medicare population. Specifically, generous payments are made by the Medicare program to the Medicare Advantage plans to provide extra benefits to a subset of the Medicare population. Under the current payment structure for Medicare Advantage, there is a net increase in program expenditures, which is estimated to decrease the viability of the Medicare Part A trust fund by two years and increases Medicare premiums (KFF, 2007b).

The importance of the study is that Medicare beneficiaries requiring home health should stay in under the Original Medicare benefits or enroll in a PFFS plan if the beneficiary has extensive home health need or is on a limited income and cannot pay large copays. Under the current plans available, there 23 PFFS plans which have no barrier to the Medicare beneficiary's access to home health care. However, the ongoing viability of the PFFS plans remains to be seen. Due to the passage of the Medicare Improvements for Patients and Providers Act of 2008, Private Fee For Service options may not remain an option for Medicare beneficiaries in the future. If the PFFS plans are terminated by the insurance companies due to the cuts under MIPPA, home health beneficiaries who require extensive home health can switch back to Original Medicare.

CHAPTER II

REVIEW OF LITERATURE

Enrollment in private Medicare plans declined every year from 1999 through 2003. However, as depicted in Appendix III, the number of Medicare beneficiaries enrolled in private Medicare health plans has almost doubled from 5.3 million in 2003 to 10.1 million as of July 2008. Appendix IV shows the Medicare Advantage enrollment as of June 2007, which was 8.7 million (19.7%) in comparison to 35.3 million (80.2%) in Original Medicare (KFF, 2007b).

In 2008, Medicare Advantage continued to increase. In 2008, nearly 45 million (about 23%) of Medicare beneficiaries were enrolled in a private Medicare Advantage plan. The remaining 77% of Medicare beneficiaries are enrolled in Original Medicare (KFF, 2008b).

As of 2007, seniors could choose from an average of 20 different health plans, depending on the healthcare market. Medicare Advantage plans offer a variety of options ranging from plans that have higher premiums and lower cost-sharing or lower premiums and higher-cost sharing. In addition to prescription drug coverage, some additional services available under Medicare Advantage plans include preventative care services, care management programs for chronic conditions, routine physical exams, routine eye and hearing exams, glasses and hearing aids, as well as additional hospitalization and skilled nursing facility stays. Presently, almost one out of five Medicare recipients is enrolled in a private health plan under Medicare Advantage. The Center for Medicare & Medicaid Services (CMS) estimates that Medicare beneficiaries covered under a

Medicare Advantage plan receive additional services worth an average of $96 per month over participants that remain in Original Medicare. (Heritage Foundation [HF], 2008).

Although Congress created access to private health plans for Medicare beneficiaries as a means to save money, the irony is that Medicare Advantage plans are costing the federal government more money. According to the General Accountability Office, Medicare paid Medicare Advantage plans $59 billion, which is estimated to be $7.9 billion more than Medicare would have paid if the people who were enrolled in Medicare Advantage plans had remained in Original Medicare (Barry, 2008).

According to Appendix V, enrollment rates for white and African American beneficiaries are similar. However, a large portion of Hispanic beneficiaries are enrolled in Medicare Advantage plans. It is important to note that half of all Hispanic Medicare Advantage enrollees live in two states where Medicare Advantage plans have a large presence: California and Florida (KFF, 2007b).

According to MedPAC's analysis of enrollment date, the percentage of rural beneficiaries who are able to enroll in a Medicare Advantage plan continues to increase. In 2005, only 2% of all Medicare beneficiaries who lived in rural areas were enrolled in a Medicare Advantage plan. By 2006, the rate of rural beneficiaries who enrolled in Medicare Advantage increased to 7% (KFF, 2007b).

A self-assessed health status is usually considered to be a relatively strong predictor of future medical needs. The analysis conducted by Kaiser Family Foundation finds that fewer Medicare Advantage enrollees report that they are either in fair or poor health in comparison to the beneficiaries that remain in Original Medicare. In fact, a

smaller number of beneficiaries who are under the age of 65 and have permanent disabilities are in enrolled in Medicare Advantage plans than in Original Medicare. Likewise, a smaller number of beneficiaries who reside in institutional settings such as nursing homes are enrolled in Medicare Advantage plans compared to Original Medicare (KFF, 2007b).

Medicare Advantage enrollees are healthier in general than beneficiaries in Original Medicare. However, 24% of enrollees in Medicare Advantage plans who self report a health status of fair or poor with regard to the Medicare Advantage plan's express concerns regarding the adequacy of coverage as well as out-of-pocket costs which are associated with their medical care. While Medicare Advantage plans attract beneficiaries with the promise of additional benefits and lower cost-sharing, beneficiaries are not necessarily better off financially than enrollees who remain in Original Medicare (KFF, 2007b).

Out-of-pocket costs vary for any given beneficiary because they depend on a number of factors, including the beneficiary's specific medical needs and the particular health plan the beneficiary chooses. For instance, many of the Medicare Advantage plans may waive deductibles, reduce the beneficiary's portion in cost-sharing requirements, offer a stop-loss limit on catastrophic spending on services that are covered under Part A and Part B, and provide the enrollee with some additional benefits such as vision, dental, or Part D drug coverage. However, out-of-pocket costs increase for Medicare Advantage enrollees through plans which impose daily hospital copayments, daily copayments for

home health visits, and daily copayments for the first few days in a skilled nursing facility that are not required under Original Medicare (KFF, 2007b).

One study conducted at Emory University Rollins School of Public Health investigating the utility of Medicare Advantage plans reports that if Medicare Advantage plans were no longer available to current enrollees, 39% of all Medicare Advantage enrollees would opt to be without supplemental coverage, while 59% of African-American Medicare Advantage beneficiaries would go without supplemental coverage. The study also finds that 22% of those who would lose Medicare Advantage plans would enroll in Medicaid and the remaining 39% would purchase Medigap policies (2005).

Of the Medicare Advantage options, PFFS plans are the most popular, with the number of companies offering them and the number of Medicare beneficiaries enrolled increasing rapidly over the last 3 years. As of February 2007, 18% of total Medicare Advantage enrollment was comprised of PFFS plan participants. The popularity of PFFS plans is attributed to the fact that they more closely resemble Original Medicare than the Medicare managed care plans such as HMOs and PPOs. Please see Appendix VI for a comparison of PFFS to other Medicare Advantage plans. PFFS plans are exempt from many of the requirements imposed by CMS on Medicare HMOs and PPOs, such as having provider networks and performing utilization management. From December 2005 to February 2007, enrollment in Medicare HMOs and PPOs grew by 18%. During the same period, enrollment in PFFS plans grew 535%. PFFS plans are now the most widely accessible type of Medicare Advantage plan, with 99% of Medicare beneficiaries having access to at least one type of PFFS plan in 2007 (KFF, 2007a). In theory, having multiple

options available to the Medicare beneficiary allows the beneficiary to choose the type of plan that best suits his or her need with respect to coverage, cost-sharing, provider network, and quality. However, in practice, these varied, non-standardized options make it difficult for beneficiaries to make an informed choice of the correct health plan (Commonwealth Fund, 2008).

PFFS plans must follow Medicare coverage guidelines to decide what services would be medically reasonable and necessary. If the services would be considered medically necessary under Original Medicare, the PFFS plan must cover the service. Beneficiaries enrolled under PFFS plans may seek health care services from any Medicare provider. However, the provider may choose to accept or decline the beneficiary depending upon the payments terms of the PFFS plan (CMS, 2006).

With regard to the extra benefits provided to PFFS enrollees (as compared to Original Medicare, PFFS plans offered extra benefits that were less valuable in comparison to other Medicare Advantage plans. The reason for this is that PFFS plans are generally unable to provide the basic Medicare benefits at a lower cost than Original Medicare (KFF, 2008a). While PFFS plans are paid under the same capitated payment system as the HMOs and PPOs, the PFFS plans generally pay providers the same or similar rate as Original Medicare (KFF, 2007a). Since, HMOs and PPOs tend to pay providers much lower reimbursement rates, they are able to capture savings which may be then used to provide more valuable benefits.

Under the 2003 the Medicare Prescription Drug, Improvement, and Modernization Act, Special Needs Plans (SNPs) were authorized for 5 years. Under the

Medicare, Medicaid, and SCHIP Extension Act of 2007, SNP authority was extended for an additional year. In addition, the 2007 act placed a moratorium on the creation of new plans as well as service area expansions in the existing plans. Without further congressional action, SNP authority will expire at the end of 2009. SNPs have experienced rapid growth. In 2008, 57 percent of the special needs plans were for Medicare beneficiaries who are dually eligible for Medicaid. 31 percent of the Medicare beneficiaries who are enrolled in special needs plans are qualified for the plans because of chronic conditions. Finally, 12 percent of the beneficiaries who have SNPs are those who live in institutions or live in the community but have needs similar to those in institutions (MEDPAC, 2008).

With the increasing popularity and growth of Medicare Advantage plans, private health insurance companies that provide these services have found themselves as targets of legislative cuts (in H.R. 6331) in the Medicare Advantage program as a way to postpone 10.6% cuts to physician payments which were scheduled to be implemented July 1, 2008 (Stout, 2008).

Beneficiary access to home health care

Under Original Medicare, beneficiaries have access to home health care. According to MedPAC, most communities have more than one home health agency. During the 12 months preceding June 2007, 99% of all Medicare beneficiaries lived in an area that was served by at least one home health agency, and 97% of Medicare beneficiaries lived in an area that was served by 2 or more home health agencies.

MedPAC's assessment of beneficiary access to home health was determined by analysis of CMS's Home Health Compare database as of October 2007. Beneficiary's were said to have access to home health care if an agency provided service in the postal ZIP code within the past 12 months. By MedPAC's own admission, this definition may overestimate access because home health agencies may not need to serve the entire ZIP code to be counted as serving it (MedPAC 2008a).

The total number of home health users in Original Medicare decreased in 2006. MedPAC noted that this is largely due to the fact that a significant number of Medicare beneficiaries have moved to Medicare Advantage plans. The number of home health users grew at a rate of 5.6% annually from 2002 to 2005, but fell by 0.4% in 2006. The total number of Medicare beneficiaries in Original Medicare decreased by 2.5% in 2006 because of the increasing number of beneficiaries enrolling in Medicare Advantage (MedPAC, 2008a).

The rate of Medicare beneficiaries in Original Medicare using home health care and home health episode volumes have increased despite the decrease in the total number of home health users due to the shift toward Medicare Advantage. In 2006, the number of episodes per beneficiary under Original Medicare increased by 4% in 2006. Due to the shift to Medicare Advantage, home health episodes growth slowed in 2006. During the period 2002 through 2005, the number of home health episodes grew by approximately 8% per year. This rate of growth fell to 1.7% in 2006 (MedPAC, 2008a).

Under the home health prospective payment system, the volume of home health visits have shifted to include a higher share of episodes with 10 or more therapy visits.

Between the years 2002 and 2005, home health episodes with 10 or more therapy visits grew at an annual rate of 13%, which was twice the rate of home health episodes with fewer than 10 therapy visits (MedPAC, 2008a).

In 2006, the difference in the growth rate became even more significant. MedPAC noted that for the first time, in 2006, therapy-intensive episodes constituted the majority of new home health episodes. The annual growth of home health episodes that have 10 or more therapy visits was 4.2% in 2006, which is 6 times the rate of growth for home health episodes which were not therapy-intensive. As result of the higher rate of growth, therapy-intensive episodes comprised about 70% of new home health episodes (MedPAC, 2008a).

MedPAC noted that the growth in the number of beneficiaries receiving therapy-intensive home health services coincides with changes in the types of patients that are served by inpatient rehabilitation facilities (IRFs). The threshold for qualifying as an IRF was tightened in 2004. In order to comply with these changes, IRFs have changed what types of patients they serve. MedPAC noted that many beneficiaries that were previously served by IRFs now use home health care instead (MedPAC, 2008a).

Because of the changes in the inpatient rehabilitation facilities practices, more patients requiring therapy (which are higher cost services) are being discharged from hospitals or inpatient rehabilitation facilities to receive therapy in the home setting. This is not a problem for Medicare beneficiaries who remain in Original Medicare or one of the PFFS plans which do not require copays, networks, or prior authorization.

However, beneficiaries enrolled in HMOs must first seek home health services from a home health provider that is in network, compared to the 433 Medicare-certified home health agencies available to the beneficiary enrolled in Original Medicare. Once the beneficiary has located a home health agency in the network, the agency must seek prior authorization to be paid for the home health service. Finally, if services are authorized by the HMO, the beneficiary may be subject to a coinsurance per home health visit or copay for the home health visit.

CHAPTER III

DISCUSSION

Prior Authorization Requirements

A survey of home health agencies conducted by National Care Planning Council indicates that many of the Medicare Advantage insurers are paying for significantly fewer days of care than Original Medicare would pay. In some cases, the plans can pay as little as 20% of the normal Medicare benefit (2006) The survey respondents indicated that patients under Medicare Advantage plans were being released from treatment far too early and that these patients may be at risk for infection of wounds that are not completely healed or are at risk of serious falls. The possibility exists that Medicare Advantage may actually be more expensive than Original Medicare because beneficiaries who are released too early from the home health agency's care may end up back in the emergency room or incur new hospital stays. The real risk of prior authorization requirements is that the Medicare Advantage insurers may deny further days of care to avoid higher cost rather than meeting the beneficiary's actual medical needs. The survey found that home health providers were advising their patients and their caregivers to return to Original Medicare because the patient would receive more care under Original Medicare. Also, the beneficiaries under Medicare Advantage may have more out-of-pocket costs due to copays. (National Care Planning Council, 2006).

The other reality of prior authorization is that home health providers who do not have to deal with prior authorization for Medicare might be reluctant to spend the administrative time required to get the approval of the health plan. That means that a

home health agencies which exclusively serve only Medicare beneficiaries under Original Medicare would be more likely to accept beneficiaries for service Original Medicare accepting beneficiaries under Medicare Advantage plans which require more administrative time.

Network Requirements

According to the National Association for Home Care & Hospice, there are changes to the Medicare Advantage private fee-for-service plans as the result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) which is Public Law No: 110-275. According to Section 162 of this law, MIPPA changes the requirements for private-fee-for-service plans which serve counties where there are two or more non-PFFS plans (either PPO or HMO). Currently, PFFS plans can "deem" providers into the plan without having to form provider networks. In counties with two or more non-PFFS plans, the private-fee-for-service plans could no longer "deem" the providers in the plan but would have to form provider networks beginning in 2011 (National Association for Home Care & Hospice, 2008).

Network requirements drastically reduce the number of home health providers available to serve the Medicare beneficiaries home health needs. A home health provider who seeks to be in any of the networks in Dallas County has to complete lengthy contracts, which also tend to have reduced rates at which providers are paid. Since Medicare reimbursement rates for home health are more generous than most of the Medicare Advantage plans, most home health providers elect not to participate in the

various Medicare Advantage networks. Also, approximately four out of every five Medicare beneficiary remains under Original Medicare at this time. As a result, home health providers have not sought to join Medicare Advantage networks. The result is few choices for the Medicare beneficiary who enrolls in a Medicare Advantage plan.

Copay/Coinsurance Requirements

Mathematic Policy Research analyzed trends in both benefits and premiums of Medicare's managed care options from 1999 to 2003 and found that the Medicare +Choice plans continued to shift more costs to the enrollees. This includes increases in copayments as well (Commonwealth Fund, 2003).

Medicare private health plans have historically enrolled beneficiaries that are lower-cost to the private health plan than those enrolled in Original Medicare. Private health plans have shown a preference toward enrolling healthier beneficiaries because the most costly 5% of beneficiaries incur 47% of the costs. In 2003, because of the design of the Medicare private health plans, the average Medicare managed care enrollee in good health spent $1,564 out of pocket on health care, compared to $5,305 by an enrollee in poor health (Biles, Dallek, & Nicolas, 2004).

MEDPAC reports that under the Prospective Pay System (PPS), the mix of visits provided to the Medicare beneficiary has moved away from home health aide visits and moved toward therapy visits, which includes physical therapy, occupational therapy, and speech therapy. During the years 2000-2007, Medicare paid substantially higher payments to home health agencies if the home health episode included 10 or more

therapy visits. In 2006, the home health visits per user under Original Medicare was 34 visits (MEDPAC, 2008a).

As a result of this shift in home health practice toward higher priced and higher skilled therapy visits as opposed to lower priced home health aide visits, Medicare Advantage beneficiaries who have copays or coinsurance for home health will have to pay significantly higher out of pocket expenses if the beneficiary is sick and requires extended home healthcare. In February 2008, the Government Accountability Office announced that beneficiaries in some of the Medicare Advantage plans may have to pay more for certain services (including home health care). Sick Medicare beneficiaries who are enrolled in Medicare Advantage plans are most likely to be affected. According the Government Accountability Report, 19 percent of the beneficiaries who are enrolled in Medicare Advantage plans are likely to experience higher out-of-pocket costs for home health than if they had under traditional Medicare in 2007 (Andrews, 2008) .

Analysis of the 61 Health plan options for Dallas Country Medicare beneficiaries

There were four categories of plans available to all Dallas County (TX) Medicare beneficiaries: 1) Original Medicare, 2) Health Maintenance Organizations (HMOs), 3) Preferred Provider Organizations (PPOs), and 4) Private Fee-For-Service (PFFS). Of the 60 alternatives to Original Medicare, 45 plans were PFFSs (75%), 10 plans were HMOs (approximately 17%), and 5 plans were PPOs (approximately 8%). See Table I.

A comparison was performed of the number of barriers in accessing home health per health plan type. Barriers evaluated were 1) copays/coinsurance, 2) network requirements, and 3) prior authorization requirements. There were no barriers for Original Medicare in accessing home health care in Dallas County, Texas.

See Table II. Of the 45 PFFS plans considered, 23 plans did not have any barriers accessing home health. Of the remaining PFFS plans, 16 plans had one barrier and six plans presented two barriers to accessing home health in Dallas County. For each of the 16 PFFS plans which had one barrier to access home health, copay/coinsurance was the cost-containment feature which acted as a barrier. With all six of the PFFS plans which utilized two cost-containment features, copay/coinsurance as well as network requirements were the two cost-containment features that acted as barriers in access to home health.

Of the five PPO plans considered, two of the plans had two barriers and three of the plans had all three barriers in accessing home health. Of the two PPO plans which utilized two cost-containment features, both utilized copay/coinsurance as well as network requirements.

Finally, of the 10 HMO plans considered, there was one plan which had one cost-containment feature (network requirement). Of the six HMO plans which utilized two cost-containment features, the two that were used were network and prior authorization.

Thus, beneficiaries who choose to remain with Original Medicare rather than a Medicare Advantage plan have the same access to home health as 23 of the PFFS plans available in Dallas County. Beneficiaries who choose to remain with Original Medicare rather than a Medicare Advantage plan have better access to home health than 37 of the Medicare Advantage options. Thus, the recommendation for Medicare beneficiaries who are users of high levels of home health is to either remain in Original Medicare or choose one of the 23 PFSS plans that do not use any of the cost containment features of copay/coinsurance, network requirements, or prior authorization.

Impact of cost containment features on home health providers

Prior Authorization is a barrier to home health providers provision of home health care. As a result, home health care providers may choose not to serve a Medicare beneficiary who is in a Medicare Advantage plan which requires prior authorization due to restrictions of number of visits authorized by the health plan representative and the time invested in obtaining the prior authorization.

Copays are a barrier as well for providers who serve indigent home health patients or patients with limited income. Patients may elect to receive fewer services than necessary for recovery due to the copay/coinsurance burden.

Finally, network requirements are a barrier to access of home health from a provider standpoint. To enroll in networks, there is a lengthy credentialing process involved. Home health agencies who are not in network may not receive reimbursement for services provided beneficiaries in plans with network requirements.

Recourse for Beneficiaries enrolled in Medicare Advantage

If a Medicare beneficiary residing in Dallas County (TX) requires extensive home health service, the beneficiary may be best served under Original Medicare or one of the 23 PFFS plans with no barriers in access to home health care. The beneficiary may switch health plans in an attempt to receive home health services. Many Medicare beneficiaries sign up for Medicare Advantage plans in an attempt to enroll in the Medicare Part D Prescription Drug benefit. Only later do they realize that they had switched from Original Medicare to Medicare Advantage. As of 2007, Medicare beneficiaries who are enrolled in Medicare Advantage (whether knowingly or unknowingly) may switch back to Original Medicare only in the three month window with effective dates from January 1 through March 31 of each year. A Medicare beneficiary who wishes to return to Original Medicare must obtain a release from the insurance company before he or she can be accepted back into Original Medicare. The Medicare Advantage plan may require either a phone call from the beneficiary or a written request from the beneficiary (National Care Planning Council, 2006).

APPENDIX I

DEFINITIONS OF TERMS

Coinsurance-amount to be paid by the beneficiaries for services as a percentage of the cost of the services, after the deductible has been met (for example, 20%). This amount is what the beneficiary must pay after meeting the Part A and/or Part B deductible. The percentage will vary depending upon the insurance plan (CMS, 2008a).

Copayments-a set amount (rather than a percentage) that beneficiaries are required to pay as the beneficiary's share of the cost for the services for a medical service or supply. Examples include paying $10 for a doctor's office visit or prescription (CMS, 2008a).

Deductible-the amount that beneficiaries must pay for healthcare or prescriptions before Original Medicare, prescription drug plan, or other types of insurance begin paying for beneficiaries' care or services (CMS, 2008a).

Home health episode-60 day periods of care for which Medicare pays a set amount of money based on the beneficiary's home health resource group (CMS, 2007).

Health Maintenance Organizations (HMOs)-refer to tightly managed health plans in which beneficiaries select a primary care physician, who coordinates the care received by the beneficiary. To receive coverage, the beneficiary must receive all care through a

prescribed network of providers, with some exceptions such as emergency care. (KFF, 2007a)

Home Health Prospective Payment System-payment system in effect since October 1, 2000. Medicare pays a predetermined base amount to home health agencies. This payment is adjusted by factors such as the beneficiary's health condition and care needs of the beneficiary. This payment rate is also adjusted to account for the geographical differences in wages across the United States. Also, the beneficiary's service needs are also taken into account into the case-mix. Payment is made by Medicare to home health agencies for 60 day episodes. There are no limits as to how many episodes of care a beneficiary may receive. When the beneficiary receives fewer than 5 visits during an episode of care, the home health agency is paid low-utilization rates, which is calculated by multiplying the services-specific per-visit amount by the number of visits of a given type. Those service-specific payment amounts are then added together to yield the total low-utilization payment to be paid the home health agency (CMS, 2008d).

Home Health Resource Group (HHRG)-the level of payment for a 60 day episode of home health care, which is calculated by a combination of factors including a beneficiary's clinical condition, functional limitations, utilization of therapy services, and timing of episode in a sequence of episodes. (MedPAC, 2008a)

Medically Necessary-services or supplies that are needed to treat or diagnose a patient's medical condition and meets the accepted standards of medical practice (CMS, 2008a).

Medicare Advantage Plan-often referred to as Part C of the Medicare program. These are plans offered through private companies that contract with Medicare. These plans include health maintenance organizations, preferred provider organizations, private fee-for-service plans, special needs plans, and Medicare medical savings account plans. Once a beneficiary is enrolled in one of these plans, services are covered through Medicare Advantage and not through Original Medicare (CMS, 2008a).

Medicare Prescription Drug Plan-referred to as Part D of the Medicare program. This is a stand-alone drug plan that adds prescription coverage to Original Medicare, Medicare Cost Plans, some of the Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans. These plans have been approved by Medicare and are offered by private insurance companies. The companies that offer Medicare Advantage plans, which include prescription drug coverage, may not have to follow the same rules as those plans that offer stand-alone Medicare Prescription Drug coverage (KFF, 2007).

Medigap Policies-are private health insurance policies designed to supplement Original Medicare. These policies cover costs ("gaps") that are not covered under Original Medicare such as copayments, coinsurance, and deductibles. Extra benefits may be

covered under these policies for extra cost. These policies only work with the Original Medicare Plan and do not work with Medicare Advantage Plans (CMS, 2008a).

Medicare Payment Advisory Commission (MedPAC)- is an independent Congressional agency which was established by the Balanced Budget Act of 1997 to advise the United States Congress regarding issues that affect the Medicare program. This group advises Congress on a variety of issues including private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program (Original Medicare) (MedPAC, nd).

Preferred Provider Organizations-are similar to Health Maintenance Organizations (HMOs). These health plans are network-based, but enrollees may go to any type of provider within the network without a referral from a primary care physician. Enrollees may seek care outside of the network but face higher out-of-pocket costs to the enrollee (KFF, 2007).

Prior Authorization-approval by an insurer or other third party payor of health care service before the service is rendered. This approval is required in order for the insurer to pay the provider for the service (Venes, 2005).

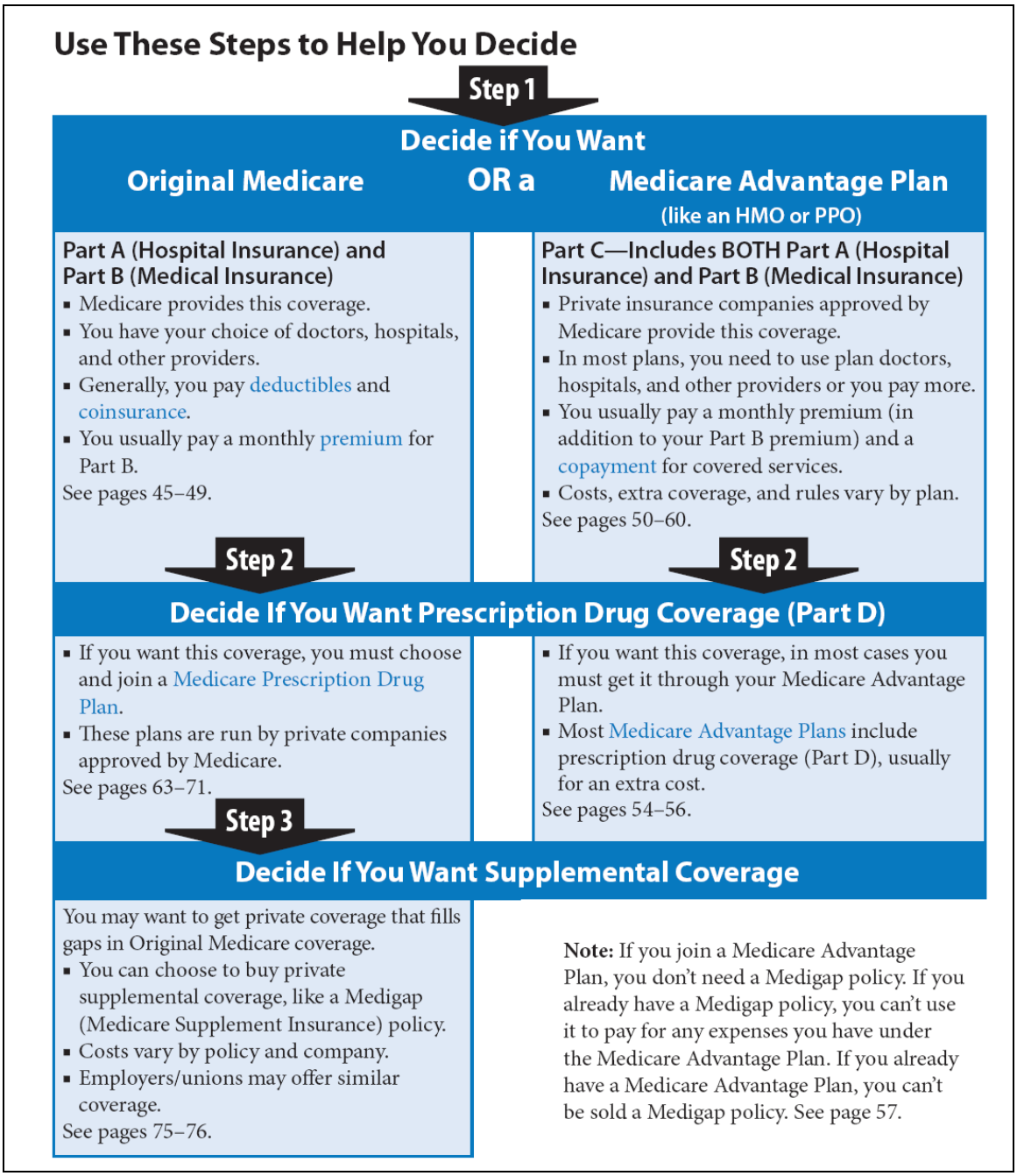
.

Private-Fee-For-Service (PFFS)-is similar to Original Medicare in many aspects. One of the purposes of these plans is to allow open access to providers. PFFS plans are

offered by private health insurance companies, which are under contract with the Medicare program. Under the contract, Medicare pays a monthly rate to the insurance company to arrange the health care coverage for those enrolled in the PFFS plan. These plans are not required to establish networks or collect and report quality measures. However, as the result of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), PFFS plans will have to comply with quality reporting. Also, due to a provision in MIPPA, PFFS plans will be required to form provider networks in certain counties, beginning in 2011. In counties where there are two or more non-PFFS plans (either an HMO or PPO), the PFFS plans can no longer "deem" providers into the plan. Beginning in 2011, these PFFS plans would have to form provider networks (KFF, 2008b; CMS, 2006, NAHC, 2008).

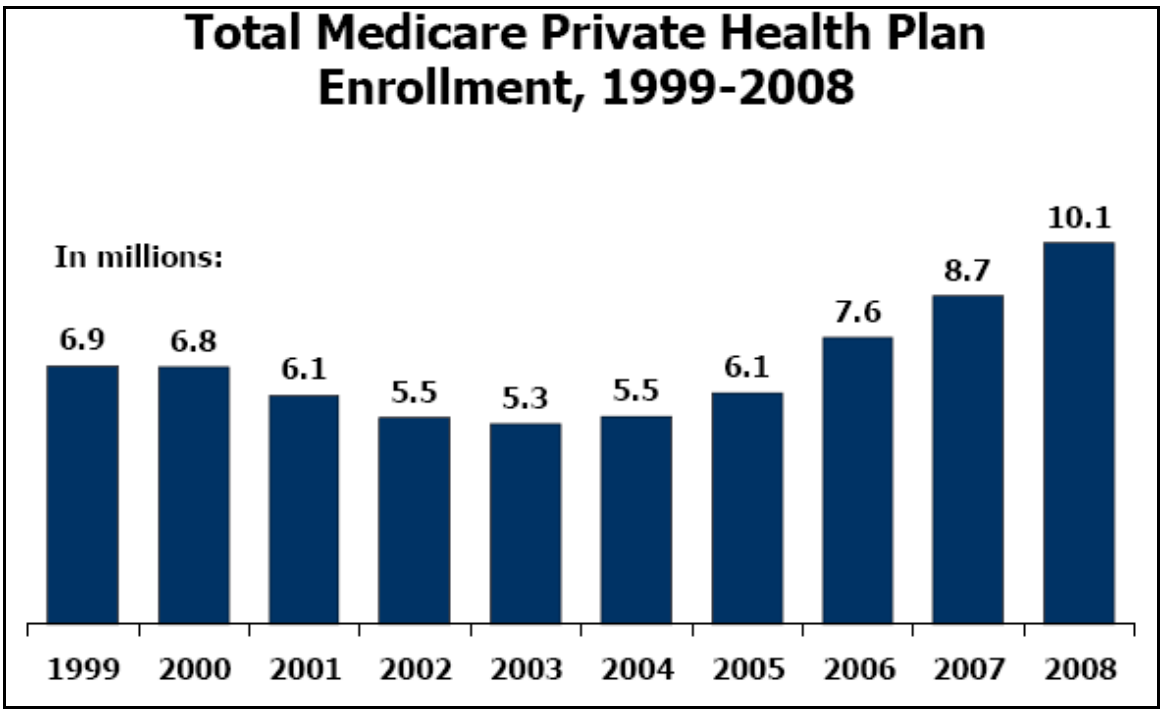
Special Needs Plans-Under the 2003 Medicare Prescription Drug, Improvement, and Modernization Act, Congress created these plans as a new type of Medicare Advantage plan for beneficiaries who had special needs. These plans are mainly HMOs, which are restricted to beneficiaries who are dually eligible for both Medicare and Medicaid, live in long-term institutions, or have certain severe and disabling conditions (MEDPAC, 2008; KFF, 2007).

APPENDIX II



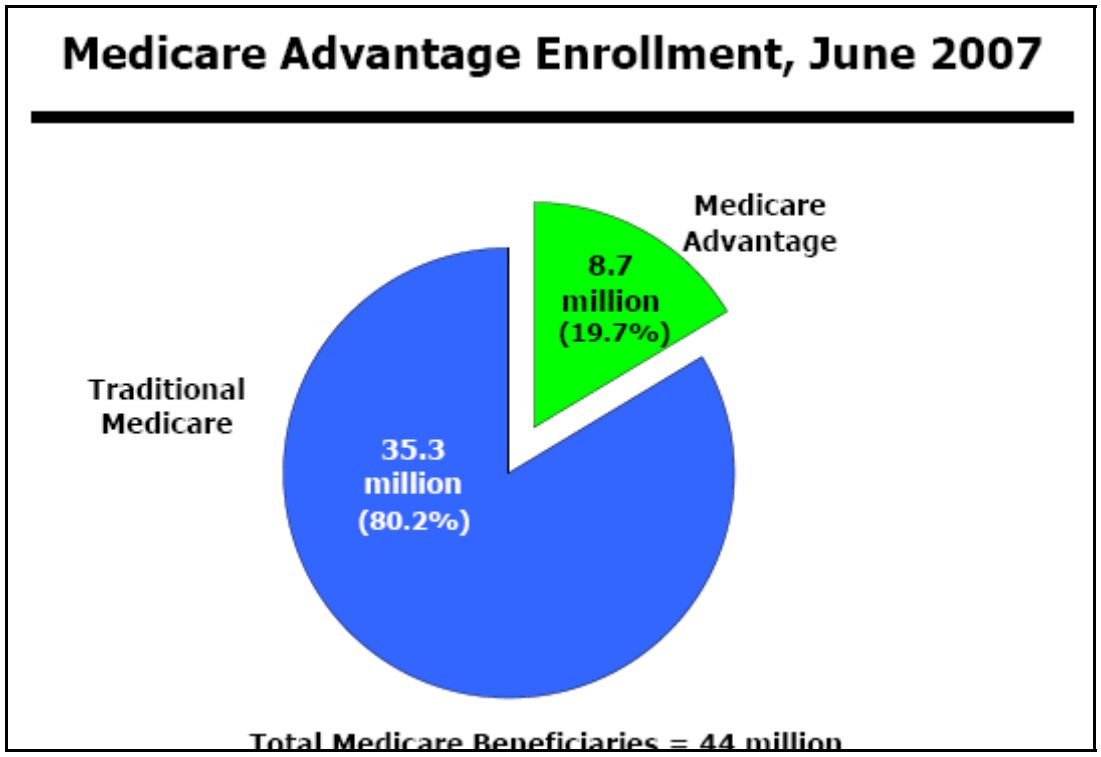
Source: Centers for Medicare & Medicaid Services. (2008a). *Medicare & You 2009*. Retrieved October 14, 2008 from http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

APPENDIX III



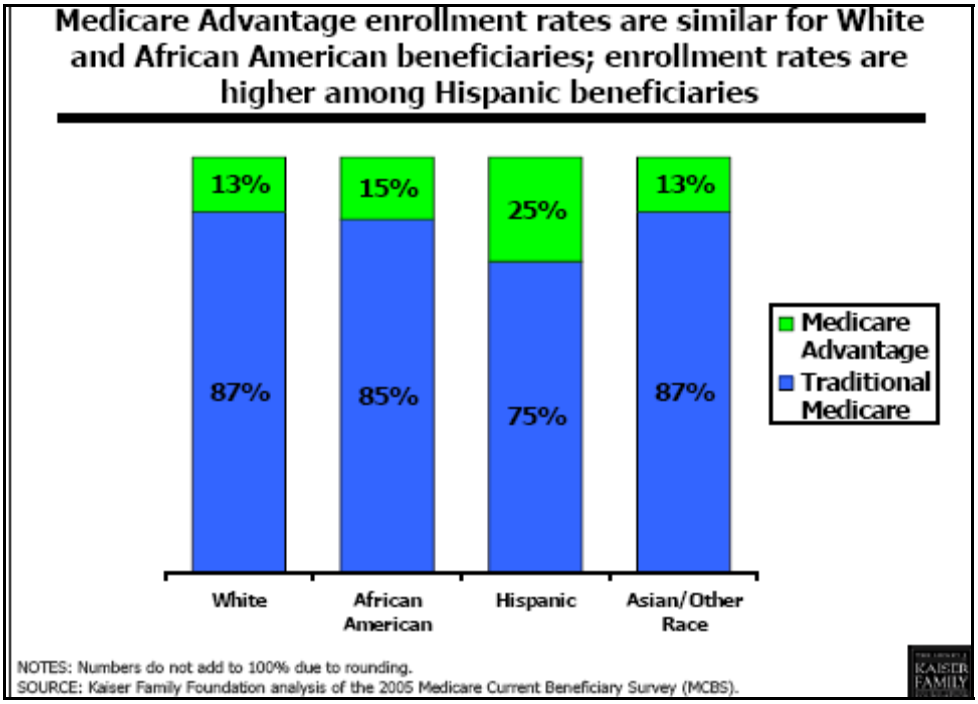
Source: Henry Kaiser Family Foundation. (2008b, September). *Medicare Advantage*. http://www.kff.org/medicare/upload/2052-11.pdf

APPENDIX IV



Source: Henry Kaiser Family Foundation. (2007b, June 28). *Medicare Advantage: Key Issues and Implications for Beneficiaries.* http://www.kff.org/medicare/upload/7664.pdf

APPENDIX V


Medicare Advantage enrollment rates are similar for White and African American beneficiaries; enrollment rates are higher among Hispanic beneficiaries
13%
87%
15%
85%
25%
75%
13%
87%
Medicare Advantage
Traditional Medicare
White
African American
Hispanic
Asian/Other Race
NOTES: Numbers do not add to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey (MCBS).

APPENDIX VI

Comparison of Requirements for Private FFS (Non-Network) Plans and other Medicare Advantage Plans*

Medicare Advantage Beneficiary Protection Plan Requirements	Network MA Plans (HMOs, PPOs)	PFFS Plans (non-network)
Beneficiary Protections		
Conduct a baseline health assessment of new enrollees	Required	Not Required
Ensure that services are accessible to members with diverse cultural and ethnic backgrounds	Required	Not Required
Identify and coordinate care of members with complex or serious medical conditions and arrange for necessary specialty care	Required	Not Required
Work with community and social service programs to ensure continuity of care and integration of services	Required	Not Required
Provider Requirements		
Establish written standards for provider consideration of member input into proposed treatment plan and advanced directives	Required	Not Required
Ensure that the hours of provider operation are convenient and do not discriminate against members	Required	Not Required
Guarantee that providers maintain member health records in accordance with established standards	Required	Not Required
Plan Review and Provider Monitoring		
Conduct utilization review and develop mechanisms to detect under- and over-utilization	Required	Not Required
Work with an independent quality review and improvement organization to perform external plan reviews	Required	Required if plan has written utilization review protocols
Collect and report data through the Health Plan Employer Data and Information Set (HEDIS) to assess and compare plan performance	Required	Not Required
Have written standards for timeliness of access to care and member services that meet or exceed CMS's standards and continuously monitor providers for compliance	Required	Not Required
Part D		
Offer an MA plan that includes the Part D drug benefit	Required	Not Required
Plans offering Part D must negotiate drug prices with manufacturers in order to provide discounted prices to members	Required	Not Required
Plans offering Part D must have a drug utilization management program and a medication therapy management program (MTMP)	Required	Not Required
Plans offering Part D must require pharmacists to disclose lower-priced generic drug options to enrollees	Required	Not Required

Source: Henry Kaiser Family Foundation. (2007a, March). *An Examination of Medicare Private Fee-for-Service Plans.* http://www.kff.org/medicare/upload/7621.pdf

REFERENCES

Andrews, M. (2008, March 6). The GAO Finds Fault With Medicare Advantage. *U.S.News & World Report*. Retrieved October 16, 2008, from http://www.usnews.com/blogs/on-health-and-money/2008/3/6/the-gao-finds-fault-with-medicare-advantage.html

Barry, P. (2008, April). The Medicare Money Muddle: Part B Premiums Are on the Rise to Pay for Private Plans. *AARP Bulletin Today*. Retrieved May 15, 2008, from http://bulletin.aarp.org/yourhealth/medicare/articles/ medicare_part_b_premiums.html

Berenson, R.A. (2004). Medicare Disadvantaged and the Search for the Elusive "Level Playing Field". Health Affairs, 27(2), w156-w165.

Biles, B., Dallek, G., & Nicolas, L.H. (2004). Medicare Advantage: Déjà Vu All Over Again? *Health Affairs*, 23(Suppl. 2), 586-597.

Centers for Medicare & Medicaid Services. (2006). *Private Fee-For Service*----- *Beneficiary Questions and Answers*. Retrieved May 30, 2008 from http://www.cms.hhs.gov/PrivateFeeforServicePlans/Downloads/benqa.pdf

Centers for Medicare & Medicaid Services. (2007). *Medicare & Home Health Care*. Retrieved September 12, 2008 from http://www.medicare.gov/Publications/ Pubs/ pdf/10969.pdf

Centers for Medicare & Medicaid Services. (2008a). *Medicare & You 2009*. Retrieved October 14, 2008 from http://www.medicare.gov/Publications/Pubs/ pdf/10050.pdf

Centers for Medicare & Medicaid Services. (2008b). *Your Guide to Medicare Private Fee-for Service Plans.* Retrieved May 30, 2008 from http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf

Centers for Medicare & Medicaid Services. (2008c). *Your Medicare Benefits.* Retrieved May 30, 2008 from http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf

Centers for Medicare & Medicare Services. (2008d) *Home Health PPS*. Retrieved October 20, 2008 from http://www.cms.hhs.gov/HomeHealthPPS/

Commonwealth Fund. (2003, April). Medicare+Choice Plans Continue to Shift More Costs to Enrollees. Retrieved October 14, 2008, from http://www.mathematica-mpr.com/PDFs/MCshiftcosts.pdf

Commonwealth Fund. (2008, April). Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choices. (Issue Brief 1117 Vol 33). Washington D.C.: O'Brien, E. & Hoadley, J.

Conditions of Participation: Home Health Agencies. 42 C.F.R. § 484 (1999).

Congressional Budget Office. (2007). *Medicare Advantage: Private Health Plans in Medicare*. Retrieved June 4, 2008 from ttp://www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf

Diamond, F. (2007, May). Medicare Advantage Hits Jackpot with Private Fee-for-service Plans. *Managed Care*. Retrieved June 15, 2008 from http://www.managedcaremag.com/archives/0705/0705.medicare_ffs.html

Emory University, Rollins School of Public Health. (2005, September). *Value of Medicare Advantage to Low-Income and Minority Beneficiaries*. Retrieved June 14, 2008, from http://www.bcbs.com/issues/medicaid/research/Value-of-Medicare-Advantage-to-Low-Income-and-Minority-Medicare-Beneficiaries.pdf

Gold, M. (2007). *Medicare Advantage In 2006–2007: What Congress Intended?* Retrieved on June 3, 2008 from http://content.healthaffairs.org/cgi/content/abstract/26/4/w445

Henry Kaiser Family Foundation. (2007a, March). *An Examination of Medicare Private Fee-for-Service Plans.* Retrieved June 9, 2008 from http://www.kff.org/medicare/upload/7621.pdf

Henry Kaiser Family Foundation. (2007b, June 28). *Medicare Advantage: Key Issues and Implications for Beneficiaries*. Retrieved June 7, 2008 from http://www.kff.org/medicare/upload/7664.pdf

Henry Kaiser Family Foundation. (2008a, January). *The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006*. Retrieved June 7, 2008 from http://www.kff.org/medicare/upload/7744.pdf

Henry Kaiser Family Foundation. (2008b, September). *Medicare Advantage*. Retrieved September 12, 2008, from http://www.kff.org/medicare/upload/2052-11.pdf

Heritage Foundation. (2008, June 13). *The Success of Medicare Advantage Plans: What Seniors Should Know*. Retrieved June 30, 2008, from http://www.heritage.org/research/healthcare/bg2142.cfm

Long Term Care Quality Reporting System--*Home Health Agencies that accept Medicare in Dallas County*: 2008 [Data File]. Austin, TX: Texas Department of Aging and Disability Services.

Madden, J.M., Graves, A.J., Zhang, F., Adams, A.S., Briesacher, B.A., Ross-Degnan, D. R., et al. (2008). Cost-Related Medication Nonadherence and Spending on Basic Needs Following Implementation of Medicare Part D. *Journal of American Medical Association*, 299 (16), 1922-1928.

Mathematica Policy Research, Inc. (2006, July 17). *Analyses of the Characteristics of Medicare Advantage Plan Participation.* (MPR Reference No: 6219-600). Washington, DC: Gold, M.

Mathews, A. W., & Zhange, J. (2008). How Changes in Medicare Affect Patients. *The Wall Street Journal Online*. Retrieved July 17, 2008 from http://online.wsj.com/article/SB121623946819959433.html?mod=2_1566_leftbox

Mays, G.P., Claxton, G, & White, J. (2004). *Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies.* Retrieved December 5, 2006 from http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.427v1.pdf.

Medicare Options Compare (2008). Retrieved July 9. 2008 from http://www.medicare.gov/PPF/Include/DataSection/Questions/SearchOptions.asp

MedPAC (nd). About MedPAC. Retrieved October 15, 2008, from http://www.medpac.gov/about.cfm

MedPAC. (2007). Medicare Advantage Program Payment System-Payment Basics. Retrieved June 3, 2008 from http://www.medpac.gov/documents/

MedPAC_Payment_Basics_07_MA.pdf

MedPAC (2008a, March). Home Health Services. In *Report to Congress* (sec. 2E). Retrieved October 18, 2008 from http://www.medpac.gov/chapters/Mar08_Ch02e.pdf

MedPAC (2008b, June). A Data Book-Healthcare Spending and the Medicare Program. Retrieved July 20, 2008 from http://www.medpac.gov/documents/Jun08DataBook_Entire_report.pdf

National Association for Home Care & Hospice (2008, July 21). How the Recently Passed Medicare Bill Affects You. Retrieved July 23, 2008 from http://www.nahc.org/tango/report/mbrs/MBRsearch.taf?function=detail&Layout1_uid1=37345

National Care Planning Council (2006, October 25) Survey Reveals Serious Flaws with Medicare Advantage Plans. Retrieved November 13, 2008 from http://www.longtermcarelink.net/article-2006-10-25.htm

Stout, D. (2008, July 10). Kennedy Casts Key Vote as Medicare Bill Passes. New York Times. Retrieved July 15, 2008 from http://www.nytimes.com/2008/07/10/washington/10kennedy.html?_r=1&oref=slogin&pagewanted=print

Venes, D. (2005). *Taber's Cyclopedic Medical Dictionary* (20th ed). Philadelphia: F.A. Davis Co.