HHFMA Medicare Advantage Managed Care Survey

Conducted: January 7, 2014 – June 9, 2014

The purpose of the survey was to identify the methods of payment and coverage variations by payor across the country by state. The results are to be provided to the membership to assist by eliminating surprises to the provider, identify most desirable payor(s) for proposals and Identify best approaches for negotiation.

Summary of Questions and page reference to survey results:

RESPONSES

Total of 202 responses received

1. In which state(s) does your company provide home health care? Please list all states where you provide home care through a Medicare Advantage plan.

Answer Options	Response Percent	Response Count
Alabama	1.5%	3
Alaska	0.5%	1
Arizona	3.0%	6
Arkansas	4.5%	9
California	9.9%	20
Colorado	1.5%	3
Connecticut	4.0%	8
District of Columbia	0.5%	1
Delaware	0.0%	0
Florida	1.5%	3
Georgia	2.5%	5
Guam	0.0%	0
Hawaii	1.5%	3
Idaho	1.0%	2
Illinois	4.5%	9
Indiana	8.4%	17
Iowa	0.0%	0
Kansas	2.0%	4
Kentucky	3.0%	6
Louisiana	0.0%	0
Maine	0.5%	1
Maryland	3.0%	6
Massachusetts	2.5%	5
Michigan	2.5%	5
Minnesota	0.5%	1
Mississippi	0.0%	0
Missouri	9.9%	20
Montana	0.0%	0
Nebraska	1.0%	2
Nevada	0.5%	1
New Hampshire	0.5%	1
New Jersey	0.5%	1
New Mexico	2.0%	4
New York	1.5%	3
North Carolina	6.4%	13
North Dakota	0.0%	0
Ohio	5.4%	11
Oklahoma	1.0%	2
Oregon	2.0%	4

Pennsylvania	5.4%	11
Puerto Rico	0.0%	0
Rhode Island	2.5%	5
South Carolina	2.5%	5
South Dakota	0.5%	1
Tennessee	1.5%	3
Texas	4.0%	8
Utah	0.5%	1
Vermont	1.0%	2
Virginia	2.0%	4
Washington	1.5%	3
West Virginia	0.5%	1
Wisconsin	1.5%	3
Wyoming	0.0%	0
answered question		202
skipped question		8
Number answering 2 or more States		10
Total State responses		227

Sorted by Response Quantity

Answer Options	Response Percent	Response Count
California	9.9%	20
Missouri	9.9%	20
Indiana	8.4%	17
North Carolina	6.4%	13
Ohio	5.4%	11
Pennsylvania	5.4%	11
Arkansas	4.5%	9
Illinois	4.5%	9
Connecticut	4.0%	8
Texas	4.0%	8
Arizona	3.0%	6
Kentucky	3.0%	6
Maryland	3.0%	6
Georgia	2.5%	5
Massachusetts	2.5%	5
Michigan	2.5%	5
Rhode Island	2.5%	5
South Carolina	2.5%	5
Kansas	2.0%	4
New Mexico	2.0%	4
Oregon	2.0%	4
Virginia	2.0%	4
Alabama	1.5%	3
Colorado	1.5%	3
Florida	1.5%	3

Hawaii	1.5%	3
New York	1.5%	3
Tennessee	1.5%	3
Washington	1.5%	3
Wisconsin	1.5%	3
Idaho	1.0%	2
Nebraska	1.0%	2
Oklahoma	1.0%	2
Vermont	1.0%	2
Alaska	0.5%	1
District of Columbia	0.5%	1
Maine	0.5%	1
Minnesota	0.5%	1
Nevada	0.5%	1
New Hampshire	0.5%	1
New Jersey	0.5%	1
South Dakota	0.5%	1
Utah	0.5%	1
West Virginia	0.5%	1
Delaware	0.0%	0
Guam	0.0%	0
Iowa	0.0%	0
Louisiana	0.0%	0
Mississippi	0.0%	0
Montana	0.0%	0
North Dakota	0.0%	0
Puerto Rico	0.0%	0
Wyoming	0.0%	0

2. Please list the Medicare Advantage plans that you contract with.

answered question		202
Total Answers		692
Blues Cross Blue Shield, Anthem	128	18.50%
UnitedHealthCare, Pacificare, Secure Horizons	95	13.73%
Humana	89	12.86%
Aetna	56	8.09%
Care Improvement Plus	21	3.03%
NONE, N/A	21	3.03%
Coventry	18	2.60%
Healthnet	16	2.31%
Tricare, VA	11	1.59%
Wellpath	10	1.45%
ADVANTRA	10	1.45%
Cigna	9	1.30%
Today's Options	8	1.16%
Connecticare	7	1.01%
ESSENSE	7	1.01%
AARP	6	0.87%
Kaiser	6	0.87%
Pyramid	6	0.87%
Windsor	6	0.87%
Universal	6	0.87%
Bravo	5	0.72%
Geisinger	5	0.72%
HealthSprings	5	0.72%
Priority Health Medicare	5	0.72%
SCAN	5	0.72%
UPMC For Life	5	0.72%
Carecentrix	4	0.58%
Molina	4	0.58%
MVP USA	4	0.58%
Sterling	4	0.58%
Advantage Preferred	3	0.43%
America's First Choice	3	0.43%
Amerigroup	3	0.43%
Care 1st Health Plan	3	0.43%
Harvard Pilgrim	3	0.43%
Improvement Plus	3	0.43%
Tufts Medicare Preferred Replacement	3	0.43%

Amerivantage	2	0.29%
ATRIO	2	0.29%
Caremore Touch	2	0.29%
CareSource	2	0.29%
CIP	2	0.29%
Easy Choice	2	0.29%
Erickson Advantage	2	0.29%
Health Advantage	2	0.29%
HMSA Medicare	2	0.29%
Lovelace	2	0.29%
Medipak Advantage	2	0.29%
Oxford	2	0.29%
Presbyterian Healthcare Services	2	0.29%
Rody	2	0.29%
Univita	2	0.29%
1st Choice	1	0.14%
4 Your Choice	1	0.14%
Advocare	1	0.14%
Aloha Care Medicare	1	0.14%
Amco Arkansas Community Care	1	0.14%
American Progressive	1	0.14%
Americheath 65	1	0.14%
Americhoice Secure Plus	1	0.14%
Arkansas Community Care	1	0.14%
BABAS GA PPO	1	0.14%
Bridgeway Advantage	1	0.14%
Buckeye	1	0.14%
Central Health	1	0.14%
Citizens Choice	1	0.14%
Community Health Plan Of Washington	1	0.14%
COMMUNITY HEALTH PLANS	1	0.14%
CrestPoint Health	1	0.14%
EOCCO	1	0.14%
Evercare	1	0.14%
Fallon Community Health	1	0.14%
First Care	1	0.14%
Gateway Assured	1	0.14%
Gemcare	1	0.14%
Generations Advantage	1	0.14%
GHI	1	0.14%
HCP	1	0.14%
Health Care Partners	1	0.14%
Health Partners Senior	1	0.14%

HIP	1	0.14%
IBC	1	0.14%
Independent Health	1	0.14%
Inland Empire Health Plan	1	0.14%
Insurance Management Systems,	1	0.14%
IU Clarion	1	0.14%
Mail Handlers Benefit Plan	1	0.14%
Martin's Point	1	0.14%
MC ADV GROUP HEALTH MC ADV	1	0.14%
Med Cost	1	0.14%
Medigold	1	0.14%
Mercycare	1	0.14%
Midcoast	1	0.14%
My Plan	1	0.14%
Neighborhood	1	0.14%
Ohana Medicare Advantage	1	0.14%
Optima	1	0.14%
PACE	1	0.14%
PFFS	1	0.14%
Premera	1	0.14%
Premier Care MODA/	1	0.14%
Primetime	1	0.14%
Professional Healthcare Network	1	0.14%
Select Health,	1	0.14%
Senior Whole Health	1	0.14%
Spring	1	0.14%
SummaCare	1	0.14%
UCare for Seniors	1	0.14%
VIP Care	1	0.14%
VIVA Health	1	0.14%
Workers Compensation	1	0.14%

3. Please list all the Medicare Advantage plans that you provide care for, but not under a contract.

answered question	157
skipped question	53
Total answers	319

Humana,	52	16.30%
United Healthcare,	52	16.30%
Aetna,	47	14.73%
Blue Cross Blue Shield,	26	8.15%
Care Improvement Plus,	13	4.08%
Today's Options,	12	3.76%
Advantra,	11	3.45%
Pyramid Today's Option,	9	2.82%
CIGNA,	8	2.51%
Coventry,	6	1.88%
Sterling	6	1.88%
Tricare	6	1.88%
America's First Choice	5	1.57%
Wellcare,	5	1.57%
Windsor,	4	1.25%
Kaiser,	3	0.94%
Universal Healthcare PPS	3	0.94%
Care Centrix	2	0.63%
CIP,	2	0.63%
First Choice VIP	2	0.63%
GEISINGER GOLD	2	0.63%
Group Health (Seattle);	2	0.63%
Health Net,	2	0.63%
Health Springs	2	0.63%
Medical Mutual,	2	0.63%
MVP Health Plans	2	0.63%
Advantage Health Solutions,	1	0.31%
All	1	0.31%
America's First Choice	1	0.31%
Arcadian	1	0.31%
Atrio	1	0.31%
Choice PPO,	1	0.31%
ConnectiCare,	1	0.31%
Dual Complete	1	0.31%
Erickson Advantage	1	0.31%

Evercare	1	0.31%
Freedom First Health and Life	1	0.31%
Guardian	1	0.31%
HAP	1	0.31%
Health Alliance	1	0.31%
Health Market,	1	0.31%
Health Partners,	1	0.31%
Healthfirst	1	0.31%
Healthne	1	0.31%
HIPP Healthplan	1	0.31%
HMSA Akamai Advantage	1	0.31%
IU Health	1	0.31%
Molina	1	0.31%
Network Hlth,	1	0.31%
Ohana Liberty Helath Plan	1	0.31%
OSF Care,	1	0.31%
PrimeTime Health	1	0.31%
Scan and	1	0.31%
Senior Unicare Plan	1	0.31%
Senior Whole Health	1	0.31%
Southeast Community Care	1	0.31%
Tufts Medicare Preferred,	1	0.31%
UPMC FOR LIFE	1	0.31%
Viva	1	0.31%

4. What is the estimated number of unduplicated Medicare Advantage home health patients that your company served in 2013?

Answer Options	Response Percent	Response Count
<100	39.6%	80
101-250	28.7%	58
251-500	6.9%	14
501-1000	12.9%	26
1001-2000	3.5%	7
>2000	8.4%	17
	answered question	202
	skipped question	8

The following matrix details answers by State. Where multiple State answers were provided, the assumed dominant State was used.

Volume of unduplicated Medicare Advantage home health patients served within 2013

	<100	101-250	251-500	501-1000	1001-2000	>2000	Total
Alabama	1				1		2
Alaska	1						1
Arizona		2	2				4
Arkansas	5	1	1	1	1		9
California	7	6		4		3	20
Colorado	2			1			3
Connecticut		4	1	1	1		7
Florida		2					2
Georgia	1	1		1			3
Hawaii		3					3
Idaho		1		1			2
Illinois	5	2	1				8
Indiana	9	5		1			15
Kansas	1			1			2
Kentucky	2	2	1				5
Maine				1			1
Maryland	3	1					4
Massachusetts	2		1	1	1		5
Michigan	1	1		3			5
Minnesota	1						1
Missouri	10	4	1	2		1	18
Nebraska	2						2
Nevada		1					1
New Hampshire		1					1
New Jersey						1	1
New Mexico	1	2					3
New York		1		1		1	3
North Carolina	5	3	1	1	1	1	12
Ohio	3	5				3	11
Oklahoma	2						2
Oregon	2	1		1			4
Pennsylvania	2	3	1	1		4	11
Rhode Island	1		1	2			4
South Carolina		1			1	1	3
South Dakota	1						1
Tennessee			1			1	2
Texas	4	1	1	1		1	8
Utah				1			1
Vermont	2						2
Virginia		1	1		1		3
Washington	2	1					3
West Virginia	1						1
Wisconsin	1	2					3
Totals	80	58	14	26	7	17	202

5. What was the estimated volume of visits that you provided to Medicare Advantage patients in 2013?

Answer Options	Response Percent	Response Count
Under 500	30.2%	61
500-1000	17.3%	35
1000-5000	28.2%	57
5000-10000	8.9%	18
Over 10000	15.3%	31
	answered question	202
	skipped question	8

Responses by State

	Under 500	500-1000	1000-5000	5000-10000	Over 10000	Total
Alabama		1			1	2
Alaska	1					1
Arizona			3	1		4
Arkansas	4	2	2	1		9
California	8	3	4	2	3	20
Colorado	2	1				3
Connecticut		1	3	1	2	7
Florida	1		1			2
Georgia	1	1		1	1	4
Hawaii		1	2			3
Idaho			1	1		2
Illinois	5	2	1			8
Indiana	7	2	4	1		14
Kansas	1				1	2
Kentucky	2		2	1		5
Maine					1	1
Maryland	2	1	1			4
Massachusetts	2			2	1	5
Michigan		1	1	1	2	5
Minnesota			1			1
Missouri	8	3	4	2	1	18
Nebraska	2					2
Nevada		1				1
New Hampshire			1			1
New Jersey					1	1
New Mexico	1		2			3
New York			1		2	3
North Carolina	3	3	2	1	3	12
Ohio	4		5		2	11
Oklahoma	1	1				2
Oregon	1	1	1		1	4
Pennsylvania	1	3	2	1	4	11
Rhode Island	1	1	2			4
South Carolina		1		1	1	3
South Dakota	1					1
Tennessee			1		1	2
Texas		3	2	1	2	8
Utah					1	1
Vermont	1	1				2
Virginia		1	2			3
Washington	1		2			3
West Virginia			1			1
Wisconsin			3			3
Totals	61	35	57	18	31	202

6. Describe your company (check all that apply).

Answer Options	Response Percent	Response Count
a. Freestanding	42.6%	86
b. Institution-based (hospital/SNF)	19.8%	40
c. Health system affiliated	13.4%	27
d. Government-based	6.9%	14
e. For-profit	29.7%	60
f. Non-profit	40.6%	82
	answered question	202
	skipped question	8
	Total answers	309

Responses by State

	Freestanding	Institution-based (hospital/SNF)	Health system affiliated	Gov-based	For-profit	Non-profit	Total
Alabama	1			1		1	3
Alaska			1			1	2
Arizona	2		1		4		7
Arkansas		3	1	1	1	5	11
California	11	2		1	10	4	28
Colorado	2		1		2	1	6
Connecticut	5	1	1			5	12
Florida	1					1	2
Georgia	3				1	1	5
Hawaii	1	2				1	4
Idaho	1		1		2		4
Illinois	1	1	1	2	3	1	9
Indiana	5	5	1		7	2	20
Kansas	1				1	1	3
Kentucky		1	1	1		5	8
Maine	1					1	2
Maryland		2	1			3	6
Massachusetts	3		1			4	8
Michigan	2		3		1	3	9
Minnesota						1	1
Missouri	10	4	1	1	5	9	30
Nebraska			1	1		2	4
Nevada		1					1
New Hampshire	1		1			1	3
New Jersey	1					1	2
New Mexico	2	1			1	1	5
New York	2		1			3	6
North Carolina	3	1	1	4	2	6	17
Ohio	4	3	3	1	3	2	16
Oklahoma	2				2		4
Oregon	2	2				1	5
Pennsylvania	5	2	2	1	3	6	19
Rhode Island	2		1		3		6
South Carolina		2			1	1	4
South Dakota					1		1
Tennessee	2		1		1		4
Texas	6	1			5	1	13
Utah	1						1
Vermont	2					2	4
Virginia	1	1				1	3
Washington		2			1	2	5
West Virginia		1				1	2
Wisconsin		2	1			1	4
Totals	86	40	27	14	60	82	309

7. What percentage of your revenue comes from traditional Medicare and Medicare Advantage?

Answer Options	Traditional Medicare	Medicare Advantage	Response Count
a. None	1	6	6
b. 0-20%	9	126	130
c. 21-40%	23	53	69
d. 41-60%	49	9	56
e. Above 60%	120	4	123
		answered question	202
		skipped question	8

Responses by State

	None - Traditional Medicare	None - Medicare Advantage	0-20% - Traditional Medicare	0-20% - Medicare Advantage	21-40% - Traditional Medicare	21-40% - Medicare Advantage	41-60% - Traditional Medicare	41-60% - Medicare Advantage	Above 60% - Traditional Medicare	Above 60% - Medicare Advantage
Alabama				2					2	
Alaska		1					1			
Arizona				2		2	1		3	
Arkansas			1	8	2		1		5	
California	1	1	3	11	2	4	2	3	12	
Colorado				3					3	
Connecticut		1		6	1		6			
Florida				2					2	
Georgia				3		1	1		3	
Hawaii					1	2	2	1		
Idaho				1			1	1	1	
Illinois				8			1		7	
Indiana		2	1	7	1	5	6		6	
Kansas				1		1	1		1	
Kentucky				3	1	1	3	1	1	
Maine				1					1	
Maryland				3		1			4	
Massachuset				5			2		3	
Michigan				3		1	1		4	
Minnesota				1			1			
Missouri				9	1	7	4		13	1
Nebraska				2					2	
Nevada				1					1	
New Hampsh				1					1	
New Jersey				1					1	
New Mexico				1	1	2	1		1	
New York				1	1	2			2	
North Carolin				9	3	1	1	1	8	1
Ohio				5	2	6	4		5	
Oklahoma				1		1			2	
Oregon			1	2	1	2			2	
Pennsylvania			1	2	1	7	4	1	5	1
Rhode Island		1	2	2		1	2			
South Carolin				2		1			3	
South Dakota				1					1	
Tennessee				1		1			2	
Texas				6	2	2	1		5	
Utah						1			1	
Vermont				2	1		1			
Virginia				2	1		1	1	1	
Washington				3					3	
West Virginia									1	1
Wisconsin				2	1	1			2	
Totals	1	6	9	126	23	53	49	9	120	4

8. What percentage of your revenue comes from Medicaid?

Answer Options	Traditional Medicaid	Waiver Programs	Medicaid Managed Care (HMO, etc.)	Response Count
a. None	20	35	37	92
b. 0-20%	90	20	61	171
c. 21-40%	22	8	16	46
d. 41-60%	7	5	1	13
e. Above 60%	3	4	1	8
			answered question	202
			skipped question	8

Responses by State

	None			0-20%			21-40%			41-60%			Above 60%		
	Traditional Medicaid	Waiver Programs	Medicaid Managed Care	Traditional Medicaid	Waiver Programs	Medicaid Managed Care	Traditional Medicaid	Waiver Programs	Medicaid Managed Care	Traditional Medicaid	Waiver Programs	Medicaid Managed Care	Traditional Medicaid	Waiver Programs	Medicaid Managed Care
Alabama			1										1		
Alaska			1				1								
Arizona	2		1	1											
Arkansas			4	3	1	1	2	1		1				1	
California		11	1	6	1	13	2		2		1			1	
Colorado			1		2	1		1							
Connecticut			3	3	2	1	3			1					
Florida	1			1											
Georgia			1	3		1									
Hawaii	3				1	2									
Idaho			1	2											
Illinois	1	1	2	4	1	2									
Indiana	2	4	4	6	3	3	1	2	1	2			1		
Kansas	1			1											
Kentucky		1		2	1	2	1	1	1		1	1			
Maine		1		1											
Maryland			1	1		2									
Massachusetts	1	1		3		1									
Michigan		2		3		2									
Minnesota				1											
Missouri	1	1	5	11		4	2								
Nebraska				1		1	1								
Nevada				1											
New Hampshire			1		1										
New Jersey						1									
New Mexico				1		2					1				
New York				2		1	1		1						
North Carolina		1	5	7	1		2			2			1		
Ohio	2	6		4	1	4	1		2						
Oklahoma		1	1	1	1										
Oregon	1			1		3			1						
Pennsylvania	1			5		5	1	1	2	1					1
Rhode Island	1			2	1				1					1	
South Carolina				1		2	2				1				
South Dakota				1											
Tennessee					1	1	1								
Texas	2	3	1	3	1	2			3						
Utah	1					1	1				1			1	
Vermont			1	1	1			2							
Virginia			1	2		1			1						
Washington			1	1		2									
West Virginia		1		1											
Wisconsin		1		3					1						
Totals	20	35	37	90	20	61	22	8	16	7	5	1	3	4	1

9. The following questions relate to the top 5, by visit volume, Medicare Advantage plans that you do business with. Please list the top 5 plans.

The following questions relate to the top 5, by visit volume, Medicare Advantage plans that you do business with. Please list the top 5 plans.		
Answer Options	**Response Percent**	**Response Count**
Plan 1	100.0%	202
Plan 2	93.1%	188
Plan 3	79.7%	161
Plan 4	59.4%	120
Plan 5	45.0%	91
answered question		202
skipped question		8
Total answers		762
Edited total answers		755

Edited Plans Sorted by Number of Responses for Top 5

PLAN	Plan Count	% to Total
Blue Cross Blue Shield, all Blues	150	19.87%
Humana	128	16.95%
United	117	15.50%
Aetna	71	9.40%
Care Improvement Plus	34	4.50%
Coventry	21	2.78%
Healthnet	14	1.85%
Today's Option	9	1.19%
AARP	8	1.06%
ADVANTRA	8	1.06%
Pyramid Life	8	1.06%
Wellcare	8	1.06%
Connecticare	7	0.93%
Essence	7	0.93%
Windsor	7	0.93%
Kaiser	6	0.79%
Tricare	6	0.79%
Advantage Health Solutions	5	0.66%

Cigna	5	0.66%
Health Spring	5	0.66%
Priority Health	5	0.66%
SCAN	5	0.66%
UPMC For Life	5	0.66%
Bravo	4	0.53%
Geisinger Gold	4	0.53%
Molina	4	0.53%
Tufts	4	0.53%
Amerigroup	3	0.40%
CareCentrix	3	0.40%
CIP	3	0.40%
HMSA Medicare	3	0.40%
Med mutual	3	0.40%
Medipak Advantage	3	0.40%
MVP	3	0.40%
Ohana	3	0.40%
America's First Choice	2	0.26%
Amerivantage	2	0.26%
Atrio	2	0.26%
Community Health Plan Of Washington	2	0.26%
Erickson Advantage	2	0.26%
Group Health	2	0.26%
Harvard Pilgrim	2	0.26%
Lovelace Senior Plan	2	0.26%
Pacific Source	2	0.26%
Presbyterian	2	0.26%
Univita	2	0.26%
VIVA Health	2	0.26%
Wellpath MA	2	0.26%
Willamette Valley Community Health Atrio Marion-Polk Commercial	2	0.26%
Advocare	1	0.13%
Aloha Care Medicare	1	0.13%
Altius	1	0.13%
American Progressiv	1	0.13%
Americhoice Secure Plus	1	0.13%
Brand New Day	1	0.13%
Bridgeway Advantage	1	0.13%
Caremore	1	0.13%
Caresource	1	0.13%

Choice VNSNY	1	0.13%
Connect Care	1	0.13%
Evercare	1	0.13%
Fallon Community Health Plan	1	0.13%
Fidelis	1	0.13%
First Advantage	1	0.13%
Gateway Assured	1	0.13%
Generations Advantage	1	0.13%
GHI	1	0.13%
Health Alliance	1	0.13%
Health America Advantra	1	0.13%
Health Partners Senior	1	0.13%
Health Plan Secure	1	0.13%
Healthcare Partners	1	0.13%
Healthfirst	1	0.13%
HIP	1	0.13%
HPSM - MC Advantage	1	0.13%
IBC	1	0.13%
Independent Health	1	0.13%
IU Clarion	1	0.13%
MEDICARE COMPLETE	1	0.13%
Medicare Replacement	1	0.13%
MEdigold	1	0.13%
Mercycare Advantage	1	0.13%
MetroPlus	1	0.13%
MODA EOCCO	1	0.13%
Neighborhood	1	0.13%
Oxford	1	0.13%
PHCN	1	0.13%
Premera	1	0.13%
Premier Care	1	0.13%
Rhody	1	0.13%
RMHP (special federal FFS program)	1	0.13%
Rocky Mt Health Plan	1	0.13%
Select Health	1	0.13%
Senior Whole Health	1	0.13%
Sterling	1	0.13%

UCare	1	0.13%
Universal	1	0.13%

10. What is the reimbursement method that the plan uses for home health services?

Answer Options	Episodic	Visit	Capitated	Response Count
Plan 1	98	96	5	199
Plan 2	84	99	1	184
Plan 3	76	79	2	157
Plan 4	59	56	2	117
Plan 5	53	35	0	88
	370	365	10	745
	49.66%	48.99%	1.34%	
			answered question	199
			skipped question	11

Detail by Top 23 Carriers

	Episodic	Visit	Capitated
Blue Cross Blue Shield	59	84	3
Humana	94	31	2
United	45	68	1
Aetna	41	29	1
Care Improvement Plus	32	1	3
Coventry	7	14	
Healthnet	3	11	
Today's Option	9		
AARP	1	7	
ADVANTRA	4	4	
Pyramid Life	8		
Wellcare	4	3	
Connecticare		7	
Essence		7	
Windsor	2	5	
Kaiser		6	
Tricare	6		
Advantage Health Solut	5		
Cigna	2	2	1
Health Spring	1	2	1
Priority Health	1	4	
SCAN	2	3	
UPMC For Life		5	

11. How are Non-Routine Medical Supplies reimbursed?

How are Non-Routine Medical Supplies reimbursed?							
Answer Options	**With Episode payment**	**Capitated rate**	**Fixed fee**	**% of charges**	**Plan provides supplies**	**Not reimbursed separately**	**Response Count**
Plan 1	90	8	11	8	24	61	202
Plan 2	67	8	9	15	23	64	186
Plan 3	64	3	7	9	13	63	159
Plan 4	50	3	6	2	11	46	118
Plan 5	49	1	3	2	7	29	91
Totals	320	23	36	36	78	263	756
	42.33%	3.04%	4.76%	4.76%	10.32%	34.79%	
						answered question	**202**
						skipped question	**11**

Detail by Top 23 Carriers

	With Episode payment	Capitated rate	Fixed fee	% of charges	Plan provides supplies	Not reimbursed separately
Blue Cross Blue Shield	51	8	10	12	17	52
Humana	78	4	3	5	7	31
United	38	3	7	2	11	57
Aetna	33	0	3	4	6	24
Care Improvement Plus	25	1	2	1	0	5
Coventry	3	2	0	2	2	12
Healthnet	11	0	0	0	0	5
Today's Option	7	0	0	0	0	2
AARP	1	2	0	0	1	4
ADVANTRA	9	0	0	0	0	4
Pyramid Life	7	0	0	0	0	1
Wellcare	4	0	0	0	1	2
Connecticare	0	0	1	1	2	3
Essence	1	0	0	0	1	5
Windsor	4	0	0	2	1	1
Kaiser	0	0	0	0	3	3
Tricare	4	0	0	0	1	1
Advantage Health Solutions	4	0	0	0	0	1
Cigna	2	1	0	0	1	1
Health Spring	1	0	0	1	1	0
Priority Health	0	0	0	0	3	2
SCAN	2	0	0	1	1	1
UPMC For Life	0	0	0	0	1	4

12. If the plan exclusively reimburses with per visit payment, how do those visit rates compare with your Medicare LUPA rate?

If the plan exclusively reimburses with per visit payment, how do those visit rates compare with your Medicare LUPA rate?					
Answer Options	**LUPA rates**	**10+% > LUPA**	**10+% < LUPA**	**Not applicable**	**Response Count**
Plan 1	28	26	56	62	172
Plan 2	24	20	60	52	156
Plan 3	15	13	60	47	135
Plan 4	12	14	37	35	98
Plan 5	14	4	28	35	81
	93	77	241	231	642
	14.49%	11.99%	37.54%	35.98%	
				answered question	**185**
				skipped question	**25**

Detail by Top 23 Carriers

	LUPA rates	10+% > LUPA	10+% < LUPA	Not applicable
Blue Cross Blue Shield	17	17	56	37
Humana	17	7	23	57
United	15	13	43	28
Aetna	8	4	19	28
Care Improvement Plus	4	0	4	22
Coventry	0	4	11	4
Healthnet	11	2	2	7
Today's Option	4	0	1	3
AARP	2	0	5	0
ADVANTRA	2	0	4	4
Pyramid Life	0	0	1	5
Wellcare	0	0	3	3
Connecticare	0	0	4	1
Essence	0	1	6	0
Windsor	2	0	3	2
Kaiser	1	2	2	1
Tricare	1	0	0	3
Advantage Health Solutions	0	0	0	2
Cigna	0	0	1	4
Health Spring	1	2	0	0
Priority Health	0	3	0	1
SCAN	0	1	2	1
UPMC For Life	1	0	4	0

13. If the plan pays on an episode basis, what is the payment rate?

If the plan pays on an episode basis, what is the payment rate?						
Answer Options	**Medicare PPS rates**	**10+% > Medicare PPS**	**10+% < Medicare PPS**	**Lower of PPS or Charges**	**Not applicable**	**Response Count**
Plan 1	77	4	10	14	75	180
Plan 2	63	4	7	12	70	156
Plan 3	62	1	5	11	58	137
Plan 4	52	1	6	4	42	105
Plan 5	47	0	4	4	25	80
	301	10	32	45	270	658
	45.74%	1.52%	4.86%	6.84%	41.03%	
					answered question	**188**
					skipped question	**22**

Detail by Top 23 Carriers

	Medicare PPS rates	10+% > Medicare PPS	10+% < Medicare PPS	Lower of PPS or Charges	Not applicable
Blue Cross Blue Shield	51	2	5	8	69
Humana	74	3	9	10	19
United	40	0	1	6	43
Aetna	35	0	2	3	24
Care Improvement Plus	19	0	8	4	1
Coventry	3	0	2	2	9
Healthnet	0	0	1	0	0
Today's Option	7	0	1	1	0
AARP	1	0	0	0	4
ADVANTRA	7	1	1	1	3
Pyramid Life	7	0	1	0	0
Wellcare	3	0	0	1	2
Connecticare	0	0	0	0	4
Essence	0	0	0	0	5
Windsor	3	0	0	0	2
Kaiser	1	0	0	0	4
Tricare	5	0	0	0	0
Advantage Health Solutions	3	0	1	1	0
Cigna	3	0	0	0	2
Health Spring	1	0	0	0	2
Priority Health	1	0	0	0	2
SCAN	2	0	0	1	2
UPMC For Life	0	0	0	0	5

14. Does the plan have a patient annual deductible?

Does the plan have a patient annual deductible?				
Answer Options	**Yes**	**No**	**Unknown**	**Response Count**
Plan 1	52	92	51	195
Plan 2	49	76	57	182
Plan 3	46	61	46	153
Plan 4	34	48	32	114
Plan 5	21	39	28	88
	202	316	214	732
	27.60%	43.17%	29.23%	
			answered question	196
			skipped question	14

Detail by Top 23 Carriers

	Yes	No	Unknown
Blue Cross Blue Shield	42	65	39
Humana	38	55	34
United	36	41	35
Aetna	25	23	21
Care Improvement Plus	11	19	4
Coventry	10	8	4
Healthnet	6	2	2
Today's Option	3	3	2
AARP	1	2	4
ADVANTRA	2	6	4
Pyramid Life	1	6	1
Wellcare	1	2	4
Connecticare	0	5	2
Essence	2	4	1
Windsor	2	5	0
Kaiser	0	4	1
Tricare	1	2	3
Advantage Health Solutions	0	2	2
Cigna	1	3	1
Health Spring	0	3	0
Priority Health	0	3	2
SCAN	2	1	2
UPMC For Life	2	1	2

15. If the plan has an annual deductible, do you bill for it?

Answer Options	Yes	No	No deductible	Unknown	Response Count
Plan 1	58	26	66	29	179
Plan 2	61	20	56	29	166
Plan 3	52	17	45	23	137
Plan 4	41	11	35	20	107
Plan 5	32	6	30	13	81
	244	80	232	114	670
	36.42%	11.94%	34.63%	17.01%	
				answered question	187
				skipped question	23

Detail by Top 23 Carriers

	Yes	No	No deductible	Unknown
Blue Cross Blue Shield	50	13	48	23
Humana	41	14	37	19
United	43	11	23	18
Aetna	31	8	17	9
Care Improvement Plus	12	2	17	2
Coventry	10	3	6	1
Healthnet	6	3	2	4
Today's Option	1	1	2	3
AARP	2	2	2	2
ADVANTRA	3	2	3	2
Pyramid Life	2	2	3	1
Wellcare	2	2	1	1
Connecticare	1	0	4	0
Essence	2	0	4	1
Windsor	2	0	5	0
Kaiser	0	1	3	2
Tricare	2	0	1	2
Advantage Health Solutions	0	2	0	1
Cigna	0	0	2	2
Health Spring	0	0	3	0
Priority Health	1	0	2	1
SCAN	4	0	0	1
UPMC For Life	2	0	1	2

16. If you answered Yes for any plan in Q15, what percentage of patients pay any portion of the deductible?

Answer Options	<25%	25-50%	51-75%	>75%	Unknown	Not applicable	Response Count
Plan 1	21	8	6	12	21	75	143
Plan 2	20	8	5	13	23	66	135
Plan 3	22	2	3	10	24	57	118
Plan 4	13	5	5	5	23	42	93
Plan 5	12	2	2	5	19	35	75
	88	25	21	45	110	275	564
	15.60%	4.43%	3.72%	7.98%	19.50%	48.76%	
						answered question	155
						skipped question	55

Detail by Top 23 Carriers

	<25%	25-50%	51-75%	>75%	Unknown	Not applicable
Blue Cross Blue Shield	15	6	5	10	20	52
Humana	21	1	2	7	18	45
United	15	5	6	8	18	34
Aetna	10	4	3	5	13	24
Care Improvement Plus	6	1	0	3	4	16
Coventry	4	1	2	2	2	3
Healthnet	2	0	0	1	1	1
Today's Option	0	0	0	1	3	3
AARP	0	0	0	1	3	2
ADVANTRA	2	0	0	0	3	4
Pyramid Life	1	1	0	0	0	3
Wellcare	0	0	0	1	1	4
Connecticare	0	0	0	1	0	4
Essence	2	0	0	0	0	4
Windsor	2	0	0	0	0	3
Kaiser	0	0	0	0	0	4
Tricare	1	0	0	0	1	2
Advantage Health Solutions	0	0	0	0	2	0
Cigna	1	0	0	0	1	1
Health Spring	0	0	0	0	0	2
Priority Health	0	0	0	0	1	2
SCAN	0	1	0	1	2	1
UPMC For Life	0	1	0	0	1	2

17. If you answered Yes to Q15, what is the percentage amount collected of what is billed?

Answer Options	<25%	25-50%	51-75%	>75%	Unknown	Not applicable	Response Count
Plan 1	16	9	9	15	20	71	140
Plan 2	17	9	7	15	20	64	132
Plan 3	11	7	5	14	21	59	117
Plan 4	10	6	3	10	22	40	91
Plan 5	7	5	1	9	19	34	75
	61	36	25	63	102	268	555
	10.99%	6.49%	4.50%	11.35%	18.38%	48.29%	
						answered question	151
						skipped question	59

Detail by Top 23 Carriers

	<25%	25-50%	51-75%	>75%	Unknown	Not applicable
Blue Cross Blue Shield	10	8	4	16	17	52
Humana	15	4	4	7	17	45
United	11	9	6	9	17	33
Aetna	7	4	2	7	13	25
Care Improvement Plus	5	1	1	2	5	16
Coventry	2	1	3	3	1	2
Healthnet	3	0	0	0	2	1
Today's Option	0	0	0	1	3	3
AARP	0	0	0	1	3	2
ADVANTRA	2	0	0	2	1	4
Pyramid Life	0	1	0	1	0	3
Wellcare	0	0	0	1	1	4
Connecticare	0	0	0	1	0	4
Essence	1	0	1	0	0	3
Windsor	1	1	1	0	0	2
Kaiser	0	0	0	0	0	4
Tricare	1	0	0	0	0	2
Advantage Health Solutions	1	0	0	0	1	0
Cigna	1	0	0	0	1	1
Health Spring	0	0	0	0	0	2
Priority Health	0	0	0	1	0	2
SCAN	0	0	0	2	2	1
UPMC For Life	0	0	1	1	0	2

18. Does the plan have a copay for home health services?

Answer Options	Yes	No	Unknown	Response Count
Plan 1	36	125	36	197
Plan 2	37	109	37	183
Plan 3	29	94	33	156
Plan 4	20	68	29	117
Plan 5	13	53	26	92
	135	449	161	745
	18.12%	60.27%	21.61%	
			answered question	199
			skipped question	11

Detail by Top 23 Carriers

Not applicable	Yes	No	Unknown
Blue Cross Blue Shield	35	85	30
Humana	21	80	26
United	22	67	25
Aetna	15	35	19
Care Improvement Plus	6	23	4
Coventry	4	16	1
Healthnet	2	2	6
Today's Option	2	5	2
AARP	0	5	3
ADVANTRA	0	10	3
Pyramid Life	2	5	1
Wellcare	1	3	3
Connecticare	0	4	3
Essence	0	7	0
Windsor	0	6	1
Kaiser	0	4	1
Tricare	0	3	3
Advantage Health Solutions	0	3	2
Cigna	0	2	2
Health Spring	2	1	0
Priority Health	1	3	1
SCAN	0	2	3
UPMC For Life	0	5	0

19. If you answered Yes in Q18, what percentage of patients pay any portion of the copay?

Answer Options	<25%	25-50%	51-75%	>75%	Unknown	Not applicable	Response Count
Plan 1	16	6	6	9	15	91	143
Plan 2	17	6	5	10	16	78	132
Plan 3	15	4	1	7	15	71	113
Plan 4	11	3	3	4	14	52	87
Plan 5	7	1	2	4	11	46	71
	66	20	17	34	71	338	546
	12.09%	3.66%	3.11%	6.23%	13.00%	61.90%	
						answered question	146
						skipped question	64

Detail by Top 23 Carriers

	<25%	25-50%	51-75%	>75%	Unknown	Not applicable
Blue Cross Blue Shield	17	7	4	8	13	61
Humana	15	2	2	1	10	61
United	11	3	4	6	11	48
Aetna	7	2	4	2	11	30
Care Improvement Plus	5	1	0	2	1	19
Coventry	1	1	0	2	0	7
Healthnet	3	0	0	0	2	0
Today's Option	0	0	0	1	1	5
AARP	0	0	0	0	2	4
ADVANTRA	1	0	0	0	1	5
Pyramid Life	1	1	0	0	0	3
Wellcare	1	0	0	0	1	3
Connecticare	0	0	0	0	1	3
Essence	0	0	0	0	0	6
Windsor	0	0	0	0	0	4
Kaiser	0	0	0	0	1	3
Tricare	0	0	0	0	1	3
Advantage Health Solutions	1	0	0	0	1	0
Cigna	0	0	0	0	1	2
Health Spring	0	0	0	2	0	1
Priority Health	0	0	0	0	1	3
SCAN	0	0	0	0	1	3
UPMC For Life	0	0	0	0	0	2

20. If you answered Yes in Q18, what is the percentage collected of what is due?

Answer Options	<25%	25-50%	51-75%	>75%	Unknown	Not applicable	Response Count
Plan 1	12	6	6	9	18	91	142
Plan 2	13	6	6	9	19	77	130
Plan 3	9	7	0	8	16	71	111
Plan 4	8	4	1	6	15	53	87
Plan 5	4	2	0	5	12	46	69
	46	25	13	37	80	338	539
						answered question	146
						skipped question	64

Detail by Top 23 Carriers

	<25%	25-50%	51-75%	>75%	Unknown	Not applicable
Blue Cross Blue Shield	14	6	3	9	16	63
Humana	11	2	2	3	12	61
United	6	8	2	6	12	48
Aetna	5	3	2	3	12	29
Care Improvement Plus	5	0	0	2	1	19
Coventry	1	1	1	1	0	6
Healthnet	3	0	0	0	2	0
Today's Option	0	0	0	1	1	5
AARP	0	0	0	0	1	4
ADVANTRA	1	0	0	0	0	5
Pyramid Life	0	1	0	1	0	3
Wellcare	0	0	0	0	2	3
Connecticare	0	0	0	0	1	3
Essence	0	0	0	0	0	4
Windsor	0	0	0	0	0	4
Kaiser	0	0	0	0	1	3
Tricare	0	0	0	0	1	3
Advantage Health Solutions	1	0	0	0	0	0
Cigna	0	0	0	0	1	2
Health Spring	0	0	1	1	0	1
Priority Health	0	0	0	0	1	3
SCAN	0	0	0	0	1	3
UPMC For Life	0	0	0	0	0	4

21. If the plan pays episode reimbursement, what billing/claim format do you use?

Answer Options	RAP and Final claim	Final Claim only	Unknown	Not applicable	Response Count
Plan 1	94	16	2	68	180
Plan 2	77	14	2	73	166
Plan 3	65	19	1	58	143
Plan 4	52	12	1	43	108
Plan 5	47	9	1	25	82
	335	70	7	267	679
	49.34%	10.31%	1.03%	39.32%	
				answered question	190
				skipped question	20

Detail by Top 23 Carriers

	RAP and Final claim	Final Claim only	Unknown	Not applicable
Blue Cross Blue Shield	55	12	0	66
Humana	88	11	2	17
United	43	10	2	42
Aetna	38	4	1	22
Care Improvement Plus	28	3	0	2
Coventry	5	3	0	12
Healthnet	3	1	0	0
Today's Option	9	0	0	0
AARP	1	0	0	4
ADVANTRA	8	1	0	3
Pyramid Life	4	2	0	1
Wellcare	2	1	1	2
Connecticare	0	0	0	4
Essence	0	0	0	6
Windsor	3	1	0	2
Kaiser	0	1	0	3
Tricare	6	0	0	0
Advantage Health Solutions	5	0	0	0
Cigna	2	1	0	2
Health Spring	1	0	0	2
Priority Health	0	1	0	4
SCAN	1	1	0	2
UPMC For Life	0	0	0	5

22. If you are billing for episode reimbursement, what claim format do you use?

Answer Options	Traditional Medicare PPS format	Plan-specific method	Unknown	Not applicable	Response Count
Plan 1	93	15	2	66	176
Plan 2	75	16	1	69	161
Plan 3	68	13	2	53	136
Plan 4	53	11	1	42	107
Plan 5	47	7	1	25	80
	336	62	7	255	660
	50.91%	9.39%	1.06%	38.64%	
				answered question	187
				skipped question	23

Detail by Top 23 Carriers

	Medicare PPS format	Plan-specific method	Unknown	Not applicable
Blue Cross Blue Shield	51	17	0	61
Humana	88	9	2	15
United	42	10	1	39
Aetna	36	6	1	21
Care Improvement Plus	24	6	0	2
Coventry	7	1	0	12
Healthnet	7	1	1	0
Today's Option	9	0	0	0
AARP	1	0	0	4
ADVANTRA	8	1	0	3
Pyramid Life	5	1	0	1
Wellcare	3	0	1	2
Connecticare	0	0	0	4
Essence	0	0	0	6
Windsor	2	0	0	3
Kaiser	1	0	0	3
Tricare	5	1	0	0
Advantage Health Solutions	4	1	0	0
Cigna	3	0	0	2
Health Spring	1	0	0	2
Priority Health	0	1	0	3
SCAN	2	1	0	1
UPMC For Life	0	0	0	5

23. What is the billing timeliness requirement for the plan?

Answer Options	30 days or less	3 months	6 months	1 year	2 years	No limit	Other	Unknown	Response Count
Plan 1	13	53	27	68	0	1	9	24	195
Plan 2	12	51	28	58	0	1	10	19	179
Plan 3	10	38	21	49	0	0	8	25	151
Plan 4	9	25	17	42	0	0	7	16	116
Plan 5	9	21	13	35	0	0	4	10	92
	53	188	106	252	0	2	38	94	733
	7.23%	25.65%	14.46%	34.38%	0.00%	0.27%	5.18%	12.82%	
								answered question	196
								skipped question	14

Detail by Top 23 Carriers

	30 days or less	3 months	6 months	1 year	2 years	No limit	Other	Unknown
Blue Cross Blue Shield	8	34	34	51	0	1	5	12
Humana	9	21	14	47	0	1	6	26
United	9	33	14	31	0	0	8	15
Aetna	4	20	8	23	0	0	4	9
Care Improvement Plus	2	3	4	16	0	0	2	5
Coventry	1	9	4	3	0	0	0	3
Healthnet	7	1	3	3	4	0	0	0
Today's Option	1	0	1	5	0	0	0	2
AARP	0	2	1	2	0	0	2	0
ADVANTRA	0	4	2	5	0	0	0	1
Pyramid Life	0	0	0	7	0	0	0	1
Wellcare	1	0	1	3	0	0	1	1
Connecticare	1	3	2	1	0	0	0	0
Essence	0	5	2	0	0	0	0	0
Windsor	1	2	0	2	0	0	1	1
Kaiser	1	2	0	3	0	0	0	0
Tricare	1	0	0	3	0	0	0	2
Advantage Health Solutions	0	1	1	2	0	0	0	1
Cigna	1	1	1	1	0	0	0	1
Health Spring	0	0	1	1	0	0	1	0
Priority Health	0	0	1	4	0	0	0	0
SCAN	0	2	3	0	0	0	0	0
UPMC For Life	0	1	2	2	0	0	0	0

24. Does the plan deduct the 2% Medicare sequestration from the payment amount?

Answer Options	Yes	No	Unknown	Response Count
Plan 1	92	64	42	198
Plan 2	77	66	36	179
Plan 3	64	55	33	152
Plan 4	53	41	20	114
Plan 5	50	26	14	90
	336	252	145	733
	45.84%	34.38%	19.78%	
			answered question	198
			skipped question	12

Detail by Top 23 Carriers

	Yes	No	Unknown
Blue Cross Blue Shield	51	60	31
Humana	85	17	23
United	44	47	21
Aetna	34	23	14
Care Improvement Plus	23	4	6
Coventry	4	9	7
Healthnet	0	3	5
Today's Option	7	0	2
AARP	3	3	1
ADVANTRA	7	5	1
Pyramid Life	4	1	3
Wellcare	5	2	0
Connecticare	0	6	1
Essence	0	5	2
Windsor	4	1	2
Kaiser	1	4	1
Tricare	4	0	2
Advantage Health Solutions	4	1	0
Cigna	0	3	2
Health Spring	1	2	0
Priority Health	1	2	0
SCAN	5	0	0
UPMC For Life	5	0	0

25. What is the average number of days from claim submission to payment receipt?

Answer Options	<30 days	30-45 days	46-60 days	61-90 days	>90 days	Unknown	Response Count
Plan 1	30	67	31	28	32	10	198
Plan 2	20	66	34	23	31	7	181
Plan 3	13	54	26	25	28	6	152
Plan 4	6	39	21	23	21	5	115
Plan 5	5	30	21	17	14	2	89
	74	256	133	116	126	30	735
	10.07%	34.83%	18.10%	15.78%	17.14%	4.08%	
						answered question	197
						skipped question	13

Detail by Top 23 Carriers

	<30 days	30-45 days	46-60 days	61-90 days	>90 days	Unknown
Blue Cross Blue Shield	20	53	26	18	24	5
Humana	15	39	17	25	23	6
United	12	42	18	12	23	5
Aetna	8	23	13	11	12	3
Care Improvement Plus	5	8	6	6	8	0
Coventry	2	7	4	1	4	2
Healthnet	3	0	3	3	1	4
Today's Option	0	1	4	3	0	0
AARP	2	2	3	1	0	0
ADVANTRA	0	2	4	3	4	0
Pyramid Life	0	2	1	3	1	1
Wellcare	0	3	0	3	0	1
Connecticare	0	6	0	1	0	0
Essence	0	3	1	1	1	0
Windsor	0	3	2	1	1	0
Kaiser	0	3	1	2	0	0
Tricare	0	2	1	3	0	0
Advantage Health Solutions	0	0	1	1	3	0
Cigna	0	1	0	2	2	0
Health Spring	0	2	1	0	0	0
Priority Health	0	2	1	1	0	1
SCAN	0	1	2	2	0	0
UPMC For Life	0	4	0	0	0	0

26. Check the box if the plan requires the following traditional Medicare documentation.

Answer Options	Physician face-to face documentation	Additional therapy documentation	Response Count
Plan 1	94	49	143
Plan 2	82	43	125
Plan 3	66	36	102
Plan 4	46	24	70
Plan 5	41	22	63
	329	174	503
		answered question	128
		skipped question	82

Detail by Top 23 Carriers

	Physician face-to face documentation	Additional therapy documentation
Blue Cross Blue Shield	64	38
Humana	69	30
United	44	20
Aetna	27	16
Care Improvement Plus	28	7
Coventry	7	5
Healthnet	0	4
Today's Option	2	1
AARP	5	3
ADVANTRA	7	1
Pyramid Life	7	2
Wellcare	4	4
Connecticare	2	0
Essence	1	2
Windsor	5	3
Kaiser	2	3
Tricare	2	0
Advantage Health Solutions	3	1
Cigna	0	1
Health Spring	0	1
Priority Health	0	0
SCAN	2	2
UPMC For Life	5	4

27. How do you determine patient coverage/eligibility for the plans?

Answer Options	Outside service	Plan website	Telephone	Other	Response Count
Plan 1	25	113	117	11	266
Plan 2	22	98	122	7	249
Plan 3	18	76	107	5	206
Plan 4	18	55	75	6	154
Plan 5	10	45	59	2	116
	93	387	480	31	991
	9.38%	39.05%	48.44%	3.13%	
				answered question	197
				skipped question	13

Detail by Top 23 Carriers

	Outside service	Plan website	Telephone	Other
Blue Cross Blue Shield	19	86	88	4
Humana	12	60	82	10
United	12	61	78	2
Aetna	10	32	48	2
Care Improvement Plus	5	14	26	5
Coventry	4	11	14	0
Healthnet	2	2	6	5
Today's Option	2	3	6	0
AARP	3	5	2	1
ADVANTRA	1	1	13	0
Pyramid Life	0	4	8	0
Wellcare	3	4	4	1
Connecticare	2	5	6	0
Essence	1	5	5	0
Windsor	1	1	6	1
Kaiser	0	2	4	1
Tricare	0	3	6	0
Advantage Health Solutions	0	0	5	0
Cigna	2	2	1	1
Health Spring	0	3	3	0
Priority Health	0	4	2	0
SCAN	0	5	3	0
UPMC For Life	0	5	2	0

28. Have you had eligibility determination problems/errors with the plan?

Answer Options	Yes	No	Response Count
Plan1	79	118	197
Plan 2	81	102	183
Plan 3	71	84	155
Plan 4	45	71	116
Plan 5	35	55	90
	311	430	741
	41.97%	58.03%	
		answered question	198
		skipped question	12

Detail by Top 23 Carriers

	Yes	No
Blue Cross Blue Shield	59	88
Humana	54	70
United	51	61
Aetna	29	42
Care Improvement Plus	15	19
Coventry	13	8
Healthnet	0	7
Today's Option	2	7
AARP	3	5
ADVANTRA	4	9
Pyramid Life	2	6
Wellcare	3	4
Connecticare	3	4
Essence	2	5
Windsor	1	6
Kaiser	1	5
Tricare	1	4
Advantage Health Solutions	4	1
Cigna	3	1
Health Spring	2	1
Priority Health	0	5
SCAN	3	2
UPMC For Life	2	3

29. Does the plan require pre-authorization for services to be provided and paid?

Answer Options	Yes	No	Unknown	Response Count
Plan 1	152	41	5	198
Plan 2	145	37	3	185
Plan 3	121	31	4	156
Plan 4	94	20	3	117
Plan 5	70	16	1	87
	582	145	16	743
	78.33%	19.52%	2.15%	
			answered question	199
			skipped question	11

Detail by Top 23 Carriers

	Yes	No	Unknown
Blue Cross Blue Shield	97	47	3
Humana	96	28	4
United	93	18	2
Aetna	61	8	1
Care Improvement Plus	28	3	1
Coventry	13	7	1
Healthnet	4	10	0
Today's Option	4	5	0
AARP	7	1	0
ADVANTRA	12	1	0
Pyramid Life	6	2	0
Wellcare	7	0	0
Connecticare	7	0	0
Essence	6	1	0
Windsor	7	0	0
Kaiser	6	0	0
Tricare	5	1	0
Advantage Health Solutions	5	0	0
Cigna	4	0	1
Health Spring	2	1	0
Priority Health	4	1	0
SCAN	4	1	0
UPMC For Life	3	2	0

30. If the required pre-authorizations are not obtained, does the plan deny payment for services rendered?

Answer Options	Yes	No	Unknown	Inapplicable	Response Count
Plan 1	130	17	13	34	194
Plan 2	126	14	13	26	179
Plan 3	109	12	11	20	152
Plan 4	83	10	6	14	113
Plan 5	65	4	3	15	87
	513	57	46	109	725
	70.76%	7.86%	6.34%	15.03%	
				answered question	197
				skipped question	13

Detail by Top 23 Carriers

	Yes	No	Unknown	Inapplicable
Blue Cross Blue Shield	88	12	8	33
Humana	76	11	13	23
United	83	8	7	13
Aetna	55	3	4	7
Care Improvement Plus	25	3	2	3
Coventry	10	0	4	5
Healthnet	0	10	1	0
Today's Option	3	1	0	3
AARP	6	1	0	1
ADVANTRA	10	1	0	1
Pyramid Life	4	0	2	2
Wellcare	7	0	0	0
Connecticare	7	0	0	0
Essence	6	0	0	0
Windsor	6	1	0	1
Kaiser	4	2	0	0
Tricare	5	0	0	1
Advantage Health Solutions	4	0	0	0
Cigna	4	0	1	0
Health Spring	2	0	0	1
Priority Health	3	0	1	1
SCAN	4	1	0	0
UPMC For Life	3	0	0	2

31. If the plan requires a reauthorization of care periodically, at what frequency is reauthorization required?

Answer Options	Every 10 days	Every 30 days	Every 60 days	Varies based on previous authorization	Other	Unknown	Not Applicable	Response Count
Plan 1	5	14	60	67	6	15	29	196
Plan 2	6	10	50	68	4	14	27	179
Plan 3	7	8	42	56	5	15	23	156
Plan 4	7	7	33	42	3	7	18	117
Plan 5	7	2	28	34	1	3	15	90
	32	41	213	267	19	54	112	738
	4.34%	5.56%	28.86%	36.18%	2.57%	7.32%	15.18%	
							answered question	196
							skipped question	14

Detail by Top 23 Carriers

	Every 10 days	Every 30 days	Every 60 days	Varies based on previous authorization	Other	Unknown	Not Applicable
Blue Cross Blue Shield	4	7	26	52	7	9	40
Humana	1	7	56	30	1	9	20
United	5	11	32	41	1	11	10
Aetna	4	3	18	28	3	5	10
Care Improvement Plus	0	1	22	8	1	0	3
Coventry	1	0	4	8	2	1	3
Healthnet	0	0	1	0	9	0	1
Today's Option	0	0	2	1	0	1	4
AARP	0	0	1	5	0	0	2
ADVANTRA	1	1	2	4	1	2	1
Pyramid Life	0	0	6	0	0	1	1
Wellcare	1	0	1	4	0	1	0
Connecticare	0	2	1	4	0	0	0
Essence	0	0	2	5	0	0	0
Windsor	2	0	2	3	0	0	0
Kaiser	0	1	1	3	0	0	1
Tricare	0	0	1	4	0	1	0
Advantage Health Solutions	0	1	1	1	0	1	0
Cigna	0	0	1	3	0	1	0
Health Spring	0	0	0	2	0	0	1
Priority Health	0	0	1	2	1	0	1
SCAN	0	0	2	2	0	0	1
UPMC For Life	1	0	0	2	0	0	2

32. Does the plan permit retroactive authorizations?

Answer Options	Yes	No	Sometimes	Unknown	Not applicable	Response Count
Plan 1	33	66	47	25	25	196
Plan 2	21	75	36	25	24	181
Plan 3	20	62	29	24	19	154
Plan 4	9	57	25	12	13	116
Plan 5	8	41	16	12	13	90
	91	301	153	98	94	737
	12.35%	40.84%	20.76%	13.30%	12.75%	
					answered question	199
					skipped question	11

Detail by Top 23 Carriers

	Yes	No	Sometimes	Unknown	Not applicable
Blue Cross Blue Shield	18	50	29	14	33
Humana	19	41	24	22	20
United	9	58	20	15	8
Aetna	9	32	10	11	7
Care Improvement Plus	6	13	8	6	2
Coventry	2	7	2	6	4
Healthnet	0	0	7	4	0
Today's Option	0	2	0	2	4
AARP	1	4	3	0	0
ADVANTRA	2	9	1	0	1
Pyramid Life	0	1	2	3	2
Wellcare	0	5	1	1	0
Connecticare	1	3	3	0	0
Essence	2	4	1	0	0
Windsor	0	3	3	0	1
Kaiser	2	3	1	0	0
Tricare	0	0	3	3	0
Advantage Health Solutions	1	3	1	0	0
Cigna	0	0	4	1	0
Health Spring	0	0	2	0	1
Priority Health	0	3	2	0	0
SCAN	2	3	0	0	0
UPMC For Life	0	2	1	0	2

33. What is the nature of the authorization process?

Answer Options	Automated (secure web-base)	Fax	Mail	Telephone	Other	Unknown	Not applicable	Response Count
Plan 1	51	63	5	111	7	7	17	261
Plan 2	38	72	6	99	4	4	20	243
Plan 3	27	62	5	86	4	4	16	204
Plan 4	23	44	4	68	3	2	8	152
Plan 5	15	33	2	51	3	1	12	117
	154	274	22	415	21	18	73	977
	15.76%	28.05%	2.25%	42.48%	2.15%	1.84%	7.47%	
							answered question	198
							skipped question	12

Detail by Top 23 Carriers

	Automated (secure web-base)	Fax	Mail	Telephone	Other	Unknown	Not applicable
Blue Cross Blue Shield	30	50	2	66	5	2	26
Humana	24	23	3	80	3	5	12
United	35	37	5	65	3	2	9
Aetna	14	30	1	46	3	2	4
Care Improvement Plus	2	21	0	22	0	0	1
Coventry	2	5	0	10	0	1	6
Healthnet	0	1	8	0	7	0	0
Today's Option	0	1	0	2	0	1	4
AARP	1	2	2	4	2	0	0
ADVANTRA	1	3	0	11	0	0	1
Pyramid Life	0	2	0	4	0	0	2
Wellcare	2	5	0	5	0	0	0
Connecticare	2	2	1	6	0	0	0
Essence	1	3	0	5	0	0	0
Windsor	2	4	1	4	0	0	0
Kaiser	0	4	0	5	0	0	0
Tricare	0	3	0	4	0	0	0
Advantage Health Solutions	0	2	0	4	0	0	0
Cigna	3	3	0	1	1	1	0
Health Spring	1	2	1	1	0	0	0
Priority Health	1	3	0	2	0	0	0
SCAN	1	5	0	3	0	0	0
UPMC For Life	3	0	0	0	0	0	2

34. As a final question, do you have any concerns about the plan that you wish to convey?

Answer Options	Response Percent	Response Count
Plan 1	80.9%	93
Plan 2	61.7%	71
Plan 3	53.0%	61
Plan 4	31.3%	36
Plan 5	31.3%	36
		297
	answered question	115
	skipped question	95

AARP Complete	works well with our agency
Advantage	Payments are often not processed or errors with billing are not communicated, insurance company communicates claims have been paid; however, checks are never received and follow up is very difficult and very time consuming.
ADVANTRA	REQUIRES AUTH FOR HHA ONLY WHICH IS STUPID WHEN YOU BILL EPISODES
Aetna	2% depends on the plan: some yes - some no, and changing July 1 to HIPPS codes for all
Aetna	20% Penalty for Retro-Auth
Aetna	Aetna will only approve authorization for 2 weeks at a time but more importantly will not approve auth requests officially for days to a week after the initial request. This creates a major hold up in how services are delivered and can interrupt care.
Aetna	and ignorance of plan participants
Aetna	Authorization requirements
Aetna	decent, but slow payer
Aetna	Denying due to auth. but we have auth.
Aetna	doesn't get the payments correct a lot of times requiring a lot of phone follow-up
Aetna	MA Plans should allow for NO DEDUCTIBLE as against CMS regs for Home Health benfit
Aetna	Managed by 3rd party, authorization delays, denials for auth
Aetna	N/A
Aetna	na
Aetna	No
Aetna	No concern.
Aetna	none
Aetna	non-responsive to provider relations issues
Aetna	Not a PPO provider so they want us to accept a contractual discount which is below our costs to provide care
Aetna	Payment is extremely untimely.
Aetna	payment schedule, current SNV rate is approx $9/15min increment. Doesn't begin to meet costs.
Aetna	Preauth cumbersome, plan rep and nurse involved
Aetna	Pricer they use often doesn't match our system or CMS pricer
Aetna	RATES ARE TOO LOW
Aetna	Reimbursement rates low

Aetna	Too many plans, too many inconsistent rules for payment
Aetna	Very time consuming
Aetna	Would like episodic; every plan can have a diff. co-pay
Americhoice Secure Plus	Too many plans, too many inconsistent rules for payment
Amerigroup	Authorization is extremely difficult to obtain in a timely manner
Amerigroup	No concern.
Amerivantage	Claims pocess not clearly defined
Atrio	none
ATRIO	Timliness with Blue Cross - United Health care
Blue Cross Blue Shield	Annual contract rates frozen; would like episodic method
Blue Cross Blue Shield	Annual contract rates frozen; would like episodic method
Blue Cross Blue Shield	Anthem most of the time will pay RAP, but not always consistent.
Blue Cross Blue Shield	Authorization frequently slow process and pt. doesn't get care while waiting for it.
Blue Cross Blue Shield	Authorization is extremely difficult to obtain in a timely manner
Blue Cross Blue Shield	Bill Rapp only receive final
Blue Cross Blue Shield	BLUE CROSS IS VERY HARD TO GET A HOLD OF A PERSON TO SPEAK WITH TO GET THE CORRECT INFORMATION YOU NEED VERY TIME CONSUMING
Blue Cross Blue Shield	Claims pocess not clearly defined
Blue Cross Blue Shield	Conflicting stance on F2F - sometimes yes, sometimes no
Blue Cross Blue Shield	delays in processing auths when patient needs care
Blue Cross Blue Shield	Difficult to obtain auth timely
Blue Cross Blue Shield	Difficult to obtiain auth timely
Blue Cross Blue Shield	do not like to work with this group
Blue Cross Blue Shield	doesn't get the payments correct a lot of times requiring a lot of phone follow-up
Blue Cross Blue Shield	eliminate the billing code discrepancies between local and out of state plans, it severely delays payment
Blue Cross Blue Shield	Extremely low rates
Blue Cross Blue Shield	Inconsistent RAP requirement
Blue Cross Blue Shield	initial denial of claims is the norm

Blue Cross Blue Shield	Low reimbursement well below costs, not willing to renegotiate rates, high proliferation in our region, patients at risk for going without care, agencies at risk, still requires Medicare OASIS, satisfaction & clinical outcomes measured but not considered in reimbursement model, acuity not considered in reimbursement model, better payment timeliness; they reap the benefit of an accredited agency with deemed status yet do their own payment audits which take an inordinate amount of time for document submission
Blue Cross Blue Shield	MA Plans should not require burdensome PA Process
Blue Cross Blue Shield	multiple system issues with claims processing
Blue Cross Blue Shield	N/A
Blue Cross Blue Shield	N/A
Blue Cross Blue Shield	na
Blue Cross Blue Shield	no
Blue Cross Blue Shield	no
Blue Cross Blue Shield	no
Blue Cross Blue Shield	No written confirmation of authorization obtained
Blue Cross Blue Shield	none
Blue Cross Blue Shield	none
Blue Cross Blue Shield	none
Blue Cross Blue Shield	none
Blue Cross Blue Shield	Paying incorrect rates in 2014. Unable to fix at this time.
Blue Cross Blue Shield	Per visit rate is 50% below cost of providing services.
Blue Cross Blue Shield	post payment audit worse than medicare deny based on supply codes
Blue Cross Blue Shield	Rates
Blue Cross Blue Shield	RATES ARE TOO LOW
Blue Cross Blue Shield	Reimburses less than Medicare
Blue Cross Blue Shield	slow payer no consistency

Blue Cross Blue Shield	TERRIBLE TO WORK WITH
Blue Cross Blue Shield	There has been Rate issues in 2014-unresolved
Blue Cross Blue Shield	This plan requirements are very strict, no payment for months, although we are finally getting to that stage.
Blue Cross Blue Shield	Too many plans, too many inconsistent rules for payment
Blue Cross Blue Shield	VERY LOW REIMBURSEMENT
Blue Cross Blue Shield	VERY LOW REIMBURSEMENT
Blue Cross Blue Shield	Very time consuming
Blue Cross Blue Shield	Why can't we have contract if other agency has but they do not provide services in out territory?
Brand New Day	We've signed the contract but they hare delaying orienting us to their protocols
Bravo	Authorization requirements
Bravo Elderhealth	very minimal volume
Care Imp Plus	very poor service to pt and home care agency
Care Improvement	requires signed 485 and F2F before authorizing subsequent episodes
Care Improvement Plus	CIP has greatly improved over the years.
Care Improvement Plus	CIP is not accepting contracts with providers and can not tell you when they will. We have several patients that we had to transfer to another in network HHA because of their 50% CoInsurance. This is a big concern in our very competitive market. In addition when they process a claim 95% of the time it is not processed correctly and I wind up having to appeal eventhough I show them the print out the HHA pricer that CMSs put out. Why do they have so much trouble processing the claims with the right payment amount. Another concern is that when you call to follow up on anything the average time on the phone is 45 min to an hour. Considering that you have problems with most of their claims I find myself spending the majority of my time on the phone with them.
Care Improvement Plus	CIP pays 75% od episodic reimbursment; challenging prior auth process where reviewers request clinical summaries but refuse to accept OASIS because documentation is too extensive. This is labor intensive for clinical staff to duplicate documentation to meet prior auth requests to receive approval for home care
Care Improvement Plus	Customer service is very poor
Care Improvemen	Delayed payments

t Plus	
Care Improvement Plus	Difficult to work with, no return calls
Care Improvement Plus	doesn't get the payments correct a lot of times requiring a lot of phone follow-up
Care Improvement Plus	Extremely hard to work with regarding getting payment and then having payment taken back at a much later date due to no known issue with claims
Care Improvement Plus	Insurance case manager requests labs and doctor report determined by their own whim
Care Improvement Plus	Insurance Rep told patients that it is just like traditional Medicare and pays just like traditional Medicare then patient found out it has to be a preferred provider, and now pays 60/40 since we are not, patient stated it was our fault because we were told to bill like Medicare, won't contract because reimbursement is less than our costs to provide service, we are small and rural and they want us to take a 40% discount
Care Improvement Plus	limiting services
Care Improvement Plus	Low reimbursement and no coverage for medical supplies
Care improvement plus	no
Care Improvement Plus	No
care improvement plus	They deduct 20% off the PPS rate payment amount.
Care Improvement Plus	This company tends to lose claims frequently causing the provider to have to re-file numerous times
Care Improvement Plus	This insurance will not pay, when they did, they would turn around and take the money back. We no longer accept this insurance. We lost reimbursed. We are thinking about reporting them to the insurance commissioner. I have spoken with other health agencies, they have experienced similiar problems.
CareCentrix	auth process very cumbersome and confusing. Auths cancel retroactively. Most difficult we deal with. They are a 3rd party processing for CIGNA and some other smaller plans.
Carecentrix	low rates. Only take them to get the Medicare business. An end to the means
Caremore	no
Cigna	Annual contract rates frozen; would like episodic method
Cigna	Very poor claims reconsideration

CIP	limited in visits they cover,have to wait to get visits approved when the patient needs to get care started
Community Health Plan Of Washington	Time we are having to wait for prior authorization causes lapse in care for our patients. These plans follow Medicare guidelines and we have to see the patient withint 48 hours of accepting the referral but this plan can take up to 14 days to give us a determination for authorization.
Connect Care	Issue checks-not really-never cashed- need to wait another 45 days for payment- whch is 180 days
Connecticare	retro auth is rare but we do get it sometimes
Connecticare Medicare Advantage	none
Coventry	Coventry continues to give us conflicting and/or incorrect information. We continually fight for payments and when payments are received they are rarely correct.
Coventry	Coventry pays less than medicaid, won't pay for supplies and gets angry if a patient cannot be accepted.
Coventry	Don't understand episodic payment system
Coventry	Low reimbursement and no coverage for medical supplies
Coventry	Payment per visit, should pay episode just like traditional
Coventry	RATES ARE TOO LOW
Coventry	Reimbursement rates low
Coventry	slow payer no consistency
Coventry	Trouble getting claim paid even with resubmission and calling for assist
Erickson Advantage	None at the moment
Essence	difficult to obtain auth, visit rates low
Essence	Extremely concerned about under-utilization!
Essence	Hard to get PCP to get auth sometime done through their office or if the PCP doesn't match the ordering home health physician
Essence	Our home care agency has to subsidize costs associated with MA's with margins from traditional PPS patients. As you can see, with our agency and it's payer mix, MCR reductions continue to negatively impact our agency.
ESSENSE	NEED TO BILL IN EPISODE, ALL ADVANTAGE PLANS NEED TO BE A LIKE
First Advantage	Reimburses less, too long, and scrutiny for documentation request
Geisinger Gold	none
Geisinger Gold	Rates are not updated annually
Generations Advantage	They seem to struggle whenever there is a change
Health Alliance	Insurance Customer Service Rep doesn't always understand how Homecare is billed and should be "like traditional Medicare", claims always in review or reject first time then have to resubmit
Health Spring	This company seems to drag out claim re-imbursments as long as possible and has a lack of communication to provider for any status updates

Health Springs/Cigna	Pays well.
Healthnet	low rates. Only take them to get the Medicare business. An end to the means
Healthnet	No
Healthnet	no
Healthnet	Payment schedule very difficult for software. Pay the lesser of the PPS rate or the billed charges.
Healthnet	Rates
Healthnet	stop requiring providers to work with Care Centrix for your patients
Healthnet	VERY LOW REIMBURSEMENT
Healthnet	Visits are are difficult to get authorization
HealthSpring	delays in processing auths when patient needs care
Humana	All MA payment structures need to change - it is killing homecare agencies!
Humana	Awful at reimbursement - not familiar with Homecare, states incorrect info regarding Medicare Advantage Plans, say they follow Medicare guidelines but then billing issues and say different because of contract, spend hours on phone trying to resolve issues, now they tell us becuase we are contracted, we need to bill line item like traditional insurance, never get told the same info
Humana	Best plan to work with, very easy to bill for the most part and they pay like Medicare.
Humana	Bill Rapp only receive final
Humana	Claim follow up is very time consuming and most paid claims are accompanied by additional documentation request.
Humana	concern is with lack of consistency between plans (confusion)
Humana	Customer service is very poor
Humana	Deny Claims for various reasons to prolong payment
Humana	Do not understand episodic reimbursement and do not understand English
Humana	Doesn't understand billing like Medicare
Humana	Don't understand episodic payment system
Humana	EASY TO WORK WITH
Humana	Humana
Humana	Humana is a mess - they pay a contracted rate less than Medicare and are no longer honoring that rate by taking out a 2% sequestration on top of that
Humana	Humana is cancelling contracts
Humana	Humana is extremely slow at paying claims, never receive RAP payment, so therefore have to wait til end of episode.
Humana	Humana is slow to pay accurately, requiring several follow-up calls and emails to assure accurate episodic payment is received
Humana	Humana is the main company that continues to serve our area. LUPAS are not as easily handled as with regular Medicare as we are paid by check through Humana. We are much more pleased with Humana than with the old United Health Care or BCBS Medicare Advantage.
Humana	Humana medicare replacement has been the easiest to work with so far. They have paid according to the Medicare PPS rates and so far we have not had any trouble with them.
Humana	Humana NEVER gets the episodice payment right. They takeback RAP payments based on the Medicare final claim billing timeframes. Then the short pay the final claims the amount of the RAP. The pricer they use often doesn't match our system or CMS pricers.

	Ensuring correct payment from Humana is very time consuming.
Humana	Humana's web site is easy to navigate
Humana	Inconsistent claim process and payment
Humana	Low reimbursement and no coverage for medical supplies
Humana	MA Plans should be required to pay Federal Levels
Humana	Managed by 3rd party, authorization delays, denials for auth
Humana	multiple system issues with claims processing
Humana	N/A
Humana	No
Humana	No
Humana	no
Humana	none
Humana	none
Humana	not able to determine how many visits will bereimbursed from patient to patient, sometimes they pay sometimes they do not, saying visits limited.
Humana	not consistent in payment methodologies- will pay full hhrg amount and then mass recoupments
Humana	Paying incorrect rates.
HUMANA	PAYMENT DELAYS, TRADITIONAL MEDICARE PAYS IN 14 DAYS, WE HAVE MOST CLAIMS TAKE UP TO 90 DAYS TO PAY. NO REPRESENTATIVE AVAILABLE TO TALK WITH FOR HOMECARE CLAIMS.
Humana	post payment audit wose than medicare deny based on supply codes
Humana	Process is very time consuming
Humana	RAP payments are not taken back, typically the final is the net amount left to be reimbursed. Difficult to track.
Humana	Rates are not updated annually
Humana	Rates exceedingly low. Unable to renegotiate.
Humana	recently they began taking money back on the technicality of inaccurate coding/missing data which we are fighting
Humana	Reimburses less than Medicare
Humana	Requiring submission of a lot of charts for review, doesn't get the payments correct a lot of times requiring a lot of phone follow-up
Humana	slow payer no consistency
Humana	Slow reimbursement; many different types of MAP plans, difficult to determine which one patient uses & if we are contracted with their version of Human; they reap the benefit of an accredited agency with deemed status yet do their own payment audits which take an inordinate amount of time for document submission
Humana	there is no consistency in what an agengy is told when calling about authorization, some say don't need it, some don't know what you're talking about and can't refer you to correct person, usually told "just handle it like you would traditional medicare"., then get refused payment for documentation that is there and submitted to them, have had to submit same documentation several times then appeal denial and won appeal. If you call they say will call in 3 days which does not happen so you keep calling, very difficult to get help from
Humana	This company is always looking for ways to get a refund from you, even after you have obtained the necessary authorization and serviced their patients.
Humana	This company tends to not convey to the provider every needed item for the claim to be

	paid; therefore, it requires several submissions to get anywhere
Humana	This insurance is similiar to Care Improvement Plus. We are still accepting, but we have problems with reimbursement. If this continues, we will no longer accept this insurance. I have spoken to other health agencies, some no longer accept this insurance.
Humana	To have a more reliable way of knowing if episodic or per visit reimb
Humana	To have a more reliable way of knowing if the plan is episodic or per visit reimb
Humana	VERY LOW REIMBURSEMENT
Humana	Very time consuming for benefits and auth
Humana	We take Humana as llittle as possible as the overhead to collect is tremendous and they do not have customer service for providers to speak of.
Humana	works well with our agency
Humana	Yes
Kaiser	no
Kaiser	Plan gets all the money and we get paid low LUPA rates and have all the problems of getting paid!
KAiser	RAtes
Lovelace Senior Plan	Lovelace recently lost its contracting partner, so dealing with them is now on a case-to-case basis and is a hassle
Medical Mutual	na
MEDICARE COMPLETE	NEED TO BILL EPISODE, ALL ADVANTAGE PLANS NEED TO BE A LIKE
MEdigold	Only pays 65% of Episode rate
Medipak advantage	no
Medipak Advantage	Pays well.
Molina	Claims pocess not clearly defined
Molina	Plan gets all the money and we get paid low LUPA rates and have all the problems of getting paid!
Molina	Unfair Auth process designed to not pay providers by slow auth processing
MVP	Recently did mass system-based adjustment and recouped large sum - appears to be do to switch from episodic to visit based payment
Neighborhood	Pay in a timely fashion
PHCN	Visits are are difficult to get authorization
Presbyterian Senior Plan	Pres does an excellent job and web site is good
Priority Health	None
Pyramid Life	Delayed payments
Pyramid Life	I didn't list Humana because we stop taking there pts due to non payment of claims. They owe us back to 2010 and we have been fighting it for a year. We had authorizations and provided the service and they said they would pay us but to date we are still owed $104,000.00.
Rhody	Do not switch patient plans monthly

RMHP (special federal FFS program)	Yes, everything is in flux and we don't know from day to day what to expect.
SCAN	do not require us to Bill RAP & FC when you are paying per visit and delaying payment until the FC is submitted.
Today's Option	slow payer no consistency
Today's Option	Slow reimbursement; they reap the benefit of an accredited agency with deemed status yet do their own payment audits which take an inordinate amount of time for document submission
Tricare	No
Tricare	very minimal volume
Tufts Medicare Preferred	Rates are too low and not episodic
United	Always difficult to get payment
United	As of Feb 1 plan does not require pre auth for 1st 60 day episode process is ver time consuming
United	Authorization process is different from online and telephone. Less information is needed via telephone. Do not always understand our requests for units, which is based on our contracted rates and codes used for billing.
United	Authorization requirements
United	BCBS DOES NOT PAY FAST ENOUGH-RATES ARE TOO LOW
United	Claims pocess not clearly defined/different from member to member
United	Cost reports may suggest to CMS that home care have margins in th 10% to 15% range, but when you figure in our loses from the MA's margins drop to 0.5% to 1% if that.
United	DEPENDS ON THE PLAN HOW THEY WORK
United	difficult to obtain payment if everything not perfect
United	Do not use every trick to not pay
United	doesn't get the payments correct a lot of times requiring a lot of phone follow-up
United	Don't understand episodic payment system
United	If verification of insurance systems are not updated timely; we may bill Medicare and be referred to a Medicare Advantage Plan only to find out that prior authorization is required and/or we have exceeded timely filing because they require within 60 to 90 days. This is the same for all. Why would they update their census base timely?!!!
United	Low reimbursement and no coverage for medical supplies
United	Low reimbursement well below costs, not willing to negotiate contract, high proliferation in our region, patients at risk for going without care, agency assuming unsustainable loss as a result, still requires Medicare mandated OASIS, results (satisfaction & clinical outcomes) measured but not considered in reimbursement model, acuity not considered in reimbursement model; they reap the benefit of an accredited agency with deemed status yet do their own payment audits which take an inordinate amount of time for document submission
United	Lower of Medicare rate or charge results to 5% lower net revenue
United	New authorization policy is confusing.
United	No

United	no
United	No concern.
United	payment is quite slow
United	Previous to 2013, they had co-payment and patients refused services
United	Rates are not updated annually
United	RATES ARE TOO LOW
United	Rates exceedingly low. Unable to renegotiate.
United	Remove the 3 to 5 advance notification requirement on some policies as this is not realistic for continuity of care from hospital to home
United	same as above
United	slow & no pay
United	slow payer no consistency
United	supplies are included in per visit rates, and are inadequate reimbursement
United	The time we are waiting for authorization causes laspe in care for our patients. No retro auth and claims must be submitted within 90 days of discharge. I also have problems getting accurate benefits for the plans. Often claims are denied even when billing per billing instructions given by provider rep.
United	They deduct for administration fees, co-pays, etc.
United	Timeliness of Payment Receipt/Difficult Verification Process
United	Timely payment, retro PAs not allowed, and per visit rate is 50% below cost of providing services.
United	Too many plans, too many inconsistent rules for payment
United	Too many plans, too many inconsistent rules for payment
United	too many types of plans with different deductables, patients didn't realize they were switched from Traditional to Medicare Advantage, State of IL switched everyone Feb. 2014, created increased calls and labor to dc off traditional and readmit with new payer
United	UHC is freezing its homecare network
United	United has issues with the RAP receoupment process. It is very inefficient.
United	United Healthcare is new to our agency. We do not have a contract with them and have just began to receive patients with their medicare replacement plan. But we are given conflicting information regarding benefits/elig every time time we call them. I haven't received payments yet, so not sure how that will go.
United	Very difficult to work with, claim processing is not consistent
United	Very difficult to work with, claim processing is not consistent
United	Very low payment rates - well below the cost of doing the visits.
United	VERY LOW REIMBURSEMENT
United	Very time consuming
United	Will not negociate rates. Rates are 8 years old & <LUPA
United	will only do 2 days retro regardless of the issue
United	works well with our agency
United	Yes
Univita	Changes auths, loses auths, deletes auths
UPMC Advantage	Occasional website/billing issues
UPMC For Life	Difficulty getting visits authorized for acutely ill patients with a chronic illness

UPMC for Life	N/A
UPMC for Life	Occasional website/billing issues
Wellcare	Authorization process is slow and claims process cumbersome
Wellcare	Have not received a payment from this company even though we have obtained an authorization for one of their members. Have gone back and forth arguing with payments with this company. I would not recommend servicing their members if you are an out of network provider.
Wellcare	Managed by 3rd party, authorization delays, denials for auth
Wellcare	Pricer they use often doesn't match our system or CMS pricer
Wellcare	Wellcare is our most difficult plan we deal with. Issues with claims processing.
Wellpath	Low reimbursement well below costs, not willing to renegotiate rates, still requires Medicare OASIS, satisfaction & clinical outcomes measured but not considered in reimbursement model, acuity not considered in reimbursement model, better timeliness of payment; they reap the benefit of an accredited agency with deemed status yet do their own payment audits which take an inordinate amount of time for document submission; they reap the benefit of an accredited agency with deemed status yet do their own payment audits which take an inordinate amount of time for document submission
Windsor	limited visits, poor payment system- unable to get an straight answer to correct bill
Windsor	Rates exceedingly low. Unable to renegotiate.
Windsor	request HH 10 and recert information in 5 work day window have trouble getting authorization.
Windsor	slow or no pay
Windsor	Very low volume