National Rural Health Association Policy Brief

Medicare Advantage growth and its impact on rural health care

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Introduction

Medicare Part C, also known as the Medicare Advantage program, was established by the Balanced Budget Act of 1997 (BBA) as a new part of the Medicare program, combining the coverage of Medicare Part A and Part B into a single plan offered by primary insurance companies. Going into effect in January 1999, the Medicare+Choice (M+C) program aimed to provide more choices and flexibility to Medicare beneficiaries but faced challenges in terms of plan availability and sustainability. The BBA authorized the Centers for Medicare and Medicaid Services (CMS) to contract with public or private organizations under M+C to offer a variety of health plan options for beneficiaries, including coordinated care plans (such as health maintenance organizations [HMOs]), provider-sponsored associations (PSOs), preferred provider organizations (PPOs), Medicare medical savings account (MSA) plans, private-fee-for-service (PFFS) plans, and religious fraternal benefit (RFB) plans.

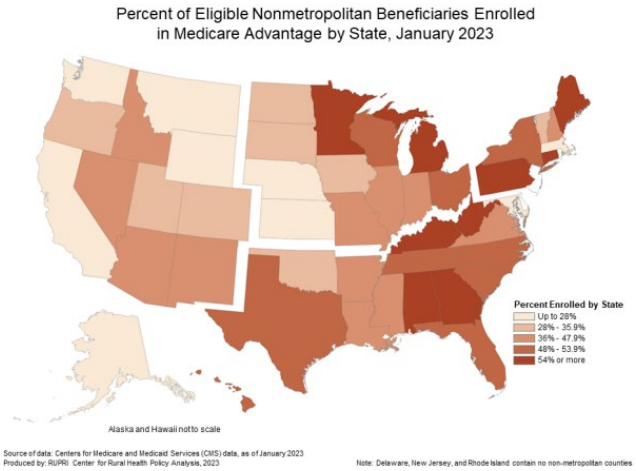
The MA program contracts with private insurers to offer traditional Medicare Part A and Part B services to beneficiaries and may offer supplemental benefits, such as vision, dental, hearing, and prescription drug coverage. Enrollment in MA plans has grown steadily since 2010, increasing nearly threefold. According to recently released CMS data, MA now provides Medicare coverage for just over half of eligible beneficiaries. In January 2023, 30.19 million of the 59.82 million people with both Medicare Part A and Part B were enrolled in an MA private plan.[1] In rural America, 38.8 percent of all rural beneficiaries are enrolled in MA plans, which is lower than urban and overall percentages (47.2 and 45.7 respectively).[2] However, the rate of growth was higher in rural counties (14.2 percent) compared to metro (6.2 percent).[2] While the basic structure of MA plans remains the same regardless of location, there are key operational differences between urban and rural health care provision, including variations in provider availability, network options, and care needs. The increase of MA enrollment in rural America has had unintended consequences, including reduced rural beneficiary medical and behavioral health care access, declining quality of care, and reduced rural provider viability.[3] NRHA believes rural Americans who are enrolled in MA plans should have equitable access to health care services, and the viability of rural providers should be ensured regardless of MA or traditional Medicare coverage.

Analysis

While MA aims to provide additional benefits and potentially lower costs for beneficiaries, NRHA members have reported inequalities between MA enrollees and traditional Medicare beneficiaries. While traditional Medicare includes virtually every provider, rural MA networks are limited and tend to be more restrictive than in suburban and urban communities. Limited provider networks in rural communities significantly reduce the options available to beneficiaries, forcing them to travel long distances to access specialized care or leaving them with no choice but to receive care from providers who may not be their preferred choice or within the MA plan network. This restricted network can have negative implications for the continuity of care and overall patient experience. Further, MA plans have flexibility to steer their enrollees to specific practitioners, which may lead to plans to selectively contract with hospitals other than the local rural provider.[4]

Several rural Medicare designations are based on an alternate payment methodology including critical access hospitals (CAH) and rural health clinics (RHCs). MA may devalue these cost-based designations, which are crucial for the financial stability of rural provider types. Cost-based reimbursement is essential

to rural hospital viability as CAHs tend to care for a costlier patient population on average including older patients with multiple comorbidities. As the frequent principal source of health care services in a rural community, CAHs often have high fixed costs spread over a lower volume of services. CAHs are reimbursed on a per-diem rate for inpatient and swing-bed services and on a cost-to-charge ratio basis for outpatient services. At cost report filing, Medicare pays the difference between the hospital's true cost and what Medicare paid throughout the year, resulting in a "make-whole" payment to the hospital if costs exceed payments. MA plans, unlike traditional Medicare, do not have a process for reconciling payments to the hospital's Medicare cost report. With a doubling of nationwide MA enrollment in the past decade and no accompanying change in CMS' cost reporting or CAH reimbursement process, the shortfall in Medicare payments to CAHs has been significant.



The support provided by Medicare through various supplemental payment programs, such as Medicare-Dependent or Low-Volume hospitals, is based on the volume of Medicare business a hospital conducts. However, CMS does not consider MA as Medicare for calculating these payments. As the MA program has expanded, it has resulted in reduced Medicare payments to CAHs and undermined rural supplemental payment programs, affecting the financial health of rural hospitals. Under MA, payment for CAH services provided to MA enrollees will be determined by MA plans either through contractual arrangements or by a default decision to pay the CAH as an out-of-network provider. The law does not require that MA plans pay any certain amount or use a particular method to pay CAHs that participate in their networks. Lag time for cost settlement for correct payments under Medicare for non-contract CAHs is significantly delayed and/or non-existent within MA.

In addition, MA plan practices routinely deny access to care through restrictive admission criteria, prior authorization denials, limitations on covered services, and denied claims. These practices can lead to delays in receiving essential medical care, which can have adverse effects on the health outcomes of rural beneficiaries and create additional administrative burden for resource-limited rural providers. In traditional Medicare, care decisions are arranged between the doctor and patient, yet care decisions made under MA must involve MA plan oversight. CMS took initial steps to address some improper prior authorization denials by MA plans in a final rule published in April 2023 by clarifying that MA plans must comply with the general coverage and benefit decisions under traditional Medicare and cannot reverse decisions during a beneficiary's course of treatment.[5] However, this rule did not resolve all concerns related to prior authorization denials.

Another issue faced by under-resourced rural providers is the increased administrative burden associated with MA. These providers often have limited resources and personnel to handle the administrative requirements imposed by private insurance plans. The additional paperwork, documentation, and reporting can be overwhelming, potentially diverting resources and attention away from patient care.

Finally, a lack of competition among MA plans in many rural communities diminishes provider leverage in negotiating Medicare-equivalent rates. With only one or two MA plans available, providers have limited options to choose from, making it difficult to negotiate favorable reimbursement rates. This lack of competition can further weaken the financial position of rural providers and hinder their ability to sustain their operations.

Policy recommendations

Policy recommendations in this section are intended to support rural MA beneficiaries, health care providers, and hospitals at a local level.

- CMS should include Medicare beneficiary education regarding traditional Medicare and MA benefits to ensure the understanding of risks and benefits associated with MA plan participation in rural areas as part of the annual contract year requirements.
- MA Plan processes should decrease administrative burden for physicians. Physicians are now devoting significant time to non-productive tasks around authorization and approvals. For example, Texas House Bill 3459 of the 87th legislative session, known colloquially as the Texas Gold Card Bill, allows assessment of approval rates for at least five prior authorization requests for services submitted in the prior year. For services with a 90 percent or greater final approval rate, providers are exempt from requesting prior authorizations and may receive exemptions for multiple services.[6]
- Congress should allow CMS to consider the MA patient days and outpatient revenue as Medicare in each hospital's cost report when calculating payments to CAHs. In supplemental programs, the problem would be solved with the Medicare annual cost report filing and settlement process.
- CMS should provide greater oversight in MA plans and practices through changes in plan accountability, data collection, and information sharing including: 1) data sharing at the county level to reflect expected performances for a population; 2) information about why claims are being denied, the process being used, and any inconsistencies to the process; and 3) publishing reports on data and marketing within rural counties, including changes in rural beneficiary enrollment.

Recommended actions

The following actions, if adopted, could positively impact rural health care provision within the MA framework.

- Amend of title XVIII of the Social Security Act to allow CAHs to include inpatient days associated with Medicare+Choice patients in cost reports to protect CAH cost-based reimbursement and secure access to care.
- Extend bad debt payments for rural providers that are incurred due to beneficiary services under MA plans equivalent to what occurs under traditional Medicare.
- Ensure that rural providers, like RHCs, are reimbursed equally between MA and traditional Medicare beneficiaries through a wrap-around payment or equivalent like supplemental payments made to federally qualified health centers.
- Require MA plans to adopt and implement the CMS HPSA bonus payment program (10 percent bonus payment paid out automatically on a quarterly basis for all MA billings).
- Implement more stringent MA plan network adequacy standards for rural counties in a plan's service area to ensure access to necessary services and competition.
- Use appropriate risk adjustment reflecting rural social determinants of health and regional variation, acknowledging that unique rural aspects critical to the success of value-based models.
- Require MA plans to reimburse rural hospitals within 14 business days of receiving a clean claim.

Conclusion

MA plans in rural areas can reduce beneficiaries' medical and behavioral health access and quality of care, in addition to challenging rural provider and hospital viability. Inequality between MA enrollees and traditional Medicare beneficiaries, questionable MA plan practices that restrict access to care, affordability concerns for low-income rural beneficiaries, and more restrictive provider networks all contribute to reduced access and quality of care for individuals in rural communities. MA has posed significant challenges for rural providers, impacting their viability and financial stability. The limited participation in value-based arrangements, administrative burdens, increased bad debt, devaluation of the CAH and other rural designations, and lack of competition among MA plans all contribute to the difficulties faced by rural providers. Addressing these issues is crucial to ensure that all Medicare beneficiaries, regardless of their geographic location, have equitable access to high-quality health care services.

References

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