

# Medicare Advantage for Rural America?

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National Rural Health Association

*This brief draws significantly from public deliberations of the National Advisory Committee on Rural Health and Human Services Subcommittee on Medicare Advantage in 2006, from "Rural Must Face Risk of Privatizing Medicare" in the November 1, 2006 "RWHC Eye on Health" and input received through NRHA Rural PPS Hospital and Critical Access Hospital conference calls late in 2006 and early in 2007.*

## INTRODUCTION

The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet understood by either the public or providers. Medicare Advantage (MA) is intended to fulfill the goals of (1) substantially increasing the number of Medicare beneficiaries enrolled in private health insurance, based on the premise believed by many policy makers that competition among these private health plans and between these plans and the traditional fee-for-service Medicare program will reduce federal spending; and (2) creating opportunities for beneficiaries to enroll in richer benefit packages than available through traditional Medicare (sometimes with tradeoffs regarding choice of providers and drug formularies, and oftentimes at a higher cost than the cost of care under traditional Medicare fee-for-service). Policy makers may also believe, at least implicitly, that private health plans can be held accountable for healthy outcomes for enrollees, as measured against benchmarks established by the National Committee for Quality Assurance.

The focus of this Policy Brief is to address MA implementation issues relevant to rural communities. It assumes that the federal policy of "privatizing" Medicare to create a competitive structure to cut costs will continue. It is left to others to argue the probability of MA taking permanent root in rural America, in a way its predecessor, Medicare+Choice, did not. What we do know is that if MA plans gain rural market share, the potential consequences to rural health is significant, and potentially quite negative.

Rural America cannot wait to see what MA does or doesn't do. Potential problems need to be identified and resolved before the MA program becomes entrenched and less readily adjusted. MA must be implemented in a manner that is sensitive to the needs of rural communities. If not, the negative impact on the rural health care infrastructure could take a generation to rebuild. Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits.

## WHAT IS THE POTENTIAL DOWNSIDE OF MEDICARE ADVANTAGE IN RURAL COMMUNITIES?

*With MA, beneficiaries' access to benefits and to local providers is determined by private sector health plan contracts with beneficiaries and with providers and only indirectly by Medicare. The spread of MA fundamentally changes how beneficiaries, providers, private health insurance plans, and the Centers for Medicare and Medicaid Services (CMS), the government agency that manages the Medicare program, will relate to and work with each other. As these relationships change, there is a real and significant risk to beneficiaries' access to local care and to the*

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ability of rural hospitals and doctors to provide local services. Medicare must continue to improve, but the fragility of our seniors and the rural health infrastructure demand something more than the haphazard approach observed to date.

*Regional Preferred Provider Organizations (RPPOs)* are MA private health insurance plans that must provide uniform benefit packages and premiums to all beneficiaries in a state or combination of states—rural and urban areas alike. RPPO plans are required to gain a certain density of network providers within their geographic area or provide out-of-network services to beneficiaries at in-network cost-sharing levels. They differ from other MA health plans in this respect since all other types of MA plans are able to determine their own service area. As an incentive for the growth of RPPOs, Congress created a “stabilization fund” that CMS can draw from to make “extra” payments to the RPPOs to incent their development. Congress was explicit in its intent to encourage private plans’ growth in rural areas. In addition, many of these same insurers have the very real advantage of already contracting with beneficiaries for their Part D pharmacy coverage—the perfect platform from which to sell RPPO products. However, as of November 2006, there is very little enrollment in regional plans and the requirement that new PPOs must be regional expires on January 1, 2008. Therefore, enrollment in these regional plans may remain very low. Furthermore, the Tax Relief and Health Care Act reduced funding to the “stabilization fund” to \$3.5 billion, and delayed availability until 2012.

*Private Fee-for-Service (PFFS)*, unlike other MA plans, are similar to traditional Medicare in that they do not include a care management component. Presently, PFFS plans are available in 96 percent of rural counties, and are the most prevalent type of private Medicare plan in rural areas. There are two kinds of PFFS plans that are quite different. The first, the “non-network” model, allows PFFS plans to operate without a contracted network of providers, but these plans must pay all providers at rates that are “comparable to traditional Medicare rates.” For providers whose payments are “cost-based” under traditional Medicare, this provision appears to be being interpreted as the provider’s interim payment rate (without the usual year-end cost settlement). The second model, still rare, is a PFFS plan with a contracted network. Contracted or deemed providers in these plans may be paid at rates lower than traditional Medicare, if community access standards are met.

Under both PFFS models, providers can be “deemed” (for a particular plan enrollee for a particular visit or admission) to be PFFS plan providers. This means, without knowing it, the provider may have agreed to accept the plan’s terms and conditions, including the rate of payment. Three conditions must be met for a provider to be deemed a PFFS plan provider: (1) the provider must know that the patient is a member of a PFFS plan, (2) the provider must be aware of a PFFS plan’s terms and conditions, and (3) the provider must perform a covered service for the patient. As a deemed PFFS plan provider, a provider must accept, as payment in full, whatever rate that particular PFFS plan pays their other contracted providers. As “non-network” PFFS plans gain market share, it is reasonable to assume these plans will convert to the “network” PFFS model and become aggressive in negotiating rates below traditional Medicare payment rates and below the cost of care in rural communities.

*MA has the potential for significant beneficiary confusion.* Choice is generally thought to be good but too much choice, too much variation among MA health plans, makes comparison shopping difficult, particularly for the elderly. The potential for confusion extends to the type of private plans and the relative merits of the type of plans in comparison to each other and to traditional Medicare, leading to a concern regarding potential abuse of the system. Testimony at field hearings by the National Advisory Committee on Rural Health and Human Services cited signifi-

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cant confusion by the elderly, an issue that is not unique to rural beneficiaries. Recently, the HHS Office of the Inspector General announced that the Office is evaluating whether certain health insurers are coercing beneficiaries to enroll in an MA plan that would include prescription drug benefit (MA-PD) versus a stand-alone drug benefit program.

*Enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by MA plans against rural providers.* The MA program statutes and regulations require CMS to ensure that plan enrollees have reasonable local access to covered services. How CMS and MA plans interpret what is “reasonable” is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. As stated in the CMS Medicare Managed Care Manual: “Plans must...ensure that services are geographically accessible and consistent with local community patterns of care.” It is not known how or whether CMS is enforcing this provision with PFFS and RPPD plans. Anecdotal evidence to date indicates enforcement is lax at best.

If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. This knowledge is particularly important for enrollees in RPPD plans, since they have the right to obtain services from certain non-network providers at in-network rates if the plan’s provider network is inadequate in the beneficiaries’ area. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region’s rural providers, undermining the rural health infrastructure in the effected communities. Plans could end up steering rural beneficiaries away from their local health care providers, forcing beneficiaries to leave their community for care that’s available locally. This loss of volume could lead to the closure of local services and loss of access to care for all beneficiaries in the community as well as all other local residents.

*MA has the potential to destabilize the existing rural safety net.* Whether or not MA plans will honor existing rural add-on payments for safety net providers is not known. All MA plans, except “non-network” model PFFS plans, are permitted to negotiate payment rates with providers at levels below amounts the providers would receive under traditional fee-for-service Medicare. This is a process that seems to favor the MA plans, particularly in rural areas where providers may have little managed care contracting experience and little or no negotiating power such as in less remote areas where MA plans can threaten to steer patients to other contracted providers. In some rural areas, individual providers may be able to force fair negotiations because of isolation from other providers and therefore a position of strength vis-à-vis health plans needing to include them to meet access standards.

Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. These payments were factored into CMS’ benchmarking process that’s described below. There is a concern whether the MA plans will recognize these targeted rural special payments that have been part of traditional Medicare payments to rural providers.

*The promise of additional benefits to beneficiaries from MA plans is unevenly distributed.* The technical specifics of the MA bidding process create inequities in the availability of plans with reduced cost sharing or additional benefits in rural areas. The benchmarks used in the bidding process are based on historical Medicare fee-for-service payments at the county level, incorporating historical geographical variation in Medicare expenditures. In general, urban areas have higher physician-to-patient ratios, higher rates of utilization and consequently higher benchmark rates. The degree to which rural county level payment “floors” mitigate this issue is not known.

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Opportunities for additional savings and benefits should not be based on a system that primarily rewards areas that historically have excess utilization and provides minimal incentives to maintain reasonable utilization in those places where the amount of care provided is already close to appropriate levels, or in fact too low.

*Traditional Medicare is not a safe harbor.* If the past is a guide, economic incentives will incent MA plans to expand by attracting healthier, lower-cost beneficiaries from traditional Medicare (based on the experiences of Medicare HMOs in the 1980s and 1990s). This would have a negative effect on the traditional Medicare program, leaving it with a disproportionate number of sicker and older patients. Traditional Medicare would be left burdened with higher costs, increasing the political pressure to reduce traditional Medicare's benefits and provider payments.

The actual impact of enrollment in MA plans will be more complex than earlier managed care efforts because of provisions of the 2003 legislations that provided for full implementation of risk adjustment, use of corridors to protect plans from unpredicted risk associated with adverse selection, and enrollment in special needs plans that are marketed specifically for chronically ill beneficiaries (the number of such plans grew in 2006 and again in 2007). Nevertheless, the possibility remains that the earlier experience of favorable risk enrollment in MA plans could be repeated.

*CMS needs to walk the transparency talk.* CMS's Hospital Compare web site is based on the concept that it is good to make provider performance available to the public. Similarly, detailed data describing CMS and plan performance must be publicly available. Just one example: enrollment figures for MA plans in rural communities were not made public until almost a year after MA plans began enrolling beneficiaries. How plans are managing the communication with beneficiaries around the key issue of access standards and how CMS is monitoring compliance to these standards is also unknown.

### **RECOMMENDATIONS**

- The Congress should pass legislation that ensures Critical Access Hospitals and Rural Health Clinics are paid by MA organizations an amount equivalent to or no less than they would be paid by traditional Medicare. S. 2819, The Rural Health Services Preservation Act and H.R. 880, The Rural Health Equity Act from the 109th Congress are two examples of recommended legislation.
- CMS must engage with rural health experts regarding how best to determine and enforce rural community access standards consistent with individual communities' historic/present patterns of care. CMS must also engage with rural citizens about these standards by developing more user-friendly web sites, train more call center workers who understand the "older learner" and/or their (mature) children or friends who have questions.
- CMS must take action to ensure that beneficiaries are given the information and support to allow them to make well-informed decisions, particularly for rural beneficiaries who typically have less experience with managed care.
- CMS Regional Offices must regain their role as an access point by providers in their regions for definitive MA information and an ombudsman for dispute resolution with plans.
- CMS needs to continue providing county or equivalent specific plan enrollment data and in a timely manner (quarterly over time).
- A web site is needed for providers to verify beneficiaries' current plan enrollments.

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- The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications.
- Payments to MA plans should not rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization.
- Administration of PFFS plan payments to non-contracted providers needs to be improved. Situations where intermediaries artificially keep interim rates low as well as the fact that the CRNA pass-through and bad debt are not included in interim rates, need to be addressed.
- The Federal Office of Rural Health Policy should be given expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in the review of MA contracts.
- Congress should increase funding for local organizations serving the elderly to provide increased technical assistance to beneficiaries enrolling in MA plans.
- State insurance commissioners' offices should be encouraged to act as state level ombudsmen for rural beneficiaries enrolled with MA plans.

### CONCLUSION

Medicare Advantage is still unfolding, with its full effect yet to be seen. If the privatization of Medicare in rural America is only partially accomplished, the rural health landscape will be significantly transformed. It is imperative that (1) rural beneficiaries are ensured appropriate access to local care, (2) rural beneficiaries have access to and receive the benefits equivalent to those able to be offered by MA in urban communities, (3) payment rates are high enough to sustain a viable rural health system, and that (4) the relationship among beneficiaries, providers, plans and, CMS be well integrated.

Selected NRHA Policy & Issue Documents Relevant to this Brief  
NRHA Policy Brief: "Health Insurance Access in Rural America," March 2004  
NRHA Policy Brief: "Quality of Rural Health Care," December 2003  
NRHA Issue Paper: "A Vision For Health Reform Models For America's Rural Communities,"  
February 1998

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