

August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Huber H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 20201

RE: Request for Information on Medicare Advantage

Dear Administrator Brooks-LaSure,

Medicare Advantage (MA), often referred to as Medicare Part C, contracts with private insurers to offer traditional Medicare services to beneficiaries and may offer added supplemental benefits, such as vision or dental care. Prevalence of MA plans have grown in recent years, including in rural communities. The National Rural Health Association (NRHA) applauds the Centers for Medicare and Medicaid Services (CMS) for issuing this Request for Information (RFI) on MA to understand the impact on access and quality of care for rural beneficiaries and providers.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes every component of rural America's health care, including rural community hospitals, CAHs, doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

According to the [Kaiser Family Foundation \(KFF\)](#), virtually all Medicare beneficiaries (99 percent) have access to a MA plan as an alternative to traditional Medicare, including many beneficiaries in non-metropolitan areas (97.7 percent). However, there are still discrepancies in access to MA between rural beneficiaries and their urban and suburban counterparts. KFF notes that in calendar year (CY) 2021, 27 percent of beneficiaries have access to MA plans offered by 10 or more firms, of which the majority reside in urban and suburban areas. In contrast, 109 counties have a single MA plan offering, most of which are in rural areas.

MA enrollment grew 10 percent from July 2020 to July 2021, and now accounts for 48 percent of all Medicare beneficiaries. According to the [RUPRI Center for Rural Health Policy Analysis](#), MA enrollment in 2021 was comparatively lower in nonmetropolitan counties (34.6 percent) than in metropolitan counties (44.6 percent). However, the rate of growth was higher in nonmetropolitan counties (14.2 percent) than in metropolitan counties (6.2 percent) between 2020-2021. [KFF projects](#) that Medicare Advantage will cover over 50 percent of Medicare beneficiaries by 2023.

MA plan features may be an attractive alternative to traditional Medicare, including coverage of both Medicare Part A and B services, possible inclusion of Part D services, possible coverage of supplemental services with no or low monthly premiums, and limits on annual out-of-pocket spending. However, for rural beneficiaries these benefits may not outweigh challenges such as

narrow provider networks, prior authorization of provider orders, and differences in deductibles. In recent months, NRHA membership has expressed increasing concerns about the impact of MA plan growth on rural beneficiary access and rural provider viability. For example, [Health Affairs](#) looked at beneficiary survey data from CY 2010 to CY 2016 examining the trends among enrollment between plans. They found that returning to traditional Medicare was more common for rural enrollees (10.5 percent), compared with urban (5.0 percent), citing dissatisfaction with care access.

NRHA appreciates the opportunity to comment on this important issue facing the rural constituency. NRHA was pleased to see CMS seeking feedback on ways to strengthen MA to align with its Vision for Medicare, and its Strategic Pillars.

A. Advancing Health Equity

NRHA is particularly concerned about the inherent inequity created between MA enrollees and traditional Medicare beneficiaries, due in part to questionable MA plan practices. We have heard several accounts of rural MA beneficiaries being denied medically necessary services typically authorized for traditional Medicare beneficiaries. MA plan practices, such as more restrictive admission criteria, prior authorization denials, limitations on covered services, and denied claims, mean that rural Medicare beneficiaries are routinely being denied access to needed care. Rural Medicare beneficiaries are already disadvantaged when compared with their urban counterparts in that they face obstacles in accessing care, including longer distances to healthcare facilities, lower median incomes, higher disability rates (leading to greater need), and healthcare workforce shortages. Denying medically necessary care for MA beneficiaries increases health disparities and worsens health equity outcomes, especially for those in rural communities. Further, affordability of MA services can become an equity issue for low-income rural beneficiaries.

Questionable MA plan practices not only delays access to care, but in many cases results in administrative burdens for under resourced rural providers. For example, restrictive networks limit access where health care options may be scarce. Concurrently, rural providers experience significant challenges when handling prior authorization requests on behalf of the rural MA beneficiary who otherwise has limited options for care. **NRHA encourages CMS to investigate the lack of prior authorization for medically necessary services as we have heard from membership concerns of beneficiaries not receiving the care they need, ultimately jeopardizing their health outcomes.** Further, evidence suggests, and member experiences support, that rural MA plan enrollee dissatisfaction is partially driven by more restrictive networks in MA plans in rural communities. **To curb this, NRHA also recommends CMS consider implementing more stringent network adequacy standards for rural counties in a plan's service area to ensure access to necessary services.**

B. Expanding Access to Coverage and Care

As mentioned above, one of the most significant issues facing rural MA beneficiaries is the lack of access to services compared to their traditional Medicare counterparts. NRHA believes this is caused, in part, by beneficiaries not fully understanding the plans they are signing up for and the

differences between MA and traditional Medicare. NRHA has heard substantial concern from membership about increasing numbers of beneficiaries entering facilities anticipating access to providers and/or benefits previously accessed under Medicare, only to be either denied care or met with higher out-of-pocket costs. In part, this is due to disingenuous and misleading marketing tactics in MA plan advertisements. **NRHA encourages CMS to review MA plans' advertising practices to put a stop to those that deceive or misinform beneficiaries.**

While taking steps to stop dishonest advertising would be helpful, beneficiary education is also needed. Recently, NRHA heard an example from Nebraska where rural providers and their communities worked with a third-party organization to limit confusion through implementation of an education campaign to explain the difference between the MA plan and traditional Medicare. **NRHA believes that CMS should provide similar education the national level with full detailed information on what MA plans cover, and what beneficiaries will be gaining and losing when choosing between MA and traditional Medicare.** Further, NRHA believes it should be required that the beneficiaries know the limitations they may have on certain communities, such as the network constraints in rural communities, if they chose an MA plan.

As noted above, tactics like prior authorization can impact rural beneficiaries and providers in a unique manner. For example, a recent survey related to swing-bed post-acute care by rural hospital leadership show significant challenges access these services. Approximately 35 percent of respondents said their organizations Swing Bed programs are not included in any MA plans. Only 1.8 percent of respondents said prior authorization was not needed for Swing Bed stays, with 83 percent of respondents sharing that it takes greater than 8 hours to receive prior authorization for Swing Bed care and 35 percent of respondents shared that it takes greater than 120 minutes of staff time. Nearly 80 percent of respondents shared that they felt there was not enough transparency from MA plans in reviewing cases requiring Swing Bed care at their organization.

For some care, such as behavioral health and SUD services, MA beneficiaries cannot afford the treatment, so it is delayed, given up, or they move forward with the care at higher costs. This is particularly concerning for rural populations often are faced with economic constraints, making it more difficult for them to receive the care they need. Lack of beneficiary ability to pay results in increases in rural provider bad debt. However, because MA is treated differently than traditional Medicare, rural providers are unable to collect bad debt incurred for providing such care. **CMS should explore opportunities to extend bad debt payments for rural providers that are incurred due for beneficiary services under MA plans.**

The advertised benefits of MA plans, such as oral health coverage, may also be misleading for rural beneficiaries. While MA plan advertisements underscore the added benefits, the reality is that full coverage is frequently not provided. For example, there substantial variation in covered dental services between plans. Some plans only cover preventive services, which generally includes oral exams, cleanings, and x-rays. Additionally, many plans place a maximum dollar amount cap on the amount they will pay for dental services. NRHA believes this underscores the

need for CMS to enforce transparency in what each plan includes, and the need to crack down on disingenuous advertisements to protect rural beneficiaries.

C. Driving Innovation to Promote Person-Centered Care

Many of the MA plan value-based contracting arrangements have a one size fits all approach that disadvantage rural areas. In rural communities, there is often less participation in the value-based arrangements they are designed for urban and suburban populations. For example, many value-based payment models require 10,000 lives, and that does not align with the number of beneficiaries in rural communities. Further, rural areas have lower denominators, which causes challenges to participation in risk-based contracting. Having appropriate risk adjustment reflecting rural social determinants of health and rural regional variation is critical to the success of these models in rural areas. **NRHA encourages CMS to acknowledge that rural areas are different, and therefore adjust MA plan requirements related to quality and value.**

NRHA members have expressed an awareness of value-based contracting opportunities but have not engaged due in part to lack of trust with the MA plans. To date, many experiences with MA plan value-based contracting have been aimed more at document and coding changes, rather than improving quality or outcomes that benefit rural beneficiaries and providers. Further, NRHA members have expressed concerns with how MA plans reimburse rural providers, refusing to guarantee many of the protections put in place to ensure rural provider viability. **NRHA asks CMS to ensure rural providers, like RHCs, are reimbursed evenly between MA and traditional Medicare beneficiaries through a wrap-around payment or equivalent.** Actions providing transparency and alignment between MA plans and traditional Medicare may improve value-based contracting relationships and outcomes.

D. Supporting Affordability and Sustainability

Payments by Medicare to rural hospitals in the Critical Access Hospital (CAH) program, and several other rural hospital Medicare supplemental payments (Medicare Dependent Hospital, Low Volume Adjustment) are based on how much Medicare business a hospital does. CMS does not consider MA to be Medicare for purposes of calculating these payments. As the MA program has grown in recent years, it is reducing the Medicare payments to CAHs and in some of the supplemental payment programs. **NRHA recommends CMS consider the MA patient days and outpatient revenue as Medicare in each hospital's cost report when calculating payments to CAHs**, and in the supplemental programs, the problem would be solved with the Medicare annual cost report filing and settlement process.

Further, 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 any particular method to pay CAHs who participate in their networks. A [2005 Rural Health Policy brief by RUPRI](#) reported that about two-thirds of signed cost-based contracts included provisions for annual cost settlement, but in most cases administrators had to negotiate to get settlement terms in the final contract. If an MA plan is paying for services rendered by a CAH not in its network, it must pay what Medicare would otherwise pay. However, lag time for cost

settlement for correct payments under Medicare for non-contract CAHs are significantly delayed and/or non-existent within Medicare Advantage. **NRHA asks that CMS force MA plans to pay hospitals cost (the same way that traditional Medicare does) and/or require MA plans to reimburse rural hospitals within 10 business days in order to address this discrepancy.**

The proliferation of MA is hurting the long-term viability of rural providers where reliance on Medicare reimbursement is higher. The rural health care safety net cannot sustain additional losses at a time when nearly 140 hospitals have closed since 2010. NRHA believes the increase in MA enrollment has resulted the unintended consequence of weakening rural America's safety net system and **encourages CMS to work within its authority to uphold rural designations and their reimbursements through MA considering the proliferation of MA plans.**

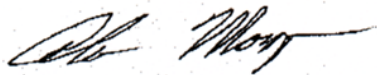
In addition to the challenges outlined in the previous section, lack of competition among MA plans results in less leverage for provider negotiation on Medicare-equivalent rates. In many communities there are only one or two MA plans for beneficiaries to choose from. Consequently, these plans have a large foothold in rural areas and thus stifle competition. While there may never be the same prevalence of plans in rural areas as in urban and suburban areas, **CMS can help ensure competition by implementing robust network adequacy standards for rural areas**, as discussed in the "Advancing Health Equity" section of the RFI.

E. Engaging Partners

CMS could engage rural providers by improving transparency in MA plans and practices through changes in data 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) reports on data and marketing within rural counties, including changes in rural beneficiary enrollment.

Thank you for the chance to offer comments on the MA program through this RFI. We very much look forward to continuing our work to ensure our mutual goal of improving quality and access to care in rural communities. If you would like additional information, please contact Josh Jorgensen (jjorgensen@ruralhealth.us).

Sincerely,



Alan Morgan
Chief Executive Officer