Rural Hospitals Seek Help as Private Medicare Patients Increase

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- Medicare Advantage pay, coverage denials irk facilities
- Plans' rural enrollment growth outpacing urban areas

Rapid enrollment growth in Medicare managed care plans is creating another layer of economic uncertainty for beleaguered rural hospitals.

The number of rural beneficiaries enrolled in private Medicare Advantage plans jumped nearly 48%, from 6.3 million to 9.2 million, between 2019 and 2023, according to health consulting firm Chartis. By 2023, 44% of rural beneficiaries were enrolled in MA plans, according to the Medicare Payment Advisory Commission.

But rural hospitals say MA plans often pay less than traditional Medicare, don't cover as many services, and are more likely to deny or delay coverage through prior authorization. And more than other commercial payers, MA plans reduce and revoke payments for care already provided, said Brock Slabach, chief operating officer of the National Rural Health Association.

Rather than appeal those decisions, rural hospitals "often just cash the check that's short what they should be paid, and don't bother," Slabach said. "They don't have the people or the resources to do the follow-up to try to get the claim paid correctly."

The growing dominance of Medicare Advantage is the latest headache for rural facilities already struggling with slim margins, growing uncompensated care costs, and high uninsured rates in states that haven't expanded Medicaid eligibility. As MA becomes the dominant payer in many rural markets, the NRHA wants a slew of payment policy changes to help rural hospitals weather the transition.

Helping or Hurting?

But some experts say that's not necessary, and recent research found Medicare Advantage has helped, not hurt rural hospitals. "I'm uncertain on how much MA is exacerbating the long list of challenges facing rural hospitals," said Jack Hoadley, research professor emeritus at Georgetown University's Health Policy Institute.

Medicare Advantage plans now cover more than half of eligible beneficiaries and are expected to receive more than $7 trillion in federal funding over the next decade, the Centers for Medicare & Medicaid Services estimates. Unlike traditional fee-for-service Medicare, which pays for each medical service provided, MA plans receive a flat monthly payment to cover each beneficiary's cost of care. The plans negotiate their own rates with providers.

The Medicare commission is studying MA's effect on rural providers and whether payment policy changes are needed. Their annual recommendations to Congress are nonbinding, but their expertise helps inform lawmakers' decisions.

In interviews with commission staff over the last year, rural providers "tended to express frustration," said Jeff Stensland, a commission principal policy analyst, during the panel's March meeting. "They were frustrated with prior authorization, with MA plans sometimes paying less than the full rates they received from fee-for-service Medicare, and the extra effort and time it takes to be paid from MA compared to fee-for-service," Stensland said.

Six months after an MA plan approved, then paid, $8,000 for a patient's October 2022 surgery in rural Colorado, the plan withdrew the entire payment, saying the surgery wasn't necessary, said Konnie Martin, CEO of San Luis Valley Health, which operates two hospitals in rural south central Colorado.

It took months of appeals and waiting to get the plan to re-submit the full payment last year—in four $2,000 payments spaced out over a month, Martin said. "We had to work twice as hard six or eight months later just to get the same payment," Martin said. "You're always going to have a very small margin, but now you've just lost whatever margin you had," because you had to go through the whole billing process twice.

Tough for Critical Access Hospitals

The situation is particularly dicey for the nation's rural critical access hospitals. Unlike other hospitals, traditional Medicare rates for these facilities are mainly based on the cost of care. The payments can also cover the shortfall between the actual cost of care and what Medicare reimbursed, according to the NRHA policy paper.

Medicare Advantage has no such "process for reconciling payments," the paper said. As more rural beneficiaries opt for MA coverage, the resulting "shortfall in Medicare payments to critical access hospitals has been significant," the paper said.

Chris Barber, CEO of St. Bernards Healthcare in Jonesboro, Ark., said Medicare Advantage payments were down 37% compared with traditional Medicare payments at St. Bernards CrossRidge Community Hospital, a critical access facility in Wynne, Ark. Barber said MA coverage denials were driving the payment declines. "That's just not a sustainable model for a critical access hospital," he said.

Martin agreed. "A big portion of what I used to count on for cost-based reimbursement is just being pulled out from under me," she said of dwindling Medicare revenue at Valley Health's Conejos County Hospital, a 17-bed critical access facility in La Jara, Colo. "It's like the ground that we're standing on is crumbling. It is really, really scary."

Hoadley, of Georgetown University, said rural hospitals' struggles stem from a larger problem: too few patients to pay the fixed costs of operating a full-service facility. Medicare Advantage payment rates closely mirror traditional Medicare rates, which are both lower than most commercial rates, Hoadley said.

“So they feel like they’re underpaid. But they’re not necessarily getting lower payments out of Medicare Advantage than they are from traditional Medicare,” Hoadley said. While MA plans’ prior authorization and payment policies may be problematic for rural hospitals, “I’m not completely convinced by their argument” for payment policy changes, Hoadley said.

New Rule

A CMS rule streamlined the MA prior authorization process this year and provided clinical criteria guidelines to ensure MA beneficiaries can access the same medically necessary care they’d get in traditional Medicare. It also required that MA coverage denials “based on a medical necessity determination must be reviewed by a physician or other appropriate health care professional.”

Martin said it’s still early, but dealings with MA plans have improved since the rule took effect. “It’s looking a little better,” she said. “But in the last two years, it’s been brutal.” Last year, a study of rural hospitals in 14 states found MA beneficiary growth and inpatient stays both increased 14 percentage points from 2008 through 2019. But a summary of the research said the increased MA penetration was “associated with increased financial stability and reduced risk of closure, countering the notion that these plans hurt rural hospitals through less generous payments than traditional Medicare” and through “additional administrative requirements.”

The findings surprised Mark Holmes, director of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina. Holmes said rural hospital administrators “at every conference I’ve gone to for the past two years” have all said “‘the biggest threat to where we are is MA.’”

The researchers and the hospital administrators could both be right, Holmes said. An 18-month to 2-year lag on hospital cost report data means the study may not fully reflect the financial effects of the pandemic, Holmes said. The research may also not have adequately factored the hospitals’ “increased cost of collecting” MA payments due to prior authorization and lengthy payment appeals, he said.
Slabach said the only way to know the true impact of MA is to conduct a large study comparing final payments from MA and traditional Medicare versus what was actually charged.

Since 2010, 83 rural hospitals have closed and 66 others no longer provide inpatient care, but do offer some health services, the Sheps center reports. Some struggling facilities could avoid closure by reclassifying as a rural emergency hospital that receives enhanced payments, and provides 24-hour emergency and observational care, but no inpatient care.

The REH designation is the first new class of rural care provider since critical access hospitals were created in 1997.

Holmes said the new designation helps facilities, but “it’s not a panacea for all of rural health care,” which continues to struggle with isolation, seasonal economies and population swings, and high rates of low-income patients.

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