National Rural Health Association

May 29, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

RE: CMS–4207–NC; Medicare Program; Request for Information on Medicare Advantage Data.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to submit a response to the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage Data request for information. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Background

The popularity of Medicare Advantage (MA) plans as an alternative to Traditional Medicare has grown significantly in recent years. Both rural and urban areas have seen MA enrollment become a larger fraction of total Medicare enrollment in the past decade, yet rural beneficiaries have increasingly chosen MA plans over Traditional Medicare with the rate of MA growth in nonmetropolitan counties higher than metropolitan counties.[1] About 45% of all rural beneficiaries are enrolled in an MA plan and current trends point to MA plans enrolling a majority of rural beneficiaries in two years.[2]

The growth of MA enrollment across the country underscores the importance of transparency, clarity, and consistency in MA for rural beneficiaries and providers. NRHA members have increasingly voiced their frustrations and concerns with MA plans and how these issues affect their beneficiaries' access to care. Rural beneficiaries already face access challenges given the unique characteristics of rural areas, and MA plan practices cannot continue to compound such barriers to care.

Payment

Reimbursement Rates

[1] Edmer Lazaro, Fred Ullrich, & Keith Mueller, *Medicare Advantage Enrollment Update 2023*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA, 2, November 2023, https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Medicare%20Advantage%20Enrollment%20Update%2023.pdf.
[2] *Id.* at 3.

NRHA members have voiced that payment-related challenges with MA plans have negatively impacted their patients, staff, and facilities. Payment challenges are heightened for providers with special rural designations and payment systems, like critical access hospitals (CAHs) and rural health clinics (RHCs) because of their specific payment rates. However, CAHs and RHCs are not alone in struggling with reimbursement. NRHA members representing various facility types have raised concerns over payment timeliness, audits, negotiating power, and payment denials.

As the proportion of MA beneficiaries compared to Traditional Medicare beneficiaries continues to grow, rural providers that are reimbursed on a different payment system are increasingly at risk. Growing MA enrollment in rural areas is diluting the original purpose of these rural designations and threatening the role they play to support rural providers. CAHs are paid 101% of reasonable costs and RHCs are paid their specific all-inclusive rate (AIR) through Traditional Medicare. Yet MA plans frequently do not adhere to these Traditional Medicare payment rates and in turn CAHs and RHCs receive unsustainable reimbursement from the plans.

NRHA members have consistently reported that MA plans are not voluntarily paying rural providers Traditional Medicare rates when there is no contract in place. Regulations on MA payment state that services furnished by 1861(u) providers (which include hospitals, CAHs, and skilled nursing facilities [SNFs]) without a contract with an MA plan must accept as payment in full the amount that it could collect if the beneficiary were enrolled in Traditional Medicare.[3] Further, sub-regulatory guidance on MA payment to out-of-network providers states that MA plans are generally required to pay at least Traditional Medicare rates for Medicare covered services.[4] In short, **MA plans must pay rural providers at least their Traditional Medicare rate if there is no contract in place. NRHA urges CMS to consider punitive measures to ensure that MA plans are paying rates equivalent to Traditional Medicare when a rural provider is out-of-network and to wield its authority to enforce this provision.**

MA regulations also call for a "deemed request" for a provider's Medicare payment rate. Out-of-network providers that furnish services to MA beneficiaries and submit information that they would normally submit for payment under Traditional Medicare is deemed to be seeking payment in the amount it would receive under Traditional Medicare unless expressly stated that they are specifically billing less to the MA plan.[5] Again, this regulation should guarantee that rural providers without a contract are paid their Traditional Medicare rate unless they explicitly tell the plan they are billing them for a lower amount.

For rural providers that have contracted with MA plans, the plans pay varying rates. Some NRHA members have noted that payment is consistent with their Traditional Medicare rates. When it is not, NRHA is concerned that rural providers do not have the negotiating power or resources to properly negotiate a beneficial contract. Rural providers do not have the data and analytical capacity in-house to successfully argue for favorable terms in the contract. This is of particular concern due to the fact that MA plan benchmark rates are set to include the specific payment rates CAHs, RHCs, and other rural providers would have otherwise received under Traditional Medicare. **CMS needs to hold MA plans accountable for rural payments they are receiving but not passing along to rural safety-net providers. NRHA believes it is CMS' role to intervene because of the marketplace inefficiencies leader to small rural provider inability to negotiate contracts with large, national MA plans.**

[3] 42 C.F.R. § 422.214(b) (2023).
[4] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf
[5] § 422.412(c).

Timeliness and Denials of Payment

Other common payment issues are timeliness and denials. Even when a rural provider receives payment equivalent to their Traditional Medicare rate, getting timely payments is difficult. For example, when a provider bills for a service, a plan may deny the claim after the beneficiary received the service despite previously receiving prior authorization which is used to determine medical necessity. NRHA members note that this happens most often for inpatient stays. In other cases, MA plans delay payment or make the process of getting paid the correct amount so time consuming and burdensome that rural providers do not have adequate staff, time, or resources to address every payment issue or to pursue timely and accurate payment. In extreme circumstances, NRHA members have noted up to $800,000 in delayed or denied payments. For rural hospitals that with thin or negative margins delayed payments are a critical cash flow issue. **Half of rural hospitals operate on negative margins, and they cannot absorb this level of untimely payments.**[6] Furthermore, administrators are frustrated with untimely payments because it is difficult to operate and plan without predictable payments from a growing number of their patients.

As the ultimate payer of MA plans, **CMS must use its authority to ensure that MA plans are properly using federal funds when paying rural providers.** MA regulations state that contracts between CMS and MA plans must include a provision mandating that the plan will pay 95% of "clean claims" within 30 days of receipt.[7] MA regulations further provide the definition of a clean claim.[8] CMS must enforce this provision and investigate whether plans are meeting the 95% threshold and if they are determining correctly whether claims are clean. MA plans must not be permitted to delay and deny payments that are properly prepared with substantiating documentation by alleging that the claim is not "clean" and therefore cannot be paid within 30 days. **Traditional Medicare must pay providers within 30 days and MA plans must be held to the same standard.** CMS should also mandate reporting by MA plans on the rate of timely payments to providers and make this information publicly available for providers.

Even after payments are made to providers, plans will perform post-audits. NRHA members have experienced audits by MA plans that probe back as far as 4 years in an effort to recoup payments. MA plans should not have unmitigated authority to perform audits that go back years. Providers are subject to billing deadlines and similarly, **MA plans should be subject to look back period restrictions for auditing payments.**

<u>Access to Care</u>

Prior authorization.

NRHA members have cited prior authorization as a major barrier to care for beneficiaries and an administrative burden to staff. NRHA appreciates the steps toward prior authorization transparency and reform in recently finalized rules from CMS yet more must be done to protect rural beneficiaries and providers. **Rural providers, including NRHA members, have been told by MA plans that they**

[6] Michael Topchik, et al., *Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory,* Chartis (2024), 2, https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf.
[7] § 422.520(a)(1).
[8] § 422.500(b).

will not comply with the prior authorization regulations finalized in the plan year 2024 final rule.[9] Prior authorization is a common issue plaguing providers both rural and urban; however, under resourced rural providers do not have the staff needed to jump through MA plans' prior authorization hoops. Consequently, rural providers experience high administrative burden, are paid less than Traditional Medicare, and have little recourse to address MA plan abuses.

Reporting by MA plans on prior authorization practices must be more robust and transparent. Beginning in 2026, plans will be required to report aggregate data on the percent of prior authorization approvals, denials, and approvals after appeal at the contract level. Plans must also post a list of all items and services that require prior authorization beginning in 2026. These will be positive changes; however, NRHA members are frustrated with the delays in implementation of revisions to the prior authorization processes and believe the final regulations did not go far enough towards providing detailed reporting by MA plans to help understand what services have the highest prior authorization denial rates and how often MA plans deny services**. Specifically, NRHA recommends mandated reporting by MA plans on:**

- **Prior authorization approval and denial rates, and approval rates after an appeal by type of service for both standard and expedited requests.** NRHA acknowledges that CMS declined to go this far in its Advancing Interoperability and Improving Prior Authorization final rule due to concerns around "data overload, patient understanding, and usability of data."[10] However, NRHA believes that the benefits of transparency around prior authorization outweigh CMS' concerns. Granular data would be more beneficial for certain users, like providers, because they would be able to see the services for which prior authorization requests are most often made. Alternatively, if this reporting requirement is too large, CMS may consider choosing a list of the top 50, for example, most utilized services for which these elements must be reported.
- **Specific reasons for prior authorization denials for standard and expedited requests.** Beginning in 2026, plans must give providers and beneficiaries a specific reason for a denial; however, nothing in the final rule touches on reporting this information. Making public the rates of denials for a specific service, along with the rate of denial for a specific reason, would increase transparency in the MA program.
- **Share of Medicare Advantage claims denied after a service has been provided.** NRHA members are increasingly seeing MA plans deny claims after the service has been furnished. More transparency is needed in this area to understand the reach and impact of this practice.
- **Timeliness of prior authorization decisions by a type of service for standard and expedited requests.** Again, MA plans will report on the average timeframe of prior authorization decisions in 2026, but NRHA does not feel this goes far enough. MA plans should report on the average response time broken down by type of service. As mentioned above, CMS could initially scale this reporting requirement by limiting it to a number of services that are most utilized by beneficiaries.
- **Timeliness of prior authorization appeals decisions by type of service for standard and expedited requests.** Beneficiaries and providers would benefit from understanding how

[9] Rylee Wilson, *Insurers aren't following CMS' new Medicare Advantage rules, AHA says*, BECKER'S HEALTHCARE, November 21 2023, https://www.beckerspayer.com/payer/insurers-arent-following-cms-medicare-advantage-rules-aha-alleges.html?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=7575J1041234H4L.

[10] Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8890 (Feb. 8, 2024) (to be codified 42 C.F.R. 422).

long a decision on an appeal is expected to take, especially for urgently needed services. NRHA members are concerned about how long MA plans take to decide on prior authorization requests, especially inpatient stays.

- **Prior authorization approval and denial rates and approval rates after an appeal by beneficiary characteristics.**

Further, **this information should be made publicly available in one central location, such as CMS' website.** Reporting requirements finalized in early 2024, referenced above, will only be available on individual plans' websites. Individuals looking for this information, particularly to compare approval and denial rates across plans, would have to search multiple plan websites.

An analysis of prior authorization requests submitted in 2021 shows that a relatively low proportion of denials are appealed but when they are, most appeals (82%) are successful.[11] While this analysis provides a hopeful picture of the prior authorization appeals process, it is nevertheless problematic that many requests for medically necessary services are denied. In addition, NRHA members note that they have not seen this level of success with the appeals process. One NRHA member in Maine has waited 90 to 120 days to hear back after filing an appeal. This timeframe is unacceptable for standard, non-urgent requests and dangerous when beneficiaries need a service urgently. While reporting by MA plans on the appeals process may be illustrative, more must be done. Beneficiaries or their physicians must file a request for reconsideration within 60 days of the denial. **Accordingly, MA plans should be subject to a timeline for appeals decisions as well.** CMS should amend 42 C.F.R. § 422.582 to subject MA plans to stricter appeals process requirements.

NRHA members have also raised concerns over prior authorization practices around specific services. NRHA hears the majority of complaints around approval for inpatient admissions. MA plans stall when responding to a prior authorization request for an inpatient stay, and in many other cases plans outright deny inpatient admissions. Delayed prior authorization has unique impacts on CAHs in particular. CAHs are subject to a 96-hour average length of stay under their conditions of participation. When MA plans do not act on a request while a beneficiary is under observation, this impacts the CAH's average length of stay.

NRHA members also experience issues with MA plans' internal guidance for approving inpatient stays. Plans should follow the two-midnight rule, which provides that inpatient stays are covered for Traditional Medicare beneficiaries who require more than a one-day stay in a hospital or who need treatment that is considered inpatient-only. CMS finalized a rule establishing that MA plans must follow this determination as well.[12] However, NRHA members expressed that plans are not following this criterion, with one member citing that a plan stated to them that the plan's internal criteria will trump CMS' rule.[13] Relatedly, NRHA members experience "downcoding," or the MA plan changing the claim to a lower-cost service than what was submitted by the provider. NRHA members frequently see this happen when plans downgrade inpatient care to observation status despite the provider expecting the beneficiary to require care for at least two midnights. This practice impacts payment to hospitals but also threatens the beneficiary's eligibility for post-acute care (for example, SNF admission requires a prior 3-day hospital stay).

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[11] Jeannie Fuglestein Biniek, Meredith Freed, & Tricia Neuman, *Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency*, KAISER FAMILY FOUNDATION, April 10, 2024, https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/.

[12] § 422.101(b)(2).

[13] Wilson, *supra* note 9.

Another example that threatens beneficiary health and safety is the delay of approval, or ultimate denial, of a request to transfer a beneficiary from inpatient care to post-acute care, such as a SNF or a swing bed. This creates a delay in discharge that means the beneficiary is not receiving the skilled care that they need. For the rural provider, they must shoulder the costs of continuing to provide care for the beneficiary when they should have been discharged. Additionally, in times of high volume such as respiratory illness season, a beneficiary that cannot be transferred in a timely manner means another patient may not be able to be admitted because of limited bed availability.

When care is approved MA plans frequently steer rural beneficiaries to a particular provider type or facility. Where rural beneficiaries receive care is important because of the more significant travel burdens in rural areas. The biggest instance of this practice is plans steering beneficiaries to a SNF rather than a swing bed in a local rural facility. This is an issue for beneficiaries when swing bed care is in their community and near their support system, and the SNF is further away. **MA plans should send rural beneficiaries to the setting that best meets their needs, which includes considering keeping them close to home.** On the hospital side, MA steerage means that some CAHs are seeing swing bed services decline because plans will not send beneficiaries to a swing bed even when they are contracted with the hospital. NRHA member CAHs have also said that MA plans will cover services at their CAH but advise beneficiaries that care will be cheaper (i.e., lower co-pay) at another non-CAH hospital that is farther away. NRHA members feel that some plans are discriminating against CAHs by driving beneficiaries elsewhere in order not to pay higher reimbursement rates needed to maintain access to care in rural areas.

Contracts.

Increasingly, hospitals and health systems are considering dropping all contracts with MA plans because they can no longer deal with the complexities and administrative burden of MA plans. Unfortunately, this leads to restrictions on access to care for beneficiaries who cannot afford out-of-network services when their local hospital is no longer contracted with their MA plan. Rural MA beneficiaries face difficult choices of forgoing care, traveling further for care, or paying out-of-network costs.[14] For example, 21 hospitals in Kansas do not have any MA contracts and a recent survey revealed that 31% of Kansas hospitals with contracts are considering dropping them. Qualitative results from this survey reveal a common theme across hospitals: Rural hospitals do not want to add new MA contracts due to unfavorable reimbursement and time-consuming administrative processes (both related to prior authorization and payment) or are considering termination of existing contracts. Rural hospitals that are not considering termination feel stuck because they want to retain access to care for their communities and penetration is too high not to contract with the plans. Hospitals also indicated that they had longstanding contracts with MA plans before enrollment grew substantially and they did not face the prior authorization and payment issues that exist today before MA became a significant portion of the market.

<u>Consumer Protection.</u>

Enrollment

[14] Gretchen Morgenson, *'Deny, deny, deny': By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, says CEOs*, NBC NEWS, Oct. 31, 2023, https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012.

NRHA members are reporting that some MA beneficiaries do not realize that they are enrolled in an MA plan as opposed to Traditional Medicare. Oftentimes beneficiaries discover their new coverage by receiving an unexpected bill from the provider. In other instances, beneficiaries belatedly realize that they cannot see their usual provider because they are no longer in-network.

While MA plans may meet the health needs of some beneficiaries, **those who were inadvertently enrolled in an MA plan or enrolled without understanding the implications to their coverage should be able to transition back to Traditional Medicare.** It is possible for beneficiaries to change plans during open enrollment, but there are barriers to doing so. One major roadblock is cost. One typical reason that beneficiaries choose MA plans is because out-of-pocket costs are lower without having to buy a supplement, or Medigap, plan. MA plans typically cover premiums, but Traditional Medicare does not do so without the beneficiary purchasing a Medigap plan. Beneficiaries that want to switch to Traditional Medicare must be underwritten for a Medigap policy and beneficiaries may be denied a policy if they do not meet medical underwriting requirements.

Beneficiaries who enroll in MA plans, particularly those who switch from Traditional Medicare, may not realize that their provider access has shrunk. Beneficiaries in Traditional Medicare can see any provider and use any facility that accepts Medicare. One tradeoff for an MA plan is that beneficiaries can only see in-network providers. NRHA acknowledges the network adequacy parameters that MA plans must meet to ensure beneficiaries have access to providers within certain time and distance standards. The problem arises when beneficiaries must find new providers because their existing provider is now out-of-network in their new MA plan. Additionally, even though plans must contract with providers to meet network adequacy rules, this does not guarantee that rural beneficiaries are able to see their closest or local provider.

Marketing Practices

NRHA appreciates the strides made towards preventing misleading marketing and advertising by MA plans and third-party marketing organizations. Nevertheless, NRHA members continue to voice concerns and share stories of beneficiaries at their facilities that have been inadvertently enrolled in an MA plan. This is most troubling when a beneficiary is moved from Traditional Medicare to an MA plan that no longer covers their care. An NRHA member in North Dakota shared experiences of two diabetic beneficiaries that were switched to MA plans by simply saying "yes" during a misleading and unsolicited phone call with a plan. Following enrollment in the new plan, neither beneficiary had critically needed diabetic and wound care covered as they did under Traditional Medicare.

These experiences with transitions to MA plans are not one-offs. NRHA members deal with beneficiaries that no longer realize they have Parts A and B coverage regularly. We are concerned about the practice of covertly enrolling beneficiaries in MA plans, especially when the plans do not meet serious health needs of the beneficiaries, as noted above. Further, rural providers have expressed concerns over beneficiaries that do not have the capacity to make informed decisions being put in MA plans without realizing it. Too often we hear from NRHA members that their patients are enticed by a plan due to promises of extra perks without an explanation as to how their benefits will otherwise change. To prevent this practice, beneficiaries must be active participants in choosing their coverage.

NRHA urges CMS to consider swift action to protect rural beneficiaries. Without complete knowledge and consent to enrolling in MA plans, rural beneficiaries may no longer have access to their normal or local provider and coverage for their specific medical needs. This is a threat to beneficiaries' health. Additionally, they may see unexpected bills due to receiving out-of-network care. **NRHA suggests**

that plans must affirmatively enroll beneficiaries, such as through a formal application and enrollment process. Further, plans should be subject to transparency measures like reporting on the number of beneficiaries that switched from Traditional Medicare to their plan.

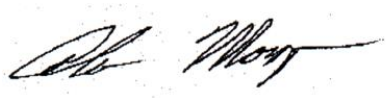
Benefits

Following the CHRONIC Act of 2018, MA enrollment grew, likely in part due to the availability of special supplemental benefits. In general, traditional health-related benefits (i.e., vision, hearing, dental, and fitness) are available at comparable rates in rural areas and urban areas, but rural areas lag slightly behind in access. For example, 92% of noncore counties, 97% of micropolitan counties, and 99.5% of metropolitan counties have plans that offer vision benefits. These numbers are similar for other primarily health-related benefits.[15] Expanded benefits such as in-home support services and home-based palliative care are available at far lower rates – only 54% and 5.5% noncore counties have plans that offer these benefits respectively.[16] In comparison, 82% of metropolitan counties have plans that offer in-home support services and 14% have plans that offer home-based palliative care.[17] Special Supplemental Benefits for the Chronically Ill address health-related social needs, like food and meals, transportation, and general support for living and are not widely available in noncore and micropolitan counties either.[18]

It is difficult to assess the impact of supplemental benefits on the health outcomes of beneficiaries enrolled in MA plans. This information would be particularly useful to gauge how the lower availability of supplemental benefits in rural areas may lead to health disparities compared to beneficiaries in areas with higher availability. **CMS should consider more robust data reporting and publishing requirements related to beneficiaries' use of supplemental benefits.** Beginning this year, CMS will collect data on use and spending for supplemental benefits but not payment and spending data that could show how much MA enrollees spend out-of-pocket each year on extra benefits. Additionally, information on the proportion of MA beneficiaries using supplemental benefits should be reported and published.

NRHA thanks CMS for the opportunity to weigh in on MA issues. We look forward to our continued work together. If you have any questions or would like to discuss our response further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[15] Edmer Lazaro, et al., *Medicare Advantage Plan Growth in Rural America: Availability of Supplemental Benefits*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA, 2-3, May 2024, https://rupri.public-health.uiowa.edu/publications/policybriefs/2024/MA_Plan_Growth.pdf.
[16] *Id.* at 3.
[17] *Id.*
[18] *Id.*