



MEDICARE ADVANTAGE AND ITS IMPACT ON RURAL HEALTHCARE

RHPTP HELP Webinar

July 9, 2024

TODAY'S WEBINAR



This webinar will explore the distinctions of Medicare Advantage and its impact on rural healthcare organizations. Participants will learn about the fundamentals of this health plan, as well as the unique challenges Medicare Advantage can pose to patients and providers. Speakers will also discuss opportunities and actionable strategies for improving rural healthcare organizations' relationship with Medicare Advantage moving forward.



Upon completion of this webinar, participants will be able to:

- Interpret the distinctions and impact of Medicare Advantage

- Identify the unique challenges and opportunities that Medicare Advantage presents

- Implement strategies for optimizing Medicare Advantage





MEDICARE ADVANTAGE 101

WHAT IS MEDICARE?

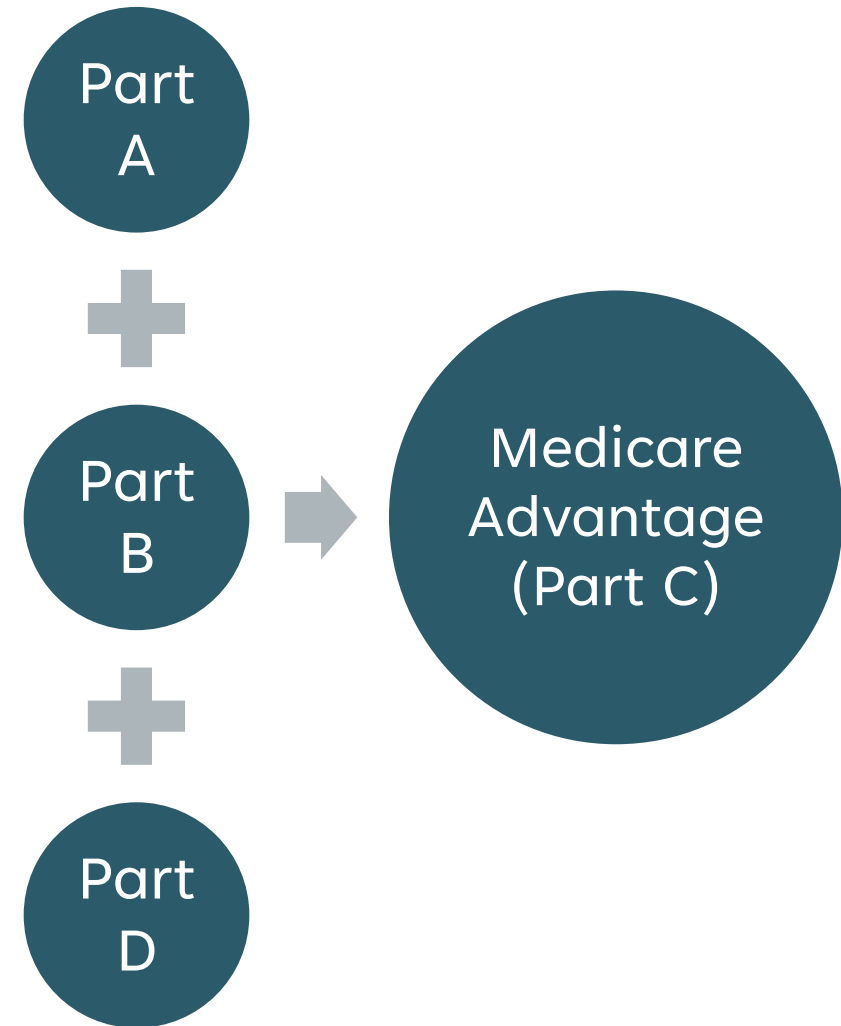


- Federal Legislation
- Enacted in 1965 under the Social Security Administration
 - Title XVIII of the Social Security Act
- Currently administered by the Centers for Medicare and Medicaid Services (CMS)
- Eligibility
 - Aged 65 and older
 - Disabled
 - End-Stage Renal Disease (ESRD)
- Four Parts to the Legislation
 - Part A – Hospital Inpatient
 - Part B – Hospital Outpatient
 - Part C – Medicare Advantage
 - Part D – Prescription Drug Benefit



BASICS OF THE MEDICARE ADVANTAGE HEALTH PLAN

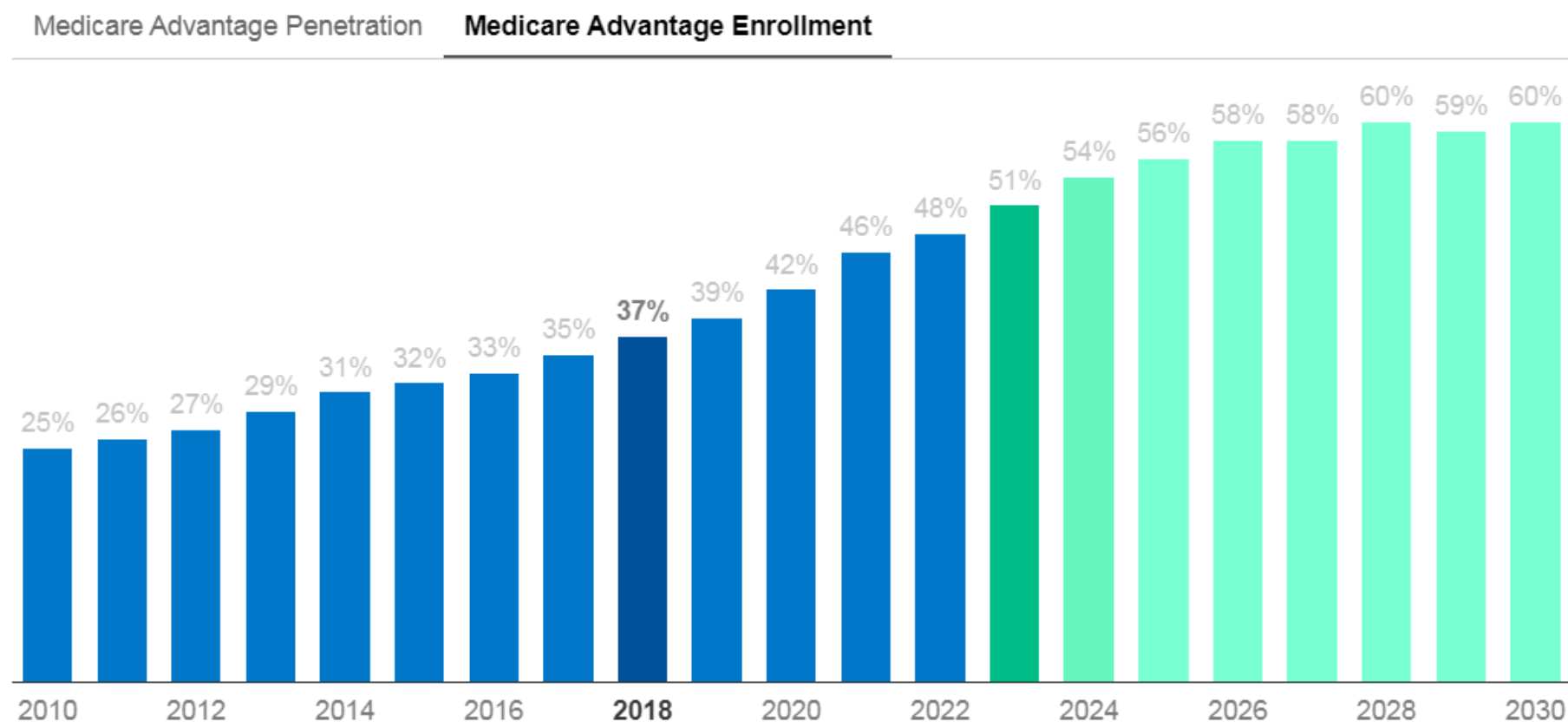
- A health plan offered by Medicare-approved private companies
- Must follow Medicare rules
- Medicare pays the Advantage plan a fixed amount per enrollee
- The coverage must meet or exceed Medicare Part A & B coverage
- Some plans include Part D benefits
- Enrollees follow rules established by health plans



RISE OF MEDICARE ADVANTAGE

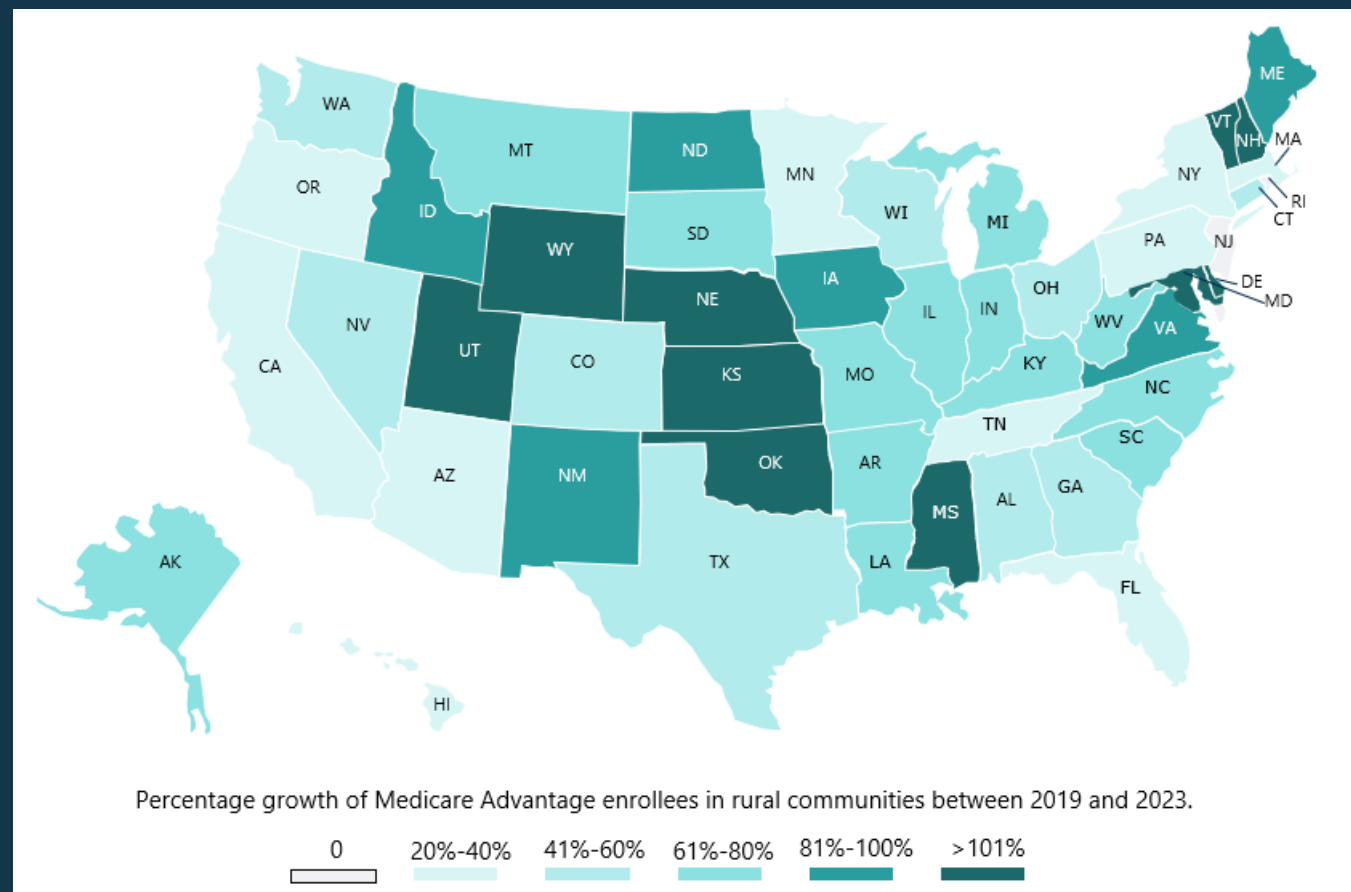
Medicare Advantage Enrollment and Projections

*Medicare Advantage Enrollment 2010-2023 & Projected Enrollment 2024-2030
(As a share of the eligible Medicare population)*



MEDICARE ADVANTAGE ENROLLMENT IN RURAL

- Medicare Advantage enrollment in rural increased 46% between 2019 and 2023
- 10 states have seen enrollment in Medicare Advantage increase by more than 100% between 2019 and 2023
- Rural communities are defined as county in which a rural hospital is located



WHY ARE ENROLLEES CHOOSING MEDICARE ADVANTAGE?

Potential Increased Benefits

- Hospital
- Outpatient
- Pharmacy
- Dental
- Vision
- Fitness Clubs

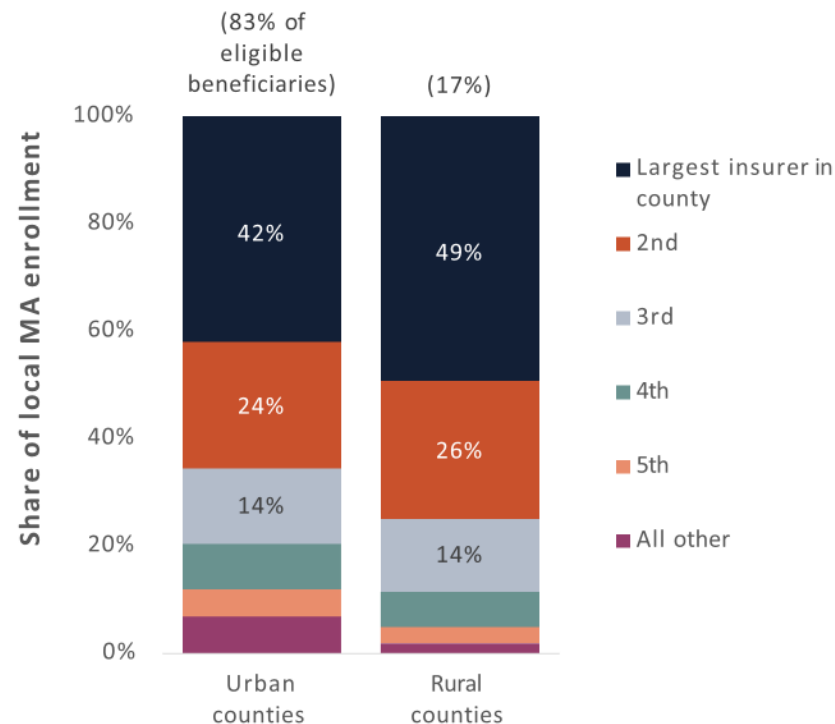
Financial

- Lower co-pays
- Limited out-of-pocket exposure



MEDICARE ADVANTAGE PROGRAM (MEDPAC) ANNUAL REPORT

The largest three insurers in a market typically enroll roughly 80 percent of enrollees



- The typical MA market has plans offered by roughly 8 insurers
- Local enrollment is generally highly concentrated in the top three insurers
- The largest insurers nationally also frequently cover the largest share of enrollees at the local level

Source: MedPAC analysis of CMS 2023 enrollment data.

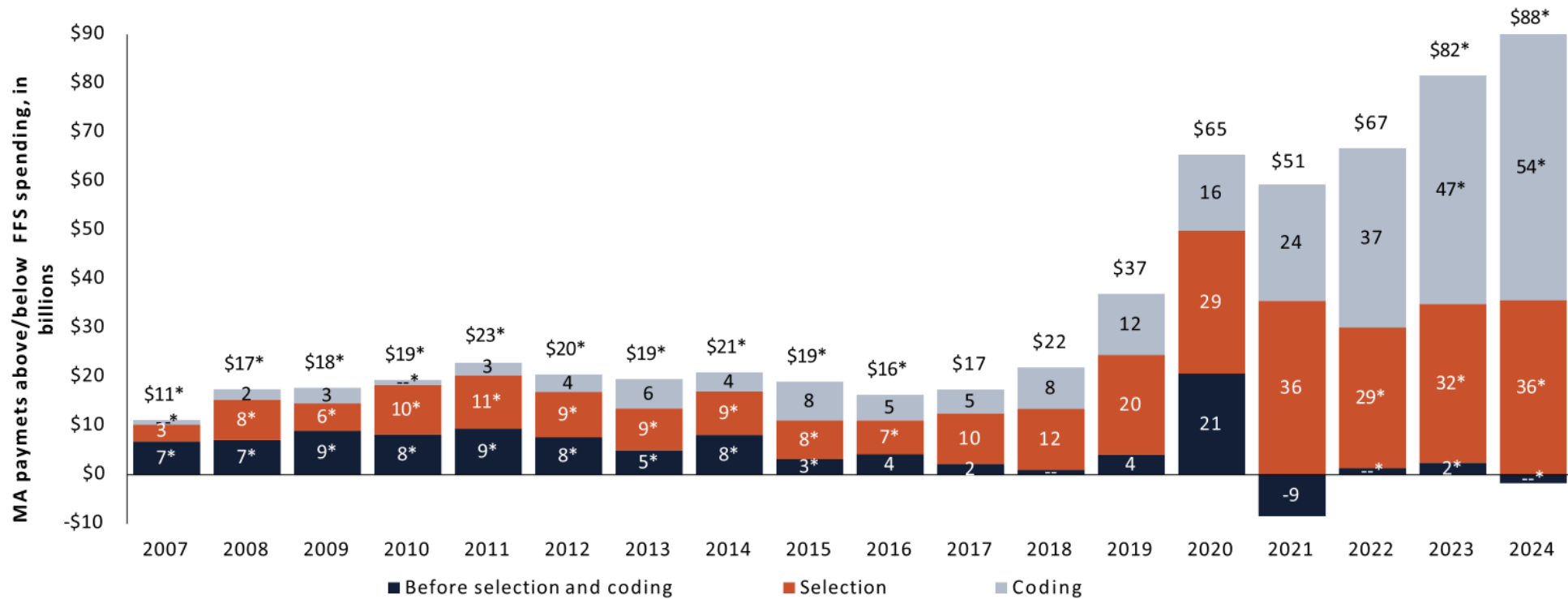




IMPACT OF MEDICARE ADVANTAGE

MEDPAC STATUS REPORT: JANUARY 2024

Coding and selection have driven substantial MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Totals may not sum due to rounding. Estimates from 2017 through 2021 use actual MA and FFS data.

* Specified values used projected data.

--Unidentified values indicate less than \$2 billion.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.



MEDICARE ADVANTAGE IN THE NEWS

Arkansas hospital files underpayment complaint against UnitedHealthcare

Alan Condon - Thursday, July 6th, 2023

Former CMS administrator: Hospital-Medicare Advantage tensions 'a manifestation of an underlying broken system'

Jakob Emerson - Wednesday, February 21st, 2024

Nearly half of health systems are considering dropping Medicare Advantage plans

Andrew Cass - Friday, March 22nd, 2024

Modern
Healthcare

NEWS BLOGS OPINION EVENTS & AWARDS MULTIMEDIA DATA & INSIGHTS MORE+

Home > Politics & Policy

June 12, 2024 04:12 PM

Medicare Advantage prior authorizations targeted in new bill

MICHAEL MCAULIFF X in

[Former CMS administrator: Hospital-Medicare Advantage tensions 'a manifestation of an underlying broken system' \(beckershospitalreview.com\)](#)

[Nearly half of health systems are considering dropping Medicare Advantage plans \(beckershospitalreview.com\)](#)

[Medicare Advantage prior authorizations targeted in new bill | Modern Healthcare](#)

<https://www.beckershospitalreview.com/finance/arkansas-hospital-files-underpayment-complaint-against-unitedhealthcare.html>



IMPACT ON RURAL: CHALLENGES

FINANCIAL

- Prior Authorization requirements
- Payment delays
- Claim denials
- Claim downgrading
- Low reimbursement rates
- Disruption of payer mix

CLINICAL/OPERATIONAL

- Restricted access to care
 - Impact on patient health outcomes
- Restricted provider networks
 - Impact on coordinated patient care and experience
- Administrative burden – additional paperwork, documentation, and reporting
- Limited publicly available data like Medicare



IMPACT BY THE NUMBERS

AHA Survey results include:

95% of hospitals and health systems report increases in staff time spent seeking prior authorization approval

84% report the cost of complying with insurer policies is increasing, while 0% say it's decreasing

62% of prior authorization denials and 50% of initial claims denials that are appealed are ultimately overturned

78% of hospitals and health systems report that their experience with commercial insurers is getting worse, while less than 1% said it's getting better

Real people, Real stories

A cancer patient was scheduled to receive an infusion, but their health plan required the supportive care drug to be supplied by the plan's specialty pharmacy. When the drug was shipped, it was left overnight in the truck, rendering it unusable; subsequent delays continued. While the hospital staff pressured the health plan to approve using the hospital's supply, the patient's care was delayed for several weeks. The plan finally approved one dose of the medically necessary drug from the hospital's supply — but no more.

A patient newly diagnosed with diabetes presented with a glucose level five times higher than the acceptable range. The patient's health plan determined that insulin was subject to prior authorization, which would take 24 hours, forcing the clinician to make do with samples to treat the patient. Insulin has been a standard medication used to treat diabetes for nearly 100 years.

A 93-year-old patient had a history of epilepsy, early-onset Alzheimer's, rheumatoid arthritis, and limited range of motion, among other issues. Medical experts determined that the patient needed a hospital bed with rails; the health plan refused to cover the cost of \$150 per month.

Certain commercial health insurer policies and administrative practices delay patient care, overburden clinicians and withhold critical payments from providers.

Contributing to workforce burden



And much of this effort and cost is unnecessary.

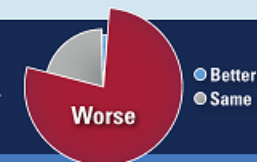
62% of prior authorization denials and 50% of initial claims denials that are appealed are ultimately overturned



And it is only getting worse.

78% of hospitals and health systems report that their experience with commercial insurers is getting worse.

<1% said it's getting better.



Inappropriate prior authorization and payment denials result in significant disruption for hospitals and health systems, challenging their ability to continue caring for their communities.



7 in 10
Hospitals

report having an outstanding claim from 2016 or older

55%

of hospitals and health systems reported their oldest Medicare Advantage claim is from 2016 or older

50%

of hospitals and health systems report having more than

\$100 Million

in accounts receivable for claims that are older than 6 months

**STATUS
DELAYED**

→ This amounts to \$6.4 billion in delayed or unpaid claims that are 6 months or older among 772 hospital survey responders

35%

of hospitals and health systems report **\$50 Million** or more in foregone payments as a result of denied claims once appeals have been exhausted

[Learn More »](#)

Survey Methodology

306 respondents, representing 111 hospitals, completed the survey. Not every respondent answered each question. All respondents are members of the American Hospital Association. Web survey administered between December 2021 and February 2022. Some participants opted to complete the survey using their devices responses. Results represent hospitals in 47 states. No responses were received from hospitals or health systems in New Mexico, Rhode Island, Vermont and Washington, D.C.

IMPACT ON RURAL: OPPORTUNITIES

- CLINICAL/OPERATIONAL

- Texas Gold Card Bill
 - Reducing prior authorization burden and delays in patient care
- Recognition of value-based payment arrangements, i.e., ACOs

- FINANCIAL

- MA Plans must reimburse hospitals Medicare rates if there is no contract with the facility
- CMS Policy:
 - <https://www.cms.gov/medicare/health-plans/medicareadvtspecratestats/downloads/oonpayments.pdf>



CHANGES AHEAD

- State/federal proposed changes

Improving Seniors' Timely Access to Care Act of 2022 Passes the House



By Thomas Sullivan — Last Updated Sep 27, 2022

CONGRESS

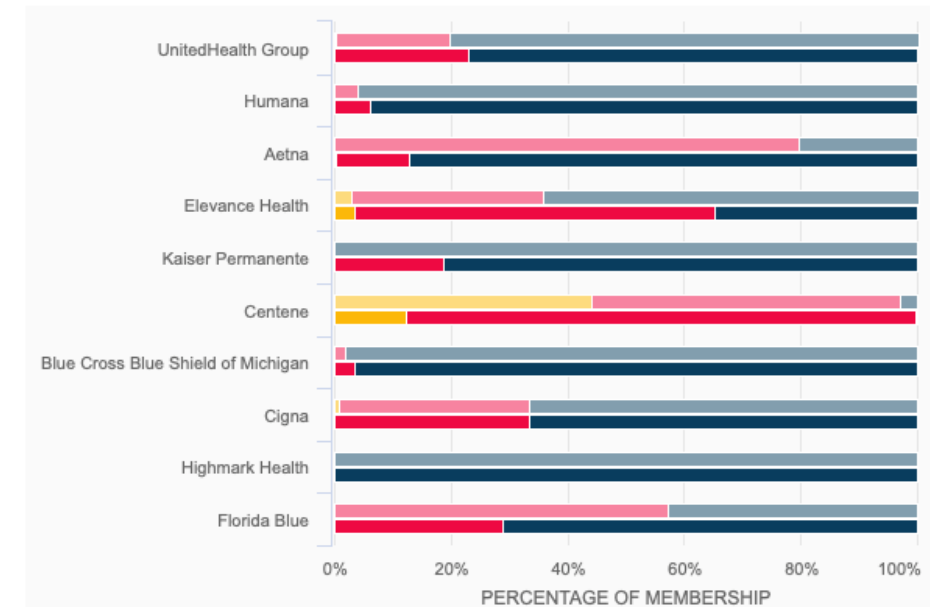


- 2024 Change in Star Ratings

The share of patients enrolled in Medicare Advantage plans with Part D drug coverage rated at least four stars increased from 2023 to 2024.

% in ...	2023	2024
4 or more stars		
3 or 3.5 stars		
2.5 stars or less		

Top 10 insurers by total 2024 membership*, ordered most to least





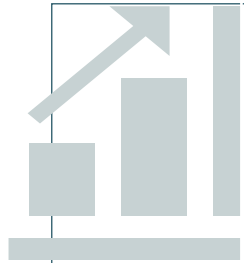
STRATEGIES FOR OPTIMIZATION

KEY STRATEGIES FOR RURAL HOSPITALS – HOLD PAYORS ACCOUNTABLE

- Meeting prior authorization timelines, beginning in 2026
 - Non-urgent prior authorization requests within 7 days
 - Urgent requests within 72 hours
- Do not “give away” Medicare rates through payor contracting
- Foster an environment of accountability through a cadence of reviewing MA performance on Key Indicators and targets



KEY INDICATORS AND TARGETS FOR PAYOR ACCOUNTABILITY



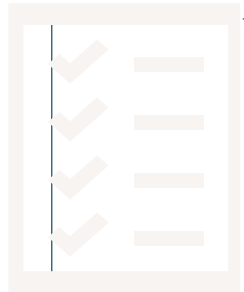
Denial Reporting

- Dollar value to total billed
- Number of claims to claims submitted to payer



Medical Necessity

- Medical records requests
- Appeals process



Prior Authorization

- Process, lag time, automation



Overall success of payer

- Financial health of the contract





DISCUSSION

QUESTIONS FOR THE GROUP

- What financial, operational, or clinical changes have you had to make to mitigate the challenges of Medicare Advantage?
- What processes or workflows have you needed to adjust for Medicare Advantage Plans?
- How has Medicare Advantage impacted patient care?





COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



Lindsay Corcoran, Senior Consultant
lcorcoran@stroudwater.com



Amy Graham, Principal
agraham@stroudwater.com

