Maintaining Essential Rural Providers Under Medicare Advantage

A Report from the NRHA Medicare Advantage Work Group, June 22nd, 2004

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Summary of Recommendations

Recommendation #1: Legislation should require for Medicare Advantage enrollees (as current law does for FQHCs) that wrap-around payments be paid directly to CAHs and RHCs by CMS.

Recommendation #2: Legislation should specifically state that access to the wrap-around provision should be available on a “contract by contract” basis.

Recommendation #3: CMS should explore at least the “Secondary Payer” and the “InterBank Process” approaches to administering the wrap-around to determine which would be most efficient for CMS, the health plans and providers.

Recommendation #4: CMS should assure that the “local community access rule” be interpreted narrowly and that it will be enforced with the same evenhanded direction as other code provisions.

Recommendation #5: The Department of Defense should assure that CAHs, RHCs and FQHCs serving TRICARE enrollees are treated in a manner similar to that sought for Medicare Advantage enrollees, or granted other special payment consideration for serving these enrollees.

The Rural Essential Provider & Medicare Advantage Issue

Unintended consequences from the mandated growth of Medicare Advantage constitute a potentially serious threat to the rural health care infrastructure. Existing NRHA Policy states that the “Centers for Medicare and Medicaid Services (CMS) should make wrap-around payments to Rural Health Clinics (RHCs), Federally Qualified Health Clinics (FQHCs) and Critical Access Hospitals (CAHs) for services provided under Medicare Managed Care.
This action is key for these essential rural providers if they are to survive in the competitive world envisioned for urban and rural markets by Congress. (The charge to the Work Group was limited to address providers currently paid on a “reasonable cost” basis for whom a technical fix under Medicare Advantage should be readily enacted.)

But having the correct Medicare payment methodology is only half the battle; Medicare beneficiaries must also have access to local rural clinicians and providers. Currently, Medicare+Choice services in a plan’s defined service area are typically only covered, apart from emergencies, if the doctor, hospital or other provider is a “participating provider.” In addition, what care will be allowed “out of area” under Medicare Advantage Plans is not yet known. It is absolutely critical that perverse incentives not be inadvertently built into the implementation of Medicare Advantage that forces beneficiaries to chose between receiving care locally or receiving the potential benefits of a Medicare Advantage plan.

The degree of current concern about this issue will vary significantly around the country on two dimensions: (1) the degree of current commercial managed care in rural markets (ranging from very significant to nonexistent) and (2) the degree to which regional providers and associations are able to advocate enrollee and provider interests separate from health plan interests. While this report may seem very theoretical for those who do not currently experience significant managed care in their region, it is fair to assume that this issue is more readily addressed before it becomes a widespread problem and while advocates for Medicare Advantage program are more open to modifications that will make the program more widely acceptable.

It is not the intent of this Work Group to make recommendations which are either timid or politically calculating. The intent is to straightforwardly assert the appropriate remedy for what could be a make or break issue for many small, rural essential providers.

Assuring access and wrap-around payments to essential rural providers must be accomplished in the context of three distinct situations: (1) an enrollee receives a covered service within a health plan’s approved service area from a provider who has a contract with that health plan (“In Area/ In Network”), (2) an enrollee receives a covered service within the health plan’s approved service area from a provider who does not have a contract with that health plan (“In Area/Out Of Network”) and (3) enrollee receives a covered service outside the health plan’s approved service area (“Out of Area”).

| CAH or RHC Medicare Advantage Payment Rules If They Are The Same As Current Medicare+Choice Rules |
|------------------------------------------------------|-----------------------------------------------|-------------------------------|-----------------------------|
| In Area/ In Network | "In Area"/ Out Of Network | "Out of Area" |
| Medicare Advantage (HMO) | Contracted Amount | Emergency Only* | Plan Will Pay* |
| Medicare Advantage (PPO) | Contracted Amount | Emergency Only* | Plan Will Pay* |

* Current rules require payment for covered services "out of area" or "out of network" at Medicare PPS rates; definition of "area" subject to change.
In addition each of these three scenarios may be affected by the type of Medicare Advantage health plan: (1) Medicare Advantage managed care (previously Medicare+Choice) and (2) the Medicare Advantage Regional PPOs. While not within the scope of this brief paper, there are regulatory and administrative details that vary amongst each of these situations that must ultimately be specifically addressed for Medicare Advantage by the Centers for Medicare & Medicaid Services (CMS).

Currently, a non-contracting hospital, serving a Medicare managed care enrollee for “in area” emergency care or any covered “out of area” care, is paid the same as under the Medicare Prospective Payment System. In a CMS Open Door Forum, CMS has indicated that “if the CAH does not sign a contract, they will get paid at the full rate instead of the discounted rate.” This is obviously not a solution as the inpatient or outpatient PPS payments are typically well less than the 101% of cost CAHs normally receive.

Proposed Wrap-Around Policy

As stated above, current NRHA policy is that the Centers for Medicare and Medicaid Services (CMS) should make wrap-around payments to Rural Health Clinics (RHCs), Federally Qualified Health Clinics (FQHCs) and Critical Access Hospitals (CAHs) for services provided under Medicare Managed Care. (RHCs obtaining a wrap-around is important for many rural hospitals, both CAHs and non-CAHs.) This has been accomplished for FQHCs and this paper addresses issues that need to be addressed for CAHs and RHCs.

This paper assumes that NRHA will collaborate with AHA and other associations who are considering internal positions separately at this time—that the goal is to have a collaborative position when NRHA takes a formal and public position.

1. Who Makes the Wrap-Around Payment?

**Recommendation #1: Legislation should require for Medicare Advantage enrollees (as current law does for FQHCs) that wrap-around payments be paid directly to CAHs and RHCs by CMS.**

The score to this technical amendment should be zero as Medicare is already paying 101% of cost and this proposal requires no additional payment. The previous CMS Administrator
repeatedly said that the introduction of Medicare Advantage “will do no harm” to rural providers; consequently, assuring that CAHs and RHCs are paid no less under Medicare Advantage than under the current system will not require additional spending.

2. Which Claims Should Be Covered by the Wrap-Around Payment?

“Contract by contract” or “claim by claim” or “all contracts”? The following was considered:

- The “contract by contract” approach was seen as giving reasonable flexibility but avoiding arguments that are anticipated to a “claim by claim” approach.

- The “claim by claim” approach may be opposed by health plans with an argument that it encourages “gaming.” I.e., a proposal that gives all the downside risk to the Medicare program and all the “upside risk” (gain) to providers is anticipated to face significant Congressional opposition. I.e., a CAH probably won’t be allowed to say to a health plan, “I’ll take the ‘wrap-around’ on outpatient but must receive higher then 101% of cost for inpatient services.”

- The “all contracts” approach would require the floor be the ceiling in all cases and would be opposed by some CAHs and RHCs who would prefer to retain the option of not asking for wrap-around protection in the case of its contracts with individual health plans (albeit this was thought to be a low probability event.)

**Recommendation #2: Legislation should specifically state that access to the wrap-around provision should be on a “contract by contract” basis.**

**Administrative Models for the Proposed Wrap-Around**

As noted below, the first approach mirrors the existing process by Medicare when it is the “Secondary Payer.” The second approach, the “InterBank Process,” makes use of an existing system for providers serving as beneficiaries “out of area” from Medicare+Choice plans in which they are enrolled.

**Recommendation #3: CMS explore at least the “Secondary Payer” and the “InterBank Process” approaches to administering the wrap-around to determine which would be most efficient for CMS, the health plans and providers.**

Using CAHs as an example, the following basic programmatic considerations must be addressed to whichever process is adopted.

- Under whatever approach is adopted, the CAH would need to bill the Medicare Advantage plan for contracted services so the plan could gather claims data on its enrollees.
• The Medicare Advantage plan will probably have a floor under what it can pay so the plan
does not shift its risk to Medicare. That minimum payment might be something that
approximates what Medicare Prospective Payment System would have paid for the service..
(The Medicare Modernization Act includes language that might be expanded and forms the
basis for such an approach—the plan “provides assurances satisfactory to the Secretary that
the organization will make payment to the hospital for inpatient hospital services of an
amount that is not less than the amount that is payable to the hospital under section 1886 with
respect to such services…”)

• The covered charges and covered days on the billing to the Medicare Advantage plan
needs to somehow get into the CAH cost report to compute the CAH’s
reimbursement at 101% of cost. These additional charges and days data must be
captured in a manner that allows the Medicare fiscal intermediaries (FIs) to audit it
without introducing excessive additional recordkeeping by the FIs or CAHs, or
introducing complexity to the system that would inevitably result in erroneous
payments.

• FIs presently summarize the bills they process for each provider in the Provider
Statistical and Reimbursement (PS&R) system. FIs audit the claim information (also
called settlement data) that providers include in their cost reports by comparing the
filed cost report settlement data to the paid claims summarized in the PS&R. Many
providers actually use the PS&R data to prepare their cost reports.

The Medicare Secondary Payer Process

Medicare presently has a system for paying claims on which Medicare is the secondary
payer. After the primary payer pays, the provider bills Medicare. If the primary payer
paid less than Medicare would have paid, then Medicare makes up the difference. These
Medicare Secondary Payer (MSP) claims get summarized in the PS&R along with the
payment amounts from the secondary payers.

Cost reports are settled including these claims. These MSP claims are included in the
cost report; total Medicare reimbursement is computed; the amount paid by the secondary
payers is subtracted; then Medicare pays the difference through the cost report settlement.

It would appear that the MSP system would lend itself well to the processing wrap-
around payments. The CAH would bill the Medicare Advantage plan. The plan would
pay its contracted amount and then the CAH would send the same billing to the Medicare
FI with some additional information such as the amount of the plan payment, which plan
it was, etc. Some modifications would be needed to the MSP system. For example,
Medicare would probably want to gather data on which plans or contracts were
generating the wrap-around payments. Also, modifications would be needed to ensure
the patient deductibles and co-pay amounts are handled properly.
It appears that the existing MSP billing/payment system already has most, if not all, of the elements needed for Medicare to implement a wrap-around payment system. One downside of what has been outlined above is the requirement that the CAH bill the Medicare Advantage plan, wait for payment then add more data to the bill and send it again to the FI. One solution to this would be to require the plans to automatically add their data to the bill and forward it on to the FI with no further CAH action. Medicare presently “crosses over” claims to Medicaid in most states where Medicaid is secondary. It would not be unreasonable to expect the plans to cross the claims over to the FIs.

In any case, the same MSP payment arrangement could work for processing RHC claims with wrap-around payments. Since there is no standard federal payment rate for RHCs for establishing a floor, the floor might be set at a regional or national average payment rate.

Providers would need to get the wrap-around payments paid on some interim basis rather than waiting until their cost report is filed. For CAHs on Periodic Interim Payments (PIP), the wrap-around payments could be estimated and included in the normal PIP payment process. For providers not on PIP, wrap-around payments could be estimated and paid on some periodic basis such as every two weeks like PIP, or monthly, or quarterly.

The InterBank Process

One idea that needs more discussion is to use the existing network of CAH FIs to clear claims on behalf of non-contracting CAHs. (This avoids the need to essentially bill twice under the above MSP, approach—once to the plan, then to the FI.) Under this alternative scenario, CAHs would bill Medicare Advantage claims for non-contracting plans to their FI. The FI would pay the claim, presumably, the full and fair Medicare rate, including cost reimbursement. The FI would then bill the Medicare Advantage plan for reimbursement of the payment made by the FI. If a CAH had a contract with a Medicare Advantage plan, this process would NOT necessarily apply. In this case, the CAH would bill the plan and the payment would occur under the terms of the contract. Of course, a hospital and plan could elect in the contract to be paid by the FI as a matter of convenience to both parties.

This general method is the one used by Blue Cross plans to process claims on behalf of other Blue Cross plans. For example, if a Blue Cross patient who lives in Tennessee goes to a hospital in Wisconsin, the hospital does not bill Blue Cross of Tennessee. It bills Blue Cross of Wisconsin and is paid under the terms of the Blue Cross of Wisconsin contract. The claim (known as an InterBank claim by Blue Cross) is then billed to Blue Cross of Tennessee. Blue Cross of Tennessee reimburses Blue Cross of Wisconsin for what they paid to the hospital. Without this system, each hospital would have to have contracts with each Blue Cross plan. This system makes the Blue Cross plans seamless nationwide to providers and patients alike.
Rural Access Standards

As noted above, those concerned for rural communities and their access to health care need to be very careful about winning the battle (achieving the wrap-around) but losing the war (having patients steered away from essential access providers). With steerage, CAHs and RHCs would still get cost for those remaining Medicare beneficiaries; the overall rural infrastructure (non-cost reimbursed allied clinicians in particular) would be weakened.

(Recognizing the significant opposition to “Any Willing Provider” the Work Group believes this issue is more effectively addressed by building on current law and regulation of the beneficiaries right to local access.)

Regional CMS reviewers of health plans’ proposed provider networks’ compliance with the Medicare Managed Care Manual looks closely at what is an admittedly ambiguous standard “local community patterns of care.” This ambiguity makes the role of state insurance commissioners (and instate advocacy) critical as allowable/tolerated commercial health plan behavior sets an implicit standard for Medicare Advantage plans (and previously Medicare+Choice Plans).

*Medicare Managed Care Manual, “Chapter 4 -Benefits and Beneficiary”* – A key section reads: “Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care. In other words, the M+C organization must ensure that providers are distributed so that no member residing in the service area must travel an unreasonable distance to obtain covered services. For example, a commonly used service must be available within 30 minutes driving time. Of course, longer travel times are permissible as long as they are based on location (such as a rural area) and/or are established and based on the routine patterns of care that are available in the geographic area.” (Emphasis added; note the potential contradiction in last sentence.)

Current federal guidance appears to allow for substantial subjectivity regarding the definition of “local community patterns.” These patterns are in part dependent upon state Insurance Commissioner’s regulation of the commercial markets, regulation that varies state by state.

The Work Group believes that “local community patterns of care” means just that, “local community patterns of care.” There is no reference to usual state, county, or other medical travel times in current Medicare regulations. Clearly if a community, i.e., a town or small city and its surrounding area, have a community hospital and physicians, the travel times are to be established with reference to travel time within that community.

A practice appears to have grown up in the managed care universe by which actual travel times within a community can be ignored as long as some arbitrary notion of reasonableness is followed. But reasonableness according to plans isn’t the standard. We disagree with current notions of reasonableness as applied to all rural areas, in all seasons, for all travel conditions, for
all roads, and for all age groups. However, putting these questions aside, the test isn’t what the plans think is reasonable. The test is what exists in a community and other tests can’t be substituted under the code for the industry’s convenience.

As a matter of practice this should mean determining whether a community has certain medical services and measuring roughly how far a member of that community must travel to reach the services. Requiring a community member to travel far from their community cannot by any stretch of the imagination satisfy the clear direction of the code.

**Recommendation #4: CMS should assure that the “local community access rule” be interpreted narrowly and that it will be enforced with the same evenhanded direction as other code provisions.**

**TRICARE, A Related Issue**

In addition, a related and third type of health plan relevant to this issue, particularly for rural providers near military bases, is the Department of Defense’s TRICARE, a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors.

The Department of Defense’s Office of Medicare Benefits and Reimbursement Systems has drafted a proposed rule to amend their regulations to exempt CAHs from the TRICARE DRG-based payment system but the change is in the “early stages of the rule writing process.” They expect the change will be implemented in early 2005.

**Recommendation #5: The Department of Defense should assure that CAHs, RHCs and FQHCs serving TRICARE enrollees are treated in a manner similar to that sought for Medicare Advantage enrollees.**