Tiny, rural hospitals feel the pinch as Medicare Advantage plans grow

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When several representatives from private health insurance companies called on him a few years ago to offer Medicare Advantage plan contracts so their enrollees could use his hospital, Bleak sent them away.

"Come back to the table with a better offer," the chief executive recalled telling them. The representatives haven't returned.

Battle Mountain is in north-central Nevada about a three-hour drive from Reno, and four hours from Salt Lake City. Bleak suspects insurance companies simply haven't enrolled enough of the area's seniors to need his hospital in their network.

Medicare Advantage insurers are private companies that contract with the federal government to provide Medicare benefits to seniors in place of traditional Medicare. The plans have become dubious payers for many large and small hospitals, which report the insurers are often slow to pay or don't pay.

Private plans now cover more than half of all those eligible for Medicare. And while enrollment is highest in metropolitan areas, it has increased fourfold in rural areas since 2010. Meanwhile, more than 150 rural hospitals have closed since 2010, according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina. Largely rural states such as Texas, Tennessee, and Georgia have had the most closures.

Medicare Advantage growth has had an outsize impact on the finances of small, rural hospitals that Medicare has designated as " critical access." Under the designation, government-administered Medicare pays extra to those hospitals to compensate for low patient volumes. Medicare Advantage plans, on the other hand, offer negotiated rates that hospital operators say often don't match those of traditional Medicare.

"It's happening across the country," said Carrie Cochran-McClain, chief policy officer of the National Rural Health Association, whose members include small-town hospitals.

"Depending on the level of Medicare Advantage penetration in individual communities, some facilities are seeing a significant portion of their traditional Medicare patient or beneficiary move into Medicare Advantage," Cochran-McClain said.

Kelly Adams is the CEO of Mesa View Regional Hospital, another rural hospital in Nevada. He said he applauds Battle Mountain's Bleak for keeping Medicare Advantage plans out of his hospital "as long as he has."

Mesa View, which is a little more than an hour's drive east of Las Vegas, has a high percentage of patients enrolled in Medicare Advantage plans.

"Am I going to say I'm not going to take care of 40% of our patients at the hospital or the clinic?" Adams said, adding that it would be a "tough deal" to be forced to reject patients because they didn't have traditional Medicare.

Mesa View has 21 Medicare Advantage contracts with multiple insurance companies. Adams said he has trouble getting the plans to pay for care the hospital has provided. They are either "slow pay or no pay," he said.

In all, the plans owe Mesa View more than $800,000 for care already provided. Mesa View lost about $1.3 million taking care of patients, according to its most recent annual cost report.

NRHA's Cochran-McClain said the growth in the plans also narrows options for patients because "the contracting that is happening under Medicare Advantage frequently has an influence on steering patients to specific types of providers." If a hospital or provider does not contract with a Medicare Advantage plan, then a patient may have to pay for out-of-network care. That generally wouldn't happen with traditional

Medicare, which is widely accepted.

At Mesa View, patients must drive to Utah to find nursing homes and rehabilitation facilities covered by their Medicare Advantage plans.

"Our local nursing homes are not taking Medicare Advantage patients because they don't get paid. But if you're straight Medicare, they'd be happy to take that patient," Adams said.

David Allen, a spokesperson for AHIP, an industry trade group formerly known as America's Health Insurance Plans, declined to respond to Bleak's and Adams' specific concerns. Instead, he said enrollees are signing on because the plans "are more efficient, more cost-effective, and deliver better value than original Medicare."

Centers for Medicare & Medicaid Services press secretary Sara Lonardo said CMS has acted to ensure "that private insurance companies are held accountable for providing quality coverage and care."

The reach of private Medicare Advantage plans varies widely in rural areas, said Keith Mueller, director of the Rural Policy Research Institute at the University of Iowa College of Public Health. If recent trends continue, enrollment could tip to 50% of all rural Medicare beneficiaries in about three years—with some regions like the Upper Midwest already higher than 50% and others lower, such as Nevada and the Mountain States, but trending upward.

In June, a bipartisan group of Congress members, led by Sen. Sherrod Brown (D-Ohio), sent a letter urging federal agencies to do more to force Medicare Advantage insurers to pay health systems what they owe for patient care.

In an August response, CMS Administrator Chiquita Brooks-LaSure

wrote that a final rule issued in April made "impactful changes" to speed up care and address concerns about prior authorization—when a hospital and patient must get advance permission for care to ensure it will be covered by an insurer. Brooks-LaSure noted another proposed rule that, once finalized, could mandate that insurers provide specific reasons for denying care within seven days.

Hospital operators Adams and Bleak also want more federal action, and fast.

Bleak at Battle Mountain said he knows Medicare Advantage plans will eventually move into his area and he will have to contract with them.

"The question is," Bleak said, "how can we match the reimbursement so that we can sustain and keep our hospitals in these rural areas viable and strong?"