BEYOND THE ROUNDS

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The Medicare Advantage Contracting Trap

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On this week's Rural Rounds, we unpacked the growing footprint of Medicare Advantage (MA) in rural communities and how the payment structures of the MAs mix with the Rural Health Clinic (RHC) payment model. The reality of MAs is traditional Medicare rules do not automatically apply to MA payers.

While traditional Medicare pays your clinic its cost-settled All-Inclusive Rate (AIR), Medicare Advantage plans pay you based strictly on what is written in your contract.

If you aren't actively managing these contracts and monitoring your payer mixes, you are likely leaving thousands of dollars on the table every single month.

Don't get caught in the MA contracting trap. Here are some simple tips to help protect your clinic's bottom line.

1. Contract Dictates Coin

Often managers and administration assume that because an MA plan is "Medicare" it will automatically pay the RHC' current AIR. Unfortunately, that is not the case.

MA payers are treated like a commercial payer and your contract dictates what your clinic will be paid. MA contracts will often pay a fee-for-service (FFS) rate based on Medicare's FFS rates or a percentage of Medicare's FFS rates.

If your AIR is $165 but your MA contract pays at a rate of $90.00 for that service, then you are absorbing a $75 loss each visit. Additionally, unlike traditional Medicare, there is no year-end cost report settlement to help make you whole. This loss is not something that most clinics can absorb

It is very important understand how each payer reimburses you. Your contract rate is your final rate.

2. You Must Negotiate

Payers will try to default you to a standard, commercial fee-for-service schedule. You must actively negotiate to secure your RHC rate (or a percentage of it).

You have the data so use it. Your cost report can be used as leverage. Present your calculated AIR to the payer to justify why a standard FFS rate of $90 will not cover the cost of care in an underserved area.

It is also important to note that most MA plans when negoitiating RHC

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reimbursement into your contract will only pay you your AIR and do not add the 20% of total charges as coinsurance. You may want to request a percentage above your your AIR to help cover that additional loss.

Ensure your contracts have "RHC-specific" language that ties your reimbursement to your actual cost-of-care increases or a percentage of the national Medicare limit. Don't forget to address payment for Part B covered vaccines, labs, technical components, telehealth, care management, and other services paid outside of the AIR.

3. Review Your Contracts Annually

When was the last time you read your payer contracts? Do you even have a copy of your contracts?

Payer contracts are not "set it and forget it" documents. As inflation, supply chain issues, and staffing costs drive your actual operational cost up, your AIR changes. Additionally, Medicare paid services are changing annually and you need to ensure the MA contracts are staying in line with these changes.

If your contracts haven't been opened or renegotiated in three years, you are operating on outdated margins,. Put a hard deadline on your calendar to review and renegotiate top payer agreements every 12 months.

4. Know Your Payer Mix

You cannot negotiate effectively if you do not know your numbers. As MA plans become more and more popular most clinics are seeing a shift in their payer mix and the percentage of traditional Medicare patients is rapidly decreasing.

Run a report of your patient encounters over the last year and split them into four buckets: Traditional Medicare, Medicare Advantage, Medicaid, and Commercial. If your MA volume is growing while traditional Medicare is shrinking, your financial risk increases because your revenue is tied to fixed, negoitated contracts rather than cost-settled rates.

Next look at your individual FFS rates for your top 10 billable services being paid by the MA plans vs your current AIR. If FFS rates are higher than your flat AIR, an FFS structure might make more sense. But often for a standard primary care clinic, the RHC rate is almost always your financial lifeline and you have to demand it.

5. Staff Awareness

Do your staff know what plans you are contracted with? Do they understand the differences in these plans?

Your front desk is your first line of defense. Ensure that your staff can accurately distinguish between "Traditional Medicare" and "Medicare Advantage" plans. They need to know what plans you participate with and the requirements of each of them. Are you in network, do they collect a copay, could there be an unmet deductible, or do I need a referral?

Additionally, your back-office/billing department should be ensuring you are being paid according to your contract or if they are seeing a change in your payer mix. Do they know how each of the plans are supposed to pay?

Equip your staff with the necessary tools they need in order to efficiently and effectively help you manage the financial success of your clinic. Utilize the tools your Practice Management system may already have, such as real-time eligibility/benefit checker and contract management reports. Create a Contract Matrix your staff can use, with list of all the payers you are in network with, along with key information based on your contract, such as payment structure, authorization requirements, and contact information

Final Thoughts

Don't let Medicare Advantage payers treat you like a standard urban clinic. You earned your RHC designation because of the unique, critical care you provide to an underserved community - make sure your contracts actually reflect that value.

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