MEDPAC

Advising the Congress on Medicare issues

Cost sharing for outpatient services at critical access hospitals

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Presentation roadmap

1. Commission principles for rural payment policies
2. Rural special payments overview
3. Current CAH coinsurance
4. Illustrative example: An alternative CAH coinsurance model

Note: CAH (critical access hospital)

MedPAC rural payment principles (2012)

- Target payment adjusters to preserve access
- Empirically justify the magnitude of payment adjustments
- Maintain incentives for cost control
- Focus low-volume adjustments on isolated providers

Source: MedPAC June 2012 report to the Congress.

Rural special payment overview

Special rural-focused hospital payments

- Higher prospective payment rates
  - Higher inpatient rates for SCHs, MDHs, and LVHs
  - 7.1% higher outpatient payment rates for SCHs
- Cost-based payments (for CAHs)
- Fixed monthly payments and higher prospective payment rates per service (for REHs)
- Over 90% of rural hospitals receive one of these types of special payments

Note: FFS (fee-for-service), SCH (sole community hospital), MDH (Medicare dependent hospital), LVH (low-volume hospital), CAH (critical access hospital), REH (rural emergency hospital).

While CAHs vary, the typical CAH in 2022 was a small rural hospital with an outpatient focus

Type of revenue	Mean CAH revenue in millions (% of total revenue)		Mean PPS hospital revenue in millions (% of total revenue)	
Total FFS Medicare revenue	$10	25%	$61	16%
FFS outpatient	5	13	21	6
FFS inpatient acute	2	5	35	9
FFS post-acute swing-bed	2	5	≈0	0
FFS other	1	2	5	1
Total all-payer revenue	$40	100%	$381	100%

Note: CAH (critical access hospital), FFS (fee-for-service). Hospital FFS revenue includes inpatient, outpatient, swing bed, and other sources of revenue such as inpatient rehabilitation unit revenue; it excludes payment for physician services, which is not distinctly shown for Medicare beneficiaries on cost reports.
Source: MedPAC analysis of Medicare cost report files.

Cost-based FFS Medicare payments provided significant financial support to CAHs in 2022

- Cost-based payments increase FFS revenue by about $4 million per CAH
  - Cost-based FFS payments averaged $10 million per CAH
  - At PPS rates, CAHs would have received about $6 million for those services
  - The $4 million in higher FFS payments was far larger than CAHs' average all-payer profit of $1 to $2 million
- Cost-based FFS payment rates also increase MA payment rates
- Implication: Many CAHs would struggle financially if they did not receive higher-than-standard FFS payment rates

Note: FFS (fee-for-service), CAH (critical access hospital), PPS (prospective payment system).

CAH outpatient coinsurance: 20% of charges

Basing CAH coinsurance on charges increases beneficiaries' cost-sharing liabilities

- CAH program payment = 101% of costs minus coinsurance
- CAH coinsurance = 20% of charges
  - Charges are list prices and are often far higher than costs or payment rates
  - Mark up of charges over costs varies widely among hospitals

- PPS hospital coinsurance = 20% of the payment rate

Note: CAH (critical access hospital). Does not include the effects of sequestration.

Half of CAHs' FFS Medicare outpatient payments are coinsurance

	Total 2022 outpatient claims with coinsurance (billions)
Coinsurance billed	$3.3
Program payments	3.2
Total for outpatient services that require coinsurance	6.5

- In 2022, 1.9 million Medicare beneficiaries (or their supplemental insurers) were billed an average of $1,750 in cost sharing for CAH outpatient services
- 84% of rural FFS beneficiaries have supplemental insurance such as a Medigap plan or Medicaid; they will not directly pay the coinsurance
- 16% of rural FFS beneficiaries do not have supplemental insurance

Note: The $6.5 billion includes only outpatient claims for which coinsurance is set at 20% of charges; outpatient services such as certain labs and vaccines that do not have cost sharing are excluded.
Source: MedPAC analysis of Medicare critical access hospital outpatient claims.

Illustrative example of how variance in markups can cause variation in coinsurance

	Low-mark-up CAH (10th percentile)	Median-mark-up CAH (50th percentile)	High-mark-up CAH (90th percentile)
Cost of line item (e.g., MRI)	$600	$600	$600
Charge for line item	1,000	1,500	2,400
Coinsurance (20% of charges)	200	300	480
Program payments	398	300	124
Coinsurance share	33%	50%	79%

Note: CAH (critical access hospital). Program payment is equal to 101% of costs, less coinsurance, multiplied by 98% if a 2% sequester is in place. Program payments are rounded to the nearest whole dollar.
Source: MedPAC analysis of Medicare CAH outpatient claims.

No cap on CAH coinsurance, unlike in PPS hospitals

	OPPS coinsurance (20% of PPS rate) $1,632 cap	CAH coinsurance (20% of charges) No cap
Cost of line item (e.g., joint replacement)	$13,000	$13,000
Charge for line item	26,000	26,000
OPPS payment rate	12,540	N/A
Billed as coinsurance	1,632 (the cap)	5,200 (20% of charges)
Paid by the Medicare program	10,908	7,771*

Note: CAH (critical access hospital) OPPS (outpatient prospective payment system). In 2022, the coinsurance cap on any OPPS line item was $1,632 (the 2024 inpatient deductible). The OPPS base rate for an outpatient hip replacement coded under APC 5115 (Level 5 Musculoskeletal Procedures) was $12,540 for hospital with a wage index of 1 in 2024). *The amount owed to the CAH by the program is computed as 101% of costs, less coinsurance, multiplied by 0.98 to account for the sequester.
Source: MedPAC analysis of Medicare CAH outpatient claims.

Charge-based coinsurance has become more problematic over the CAH program's 26-year existence

- Coinsurance > 50% of total payment
  - High coinsurance relative to the payment rate reflects high mark ups
  - Mark ups have grown substantially since the CAH program was formed in 1997
  - Mark ups vary widely by hospital
- No cap on coinsurance
  - More problematic due to mark-up growth
  - More problematic due growth of high-cost services in CAHs
    - High-cost part B drugs
    - Joint replacements (used to be inpatient-only procedures)

Note: CAH (critical access hospital). Examples do not include the effects of sequestration.

Illustrative example of an alternative CAH coinsurance model

Illustrative model: Set coinsurance at 20% of the payment rate

- Model reduces cost sharing to 20% of payment amount
- We assume total payment to CAH will remain unchanged
  - Therefore, reduction in beneficiary cost sharing results in higher program payments funded by the taxpayer
- Consistent with how outpatient supplemental payments work in sole community hospitals

Note: CAH (critical access hospital)

How would setting coinsurance at 20% of payments have affected cost sharing in 2022?

- Beneficiary coinsurance would have been $2.1 billion lower
  - Reduction in supplemental insurer coinsurance
  - Reduction in Medicaid coinsurance
  - Reduction in coinsurance billed to beneficiaries without supplemental insurance
- Medicare payments to MA plans would have been $1.3 billion higher
  - Higher MA plan bids for the A/B benefit
  - Increased supplemental benefits for MA beneficiaries
- Total increase in program spending: $3.2 billion

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: MedPAC analysis of claims and cost report files.

How would setting coinsurance at 20% of payments have affected taxpayers and Part B premiums in 2022?

- Estimated using 2022 data
- Taxpayers would have funded 75% of $3.2 billion (or $2.5 billion)
- Part B premiums would have increased by about $0.8 billion (or about $13 per beneficiary per year)

Source: MedPAC analysis of claims and cost report files.

Commissioner discussion

- Questions about the material?
- Should outpatient coinsurance continue to be set based on charges? If not, is setting coinsurance based on 20% of the payment rate a reasonable alternative?
- Should there be a cap on CAH coinsurance, as in the OPPS?

Note: CAH (critical access hospital, OPPS (outpatient prospective payment system).

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