American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

February 28, 2025

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Dr. Chernew:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to share our comments regarding Medicare beneficiary cost-sharing in rural facilities.

In particular, we thank the Medicare Payment Advisory Commission (MedPAC) for recognizing that critical access hospitals (CAHs) are vital care access points for their communities and, as such, their financial stability and sustainability are critical. We support the Commission's recommended changes to beneficiary cost sharing in CAHs, including to ensure that total payments to CAHs remain unchanged. However, rural health clinics (RHCs) also serve as important access points; as such, we encourage the commission to examine more closely the potential impact of its proposed changes to their beneficiary cost-sharing structure.

COST SHARING FOR OUTPATIENT SERVICES AT CAHS

During the January 2025 meeting, commissioners discussed patient cost sharing for outpatient services in CAHs and its impact on care access. The commission voted to recommend that CAH outpatient beneficiary cost-sharing be set at 20% of the payment amount and subject to a cap equal to the inpatient deductible. **The AHA appreciates MedPAC's consideration of outpatient patient cost sharing in CAHs and agrees it poses challenges to Medicare beneficiaries.**

Currently, CAHs receive cost-based fee-for-service (FFS) Medicare payments. As the commission concluded, these payments provide them with much-needed financial

support. However, under this system, Medicare calculates beneficiaries' cost-sharing for outpatient services as a percentage of *charges*, as compared to the outpatient prospective payment system (PPS) where beneficiary cost-sharing is a percentage of the outpatient PPS *payment rate*. As a result, half of CAH FFS Medicare outpatient payments are from beneficiary coinsurance.[1,2] The majority of rural Medicare beneficiaries do not directly pay this coinsurance because many have supplemental coverage in Medigap or Medicaid. However, for the small proportion that do not have this coverage, these costs may be an undue financial burden and a barrier to accessing care. **We share in the concerns presented by the commission regarding the implications of this cost-sharing structure for patient access to care and financial burden, especially in these historically underserved communities.**

Commission staff presented a policy solution to reduce beneficiary cost-sharing for outpatient services in CAHs. Under this solution, cost-sharing would be reduced from 20% of charges to 20% of the outpatient PPS payment rate. Additionally, a cap would be placed on the CAH outpatient coinsurance amount equal to the inpatient deductible; for 2025, this amount is $1,676. Importantly, the policy solution also would ensure that total payments to CAHs remain unchanged. That is, any reductions in CAH payments resulting from reductions in beneficiary cost-sharing would be made up by the Medicare program. **We agree with this framework and emphasize the importance of maintaining stable and consistent total payments for CAHs. Indeed, any reductions in CAH payments would be extremely detrimental to their financial sustainability and, in turn, to beneficiary access to care.** The commission itself recognized that "many CAHs would struggle financially if they did not receive [cost-based] FFS payment rates." In fact, 70 CAHs have already closed or had to significantly scale back their services since 2005, including the closure of inpatient units.[3]

Staff indicated that its recommendation, however, would mean an *additional $1.3 billion would flow to MA plans in capitation payments*. The fact that this would happen at a time when MedPAC itself has found that MA plans were overpaid by $88 billion is of great concern to the AHA.[4] **As such, we continue to urge the commission to fully study the role MA plays in rural communities and the impact plan policies and practices have on patients' access to care and the financial solvency of rural providers.** In particular, both the AHA and MedPAC have detailed numerous problems with MA prior authorization denials and other utilization review practices and their

---

[1] RTI International. (2016). Medicare Copayments for Critical Access Hospital Outpatient Services – Update. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/medicare-copayments-for-critical-access-hospital-outpatient-services-update.pdf

[2] HHS Office of the Inspector General. (2014). Medicare Beneficiaries Paid Nearly Half of the Costs For Outpatient Services at Critical Access Hospitals. https://oig.hhs.gov/reports/all/2014/medicare-beneficiaries-paid-nearly-half-of-the-costs-for-outpatient-services-at-critical-access-hospitals/

[3] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

[4] https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf

effects on timely access to care for patients.[5] These dynamics are increasingly problematic as MA penetration grows in rural areas. Specifically, some plans are restricting patient access to Medicare-covered services, delaying patient care, and adding tremendous administrative burden to small hospitals without the resources to absorb these costs.[6] Paying plans more in the face of such practices is misguided.

COST SHARING FOR RURAL HEALTH CLINICS

Commissioners also discussed challenges to RHC patient cost sharing and its impact on patient access to care. **The AHA appreciates MedPAC's consideration of this important topic and agrees that wide variation in RHC cost-sharing poses challenges to Medicare beneficiaries. However, we urge the commission to consider the impact payment cuts to RHCs would have on their financial sustainability, especially given payment cuts implemented in recent years.**

RHCs must be located in nonurbanized areas and predominantly serve underserved and rural populations. They provide outpatient services and are intended to increase access to primary care. Currently, Medicare pays RHCs 80% of an all-inclusive rate (AIR) per visit.[7] Medicare beneficiary cost sharing at RHCs is set at 20% of RHC charges. Therefore, RHC payments are 80% of the AIR (from Medicare) and 20% of charges (from patient cost-sharing).[8] As such, there is wide variation in beneficiary liability. For example, in independent RHCs, the average beneficiary cost sharing as a share of the AIR is 34%, whereas in provider-based RHCs, the average beneficiary cost sharing as a share of the AIR ranges from 17% to 38%.

Staff presented a potential policy solution to address this variation — to reduce cost sharing by capping it at 20% of an RHC's AIR. MedPAC found that for 2022, this would have reduced beneficiary cost sharing by 43% in independent RHCs and 8% to 49% in provider-based RHCs. However, unlike for CAHs, staff did not propose to ensure that total payment to RHCs remains unchanged. As such, AHA's analysis indicates that the proposed policy would have translated to a $111 million payment cut to RHCs in 2024.

These cuts come at a time when RHCs are still working to reconcile existing Medicare payment reductions. Specifically, the Consolidated Appropriations Act of 2021 set new payment limits capping reimbursement and only allowing growth by medical inflation. These cuts are particularly troubling because these facilities predominantly serve historically underserved communities and provide increased access to primary care,

---

[5] https://www.aha.org/lettercomment/2023-11-30-aha-urges-medpac-examine-medicare-advantage-denials-hospital-market-basket
[6] https://www.aha.org/guidesreports/growing-impact-medicare-advantage-rural-hospitals-across-america
[7] As of 2021, they have been subject to a national statutory payment limit per visit (i.e., in 2025, this payment limit is $152).
[8] In contrast, beneficiary cost-sharing for clinician services in other settings such as federally qualified health centers (FQHCs) is set at 20% of the lesser of the physician fee schedule or FQHC charges.

mental health care, pharmacy and dental services for these communities. RCHs act as safety net clinics designed to increase access to care for rural residents.[9] Research has shown that over half of RHCs have night or weekend hours and the majority accept walk-in services and provide language interpretation services. **Therefore, we urge MedPAC to carefully consider the impact these payment cuts would have on patient access to care. In particular, we urge the commission to ensure that total payments to RHCs remain unchanged. That is, any reductions in RHC payments resulting from reductions in beneficiary cost-sharing would be made up by the Medicare program.**

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Shannon Wu, AHA's director of policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Paul Masi, M.P.P.
MedPAC Commissioners

[9] University of Minnesota, Rural Health Research Center. (Dec. 2019). Access and Capacity to Care for Medicare Beneficiaries in Rural Health Clinics. https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-access-to-care-RHCS-policy-brief-12.10.19.pdf