National Rural Health Association

February 21, 2025

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission
425 I Street N.W., Suite 701
Washington, D.C. 20001

Dear Chairman Chernew,

On behalf of the National Rural Health Association (NRHA), we are pleased to provide the following comments to the Medicare Payment Advisory Commission (MedPAC) meeting discussions on beneficiary cost-sharing for outpatient services at Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs).

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA strongly supports the recommendation to modify CAH cost-sharing policies to align more closely with those of other outpatient hospital services, ensuring that rural Medicare beneficiaries do not face disproportionate financial burdens when seeking care. As MedPAC considers expanding this policy to RHCs, we also wish to provide clarification and corrections to several statements made during the meeting that may misrepresent the structure and financial realities of RHCs.

Support for CAH Cost-Sharing Reform

NRHA is encouraged that MedPAC is exploring options to ensure access to local Medicare services is affordable for rural beneficiaries. NRHA has historically supported legislation that would create equity between beneficiaries at CAHs and Prospective Payment Systems (PPS) hospitals by changing the copayment calculation from "actual charges" to "reasonable charges."[1] Medicare beneficiaries who use their local CAHs are charged 2 to 6 times more coinsurance for the same services as beneficiaries seeking care in other settings.[2] We support the proposal presented during the Commission's discussion that reduces cost sharing to 20% of the payment amount, with the difference covered by the Medicare program, similar to how supplemental payments work for outpatient services in Sole Community Hospitals. We are pleased to see that the recommended MedPAC approach safeguards current payments to CAHs viability while equalizing cost sharing obligations on rural beneficiaries.

[1] H.R.833 - Save America's Rural Hospitals Act
[2] https://oig.hhs.gov/reports/all/2014/medicare-beneficiaries-paid-nearly-half-of-the-costs-for-outpatient-services-at- critical-access-hospitals/

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Considerations for RHC Cost-Sharing Policy

NRHA appreciates the discussion on extending cost-sharing reforms to RHCs but believes that some key aspects of RHC payment policy need to be clarified before recommendations can be made.

- The term "rural health center" was inaccurately used during the discussion, which can lead to confusion between the unique Medicare designations of Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) located in rural communities. Unlike FQHCs, RHCs are not eligible for Section 330 grant funding, do not receive a Medicare Advantage wrap payment, and do not have Medicare deductibles waived for their patients. Conflating these two distinct provider types may contribute to policy recommendations that do not appropriately address the unique financial and operational challenges of RHCs.

- The data presented at the meeting estimated beneficiary coinsurance as a percentage of an RHC's All-Inclusive Rate (AIR). However, because AIRs vary significantly across RHC types, this presentation may not provide an accurate comparison. A more informative approach would be to analyze the average charge amounts for common CPT codes across different RHC categories, rather than using AIR percentages.

- While NRHA supports efforts to address beneficiary cost-sharing in RHCs, we urge MedPAC to consider waiving the Part B deductible for RHC services. This would align RHC policies with FQHCs and promote equity for Medicare beneficiaries regardless of which safety net provider they receive care.

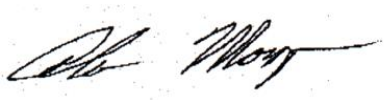
- The Consolidated Appropriations Act (CAA) of 2021 attempted to stabilize independent RHCs that had been severely underpaid compared to traditional physician offices. Comments made during the discussion incorrectly suggested that the changes to independent RHC payment policy made in dramatically increased costs for beneficiaries. Prior to these changes, independent RHCs were often forced to set charges above the capped reimbursement rate to sustain operations, inadvertently increasing coinsurance costs for patients. The updated policy now allows for a phased increase in the RHC reimbursement cap, bringing these clinics closer to parity with other providers without directly impacting beneficiary cost-sharing.

NRHA would also note that while the CAA, 2021 made necessary increases in payment for independent RHCs, it dramatically changed payments for provider-based RHCs, many of which are affiliated with CAHs. One intent of the provider-based RHC program was to provide access to care at rates that reflect costs associated with care, including the allocation of hospital overhead. Even with previous payment policies, data suggests that CAHs with provider-based RHCs perform less well financially than CAHs without provider-based RHCs. We request that MedPAC continue to monitor impacts of the CAA, 2021 policy change on the financial feasibility of investing in new provider-based RHCs, leading to potential access concerns for individuals living in rural, low-volume areas.

Again, NRHA applauds MedPAC for addressing cost-sharing reforms that alleviate financial burdens on rural Medicare beneficiaries. As the Commission continues to refine its recommendations on beneficiary cost-sharing policies, we urge policy adjustments made to RHCs are based on a comprehensive understanding of reimbursement structures that do not harm rural beneficary access or the financial viability of RHCs.

If you have any questions or would like to discuss our comments further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us). We look forward to MedPAC's future work on rural Medicare issues.

Sincerely,



Alan Morgan
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National Rural Health Association