MEDPAC

Advising the Congress on Medicare issues

Reducing beneficiary cost-sharing for outpatient services at critical access hospitals

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January 17, 2025

Overview of MedPAC's work on CAH cost-sharing

- Discussed CAH cost sharing in the spring of 2024 and again in September 2024
- Given strong commissioner interest in moving away from charge-based coinsurance, the Chair has proposed a draft recommendation for discussion
- Today's mailing materials and discussion will form the basis for a chapter in our June 2025 report to Congress

Note: CAH (critical access hospital).

Presentation roadmap

1. Types of rural special payments
2. Current critical access hospital coinsurance
3. Chair's draft recommendation on CAH coinsurance
4. Rural health clinic coinsurance

Types of rural special payments

- Add-on payments to PPS rates
  - E.g., low-volume hospital add-on, sole community hospitals
  - Discussed at length in past reports
- Fixed payment plus PPS rates
  - Rural emergency hospital model
  - Discussed in our March 2024 report to Congress
- Cost-based payment rates
  - CAH: 101% of costs
  - RHC: Program payments are limited to 80% of costs and other payment limits; coinsurance is not limited
  - Both programs have charge-based beneficiary coinsurance

Note: PPS (prospective payment system), CAH (critical access hospital), RHC (rural health clinic).

CAH outpatient coinsurance: 20% of charges

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

- CAH program payment = 101% of costs minus coinsurance
  - Program payments decrease as beneficiary coinsurance increases
- 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 and across services within hospitals
- PPS hospital coinsurance = 20% of the payment rate

Note: CAH (critical access hospital), PPS (prospective payment system). 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
- 16% of rural FFS beneficiaries do not have supplemental insurance
- On average, coinsurance represented 52% of all outpatient payments; in 4% of cases, the full cost was billed as coinsurance

Note: CAH (critical access hospital), FFS (fee-for-service). 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 payment (20% of charges)	**200**	**300**	**480**
Program payment*	406	306	126
Coinsurance share of total payment*	33%	50%	79%

Note: CAH (critical access hospital).
* Payments are presented as 101% of costs without factoring in the sequester. With the sequester, program payment would equal to 101% of costs, less coinsurance, multiplied by 98% if a 2% sequester is in place.

Source: MedPAC analysis of Medicare CAH outpatient claims.

No cap on CAH coinsurance, unlike in PPS hospitals

	OPPS coinsurance (20% of OPPS rate); $1,676 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	12,867	N/A
Billed as coinsurance	**1,676 (the cap)**	**5,200 (20% of charges)**
Paid by the Medicare program	11,191	7,771*

Note: CAH (critical access hospital), OPPS (outpatient prospective payment system). In 2025, the coinsurance cap on any OPPS line item is $1,676 (the 2025 inpatient deductible). The OPPS base rate for an outpatient hip replacement coded under APC 5115 (Level 5 musculoskeletal procedures) is $12,867 for hospital with a wage index of 1 in 2025). * 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.

Policy option presented in September: Eliminate charge-based coinsurance for CAH services

- Option would reduce cost sharing to 20% of payment amount
- Total payment to CAHs would remain unchanged
  - Therefore, reduction in beneficiary cost sharing would result in higher program payments funded by taxpayers
- Consistent with how outpatient cost sharing works at PPS hospitals

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

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

- Beneficiary coinsurance would have been $2.1 billion lower
  - Lower coinsurance billed to beneficiaries without supplemental insurance
  - Less inequity in cost sharing across CAHs
  - Reduced coinsurance billed to Medigap plans and state Medicaid programs
- Total increase in program spending: $3.2 billion
  - Higher program payments to CAHs
  - Higher MA benchmarks and MA spending

Note: CAH (critical access hospital), MA (Medicare Advantage).
Source: MedPAC analysis of claims and cost report files.

Chair's draft recommendation

The Congress should:

- Set coinsurance for outpatient services at critical access hospitals equal to 20 percent of the payment amount for services that require cost sharing and
- Place a cap on critical access hospital outpatient coinsurance equal to the inpatient deductible

Implications

Spending: Would increase program spending relative to current law

Beneficiary and provider: Would reduce cost-sharing liability for beneficiaries who use CAH services, reduce Medigap premiums for beneficiaries, and increase Part B premiums for all beneficiaries. No material impact on CAHs' revenues or willingness or ability to treat beneficiaries

Note: CAH (critical access hospital).

Rural health clinic coinsurance: 20% of charges

Overview of RHC spending and use, 2022

RHCs billing FFS	4,800 total (3,300 provider-based; 1,500 independent)
FFS patients	2.3 million beneficiaries
FFS visits	9.5 million
FFS payments	$1.9 billion

Note: RHC (rural health clinic), FFS (fee-for-service). Spending figures do not include services paid on a cost basis (e.g., certain vaccines), services paid under other payment systems (e.g., the technical component of imaging services and tests billed under the clinical laboratory fee schedule), and cost-report-reconciliation payments.

Source: MedPAC analysis of FFS RHC claims data.

RHC basics

- RHCs must initially be located in a nonurbanized area that qualifies as a HPSA, MUA, or governor-designated shortage area
- RHC services are generally outpatient visits furnished by clinicians
- FFS Medicare pays RHCs an all-inclusive rate (AIR) per visit, subject to limits
- Over time, the Congress added per visit payment limits
  - As of 2021, all RHCs are subject to payment limits per visit
  - Payment limits vary based on whether an RHC is independent or provider based, and other factors

Note: RHC (rural health clinic), HPSA (health professional shortage area), MUA (medically underserved area), FFS (fee-for-service). Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). We use the term "per visit" to reflect this payment unit.

Source: MedPAC analysis of regulations.

Payment limits vary by RHC type

- Independent and nonspecified provider-based RHCs are subject to the national statutory payment limit
  - Starting in 2029, payments increase annually by MEI growth
- Specified provider-based RHCs are subject to special payment limits
  - Criteria: Part of a hospital with fewer than 50 beds, enrolled in Medicare as of Dec. 31, 2020
  - Payment limit: Greater of the national statutory payment limit or 2020 AIR (~$255 per visit), increased annually by MEI growth

Year	National statutory payment limit per visit
2020	$86
2021	100
2022	113
2023	126
2024	139
2025	152
2026	165
2027	178
2028	190
Percent change (2020–2028)	120%

Note: RHC (rural health clinic), MEI (Medicare Economic Index), AIR (all-inclusive rate).
Source: MedPAC analysis of Medicare cost report files and regulations.

RHCs' charge-based coinsurance can increase beneficiary liability and total payments to RHCs

- Beneficiary coinsurance = 20% of RHC charges
- Medicare payment = 80% of RHCs' AIR, subject to payment limits
  - Program payments do not change based on beneficiary coinsurance
  - Therefore, RHCs can increase total payments by increasing charges
- For clinician services in other settings, beneficiary coinsurance is capped
  - PFS = 20% of the lesser of the PFS rate or actual charges
  - FQHC = 20% of the lesser of the PPS rate or FQHC's charges

Note: RHC (rural health clinic), AIR (all-inclusive rate), PFS (physician fee schedule), FQHC (federally qualified health center). Examples do not include the effect of sequestration.

Higher charges result in higher beneficiary coinsurance and total payments to RHCs: Illustrative example

	RHC 1	RHC 2
RHC AIR (subject to payment limits) per visit	$152.00	$152.00
FFS Medicare payment per visit (80% of AIR, subject to payment limits)	121.60	121.60
RHC charges per visit	152.00	225.00
Beneficiary coinsurance per visit (20% of RHC charges)	30.40	45.00
Total payment to RHC per visit (FFS Medicare payment + beneficiary coinsurance)	152.00	166.60

Note: RHC (rural health clinic), AIR (all-inclusive rate), FFS (fee-for-service). Examples are of independent RHCs, do not include the effect of sequestration, and assume that RHCs' average cost per visit is higher than the national statutory payment limit and that the beneficiary has already met their Part B deductible. Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment, with limited exceptions (e.g., a qualified medical visit and a qualified mental health visit on the same day). We use the term "per visit" to reflect this payment unit.

Source: MedPAC analysis of Medicare regulations.

Charge-based coinsurance in RHCs results in increased and widely varying beneficiary liability, 2022

Average beneficiary coinsurance as a share of estimated AIRs per visit:

- Independent: 34%
- Nonspecified provider based: 38%
- Specified provider based: 17%

Note: RHC (rural health clinic), AIR (all-inclusive rate). Analysis limited to claims that were paid on an AIR basis where full beneficiary coinsurance was applicable.

Source: MedPAC analysis of FFS RHC claims data, cost-report data, CMS's Quality, Certification and Oversight Reports, and RHC websites.

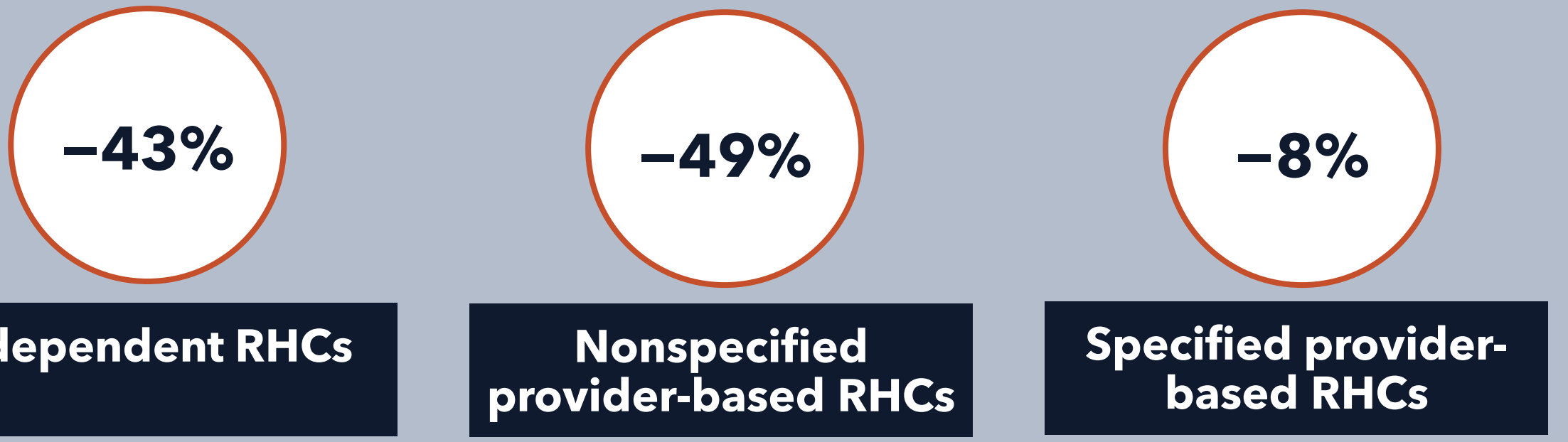
Beneficiary coinsurance rates varied widely among types of RHCs

RHC type	Percentile			
	10th	25th	75th	90th
Independent	20%	24%	40%	57%
Nonspecified provider based	23	29	45	62
Specified provider based	10	13	22	28

Average coinsurance at RHCs owned by a private-equity firm: ~60%

Estimated effects of capping beneficiary coinsurance at 20% of AIRs, subject to payment limits

In 2022, we estimate that capping beneficiary coinsurance would have substantially reduced beneficiary liability



Note: AIR (all-inclusive rate), RHC (rural health clinic). Analysis limited to claims that were paid on an AIR basis where full beneficiary coinsurance was applicable.
Source: MedPAC analysis of fee-for-service RHC claims data and cost-report data.

Estimated effects of capping beneficiary coinsurance at 20% of AIRs, subject to payment limits (cont.)

- In 2022, we estimate that capping beneficiary coinsurance would have reduced total FFS payments to RHCs
  - Independent RHCs: −12.9%
  - Nonspecified provider-based RHCs: −15.8%
  - Specified provider-based RHCs: −1.4%
- Effects on independent and nonspecified provider-based RHCs likely to be smaller in the future because of rapid growth in payment limits
  - Estimated 2028 effect on total FFS payments to independent RHCs: −7%
  - Reductions are small relative to 120% increase in payment limits

Note: AIR (all-inclusive rate), FFS (fee-for-service), RHC (rural health clinic). Analysis limited to claims that were paid on an AIR basis where full beneficiary coinsurance was applicable. 2028 simulation projects beneficiary coinsurance using 2022 coinsurance and average historical growth in RHC charges. AIRs, subject to payment limits, projected based on 2022 data and current law updates to the national statutory payment limit.

Source: MedPAC analysis of FFS RHC claims data and cost-report data.

Commissioner discussion

- Questions
- Reactions to the Chair's draft recommendation on CAH coinsurance

Note: CAH (critical access hospital).

Chair's draft recommendation

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