MEDPAC | Medicare Payment Advisory Commission

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September 29, 2023

Jason Smith
Chairman
House Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

**RE: Congressional Request for Information on Improving Access to Health Care in Rural and Underserved Areas**

Dear Mr. Chairman:

The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is a Medicare program that ensures beneficiary access to high-quality, well-coordinated care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends taxpayer dollars responsibly. The Commission recognizes the unique challenges faced by rural beneficiaries and providers and has continuously supported the development of targeted payment policies to ensure rural beneficiaries' access to essential services while protecting the taxpayers and beneficiaries whose dollars finance the program. We welcome the opportunity to respond to the House Committee on Ways and Means' September 7, 2023, Request for Information (RFI) on improving access to health care in rural and underserved areas.

The Commission has a long history of developing Medicare payment policies to improve access to care, quality of care, and efficiency of care delivery in rural and low-income areas. We conducted broad-based reviews of Medicare payment policy in rural areas in our June 2001 and June 2012 reports to the Congress. In our June 2018 report, the Commission recommended that the Congress help preserve rural beneficiaries' access to emergency department (ED) services by providing annual payments to isolated rural stand-alone EDs and allowing those EDs to bill Medicare for the services they provide.[1]

More recently, in response to a bipartisan request from the House Committee on Ways and Means, we analyzed rural beneficiaries' access to care and reported on recent trends that may have affected rural communities in our June 2021 report to the Congress. Overall, we found that, although some minor differences existed, rural and urban beneficiaries had similar utilization of care, suggesting similar access to care between rural and urban areas. Utilization data serve as a proxy for access to care. Yet, since utilization data can tell us only what services were used, not

[1] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

what services might have been forgone, they are imperfect measures of access. However, most surveys of Medicare beneficiaries find similar results as the utilization data (that rural beneficiaries' satisfaction with access to care is similar to that of urban beneficiaries). There has been substantial heterogeneity in the profitability of rural hospitals, with some exhibiting strong profit margins and others facing losses and even closure. The Commission's June 2021 report examined rural hospital closures from 2014 to 2019 and found that rural hospitals that closed typically experienced large declines in all-payer inpatient admissions in the years before closure—mostly due to patients bypassing their local hospital in favor of other, more distant hospitals.[2]

In considering policies with respect to rural access, quality, and payment, the Commission is guided by three principles established in our June 2012 report to the Congress.[3] First, access to care should be equitable for rural and urban beneficiaries, but equitable access does not mean equal travel times for all services. Indeed, small rural communities are expected to have longer travel times to access highly specialized services given the large population base needed to support such services. Second, expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. (Emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural areas. For example, a patient may have a heart attack with a significant blockage where the standard of care is angioplasty and a stent in a catheterization lab. Urban areas all have catheterization labs. However, small rural hospitals, which may be too far from the nearest catheterization lab to safely transport heart attack patients (even by helicopter), may be forced to use a thrombolytic to treat the blockage.) Third, rural payment adjustments should be empirically justified; targeted toward low-volume, isolated providers; and designed to encourage cost control on the part of providers. These three principles undergird the policy discussion below.

## MedPAC has recommended policies to target payments to better support rural and vulnerable beneficiaries' access to care

The Medicare program has several rural payment programs designed to preserve rural hospitals, including the critical access hospital (CAH) program, the sole community hospital (SCH) program, the Medicare dependent hospital (MDH) program, and the low-volume hospital (LVH) program. In 2018, over 95 percent of rural hospitals were CAHs, MDHs, or SCHs or qualified as LVHs and received higher-than-standard Medicare rates.[4] Some rural hospitals qualify for more than one of these programs, receiving an LVH adjustment while also receiving cost-based payments through their designation as an SCH or MDH. The Commission has recommended financial support for necessary providers that have high costs due to factors outside of their control, such as isolated providers with low patient volume.[5] However, these special payments should be empirically determined, narrowly targeted, and not duplicative of other payment adjustments.[6]

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[2] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[3] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[4] Medicare Payment Advisory Commission. 2021, op cit.
[5] Medicare Payment Advisory Commission. 2001. *Report to the Congress: Medicare in rural America*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[6] Medicare Payment Advisory Commission. 2012, op cit.

**Rural emergency hospital program**

In some communities, special payment policies under the CAH, SCH, MDH, and LVH programs have not preserved access to high-quality, efficient care. The dilemma is that, for many rural communities, an expensive inpatient delivery model may not be a financially viable option but, to receive these special payments from Medicare, a hospital must maintain its inpatient status and all of the associated costs (e.g., complying with certain staffing and facility requirements). This dilemma has become more acute as the volume of inpatient admissions in rural hospitals has continued to decline, with many hospitals admitting less than one patient per day.[7]

Declining inpatient volume has important consequences for a rural hospital's financial viability. As the number of admissions falls, the hospital has fewer inpatients over whom to spread its fixed costs. Thus, the cost per admission increases, undermining the efficient delivery of care. In addition, as volume declines, special payments, which are linked to inpatient volume, also decline. The drop in inpatient volume has thus contributed to hospital closures. From 2018 to 2022, 46 rural general acute care hospitals closed.[8] Though beneficiaries in these 46 areas may be able to receive planned, nonemergent inpatient care from other hospitals, these closures may leave beneficiaries without access to timely emergency care.

The closure of rural hospitals is often preceded by a loss of inpatient volume that reflects patients choosing to bypass their local hospital for nonemergency care. We examined changes in inpatient volume at 40 rural hospitals that closed between 2015 to 2019. In a decade prior to closure (2005 to 2014), we found all-payer inpatient admissions at these 40 hospitals fell by an average of 54 percent.[9] Over the same period, the population of the counties in which these hospitals were located declined by an average of only 1 percent, suggesting that the loss of inpatient volume was not driven by population changes. The history of patients bypassing rural hospitals and the closure of those rural hospitals suggests the need for rural payment and delivery models to adapt to the choices being made by rural patients.

In 2018, the Commission recommended that Medicare allow isolated rural stand-alone emergency departments (EDs) to bill Medicare and provide such EDs with annual payments to assist with fixed costs. The new payment option would allow rural communities that cannot support a full-service hospital a way to maintain access to emergency care in their community, while retaining the option to convert back to a full-service hospital if circumstances change. Such flexibility may make it easier for hospitals to try the model.

In 2020 the Congress enacted a policy that allows certain hospitals to convert to "rural emergency hospitals" (REHs). REHs do not provide inpatient care but do provide round-the-clock ED care and are able to furnish other services, such as outpatient services and ambulance services. Medicare pays these providers a monthly fixed payment, enhanced outpatient rates, and standard rates for other types of care. The REH model allows hospitals to eliminate the costs of maintaining an underutilized inpatient department while providing financial flexibility to furnish outpatient and emergency care that the local community requires. In subsequent rulemaking, CMS set the annual fixed payment ($3.3 million per REH in 2023) and set staffing requirements. However, MedPAC

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[7] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[8] Medicare Payment Advisory Commission. 2023. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.
[9] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

raised some concerns that the staffing requirements would not meet the goals of the new REH designation and that the fixed payment is excessive, especially given the minimal staffing requirements.[10]

The law creating the REH model also mandated that, beginning in 2024, MedPAC's annual report to the Congress include a review of payments to REHs. As the first REHs began converting in 2023 and data on the payments they received are not yet available, MedPAC's first review of the REH model will focus on a status update on how it is being implemented.

**Medicare Safety-Net Index**

The Commission has a long history of supporting hospitals that provide care to low-income beneficiaries and admit patients with greater health care needs.[11] In March 2023, MedPAC recommended a new policy to increase payments to hospitals serving a disproportionate share of low-income Medicare patients.

Medicare currently makes safety-net payments to hospitals in the form of disproportionate share hospital (DSH) payments and uncompensated care payments. But there are several problems with the formulas used to distribute safety-net payments. First, DSH payments are applied only to hospital inpatient rates, so hospitals do not receive any increase to the payments they receive for providing outpatient care. Second, the DSH formula is primarily driven by Medicaid patient shares. Thus, Medicare subsidizes Medicaid through its DSH payments and hospitals that serve high shares of Medicare patients may be disadvantaged under the DSH formula. It is important for hospitals that treat large shares of Medicaid patients to be supported, but that cost should be Medicaid's responsibility and not be absorbed by Medicare. Third, Medicare's uncompensated care payments are biased toward providing greater uncompensated care payments to hospitals with few Medicare fee-for service (FFS) inpatient stays and more Medicare Advantage (MA) inpatient stays.

To address the issues with the current DSH and uncompensated care payment metrics and better direct supplemental payments to hospitals that care for a high share of Medicare beneficiaries with low incomes, the Commission recommended a new measure called the Medicare Safety-Net Index (MSNI). Each hospital's MSNI is computed using three components:

(1) the share of its Medicare volume associated with low-income beneficiaries,
(2) the share of revenue the hospital spends on uncompensated care (bad debts and charity care), and
(3) the share of total volume associated with Medicare beneficiaries.

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[10] Medicare Payment Advisory Commission. 2022. MedPAC comment on CMS's proposed rule on hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs. September 12.
Medicare Payment Advisory Commission. 2022. MedPAC comment on CMS's proposed rule on conditions of participation (CoPs) for rural emergency hospitals and critical access hospital CoP updates. July 27.

[11] Medicare Payment Advisory Commission. 2001. *Report to the Congress: Medicare in rural America*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2005. *Report to the Congress: Physician-owned specialty hospitals*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

The MSNI model and the current uncompensated care policy differ importantly in that the MSNI payments would be structured as add-on payments to Medicare payment rates (meaning a percentage increase to FFS rates for each claim). Providers who tend to serve relatively more Medicare patients (particularly low-income Medicare patients) and patients who are unable to pay for their cost sharing would receive higher Medicare payment rates under the MSNI model. In contrast, the current uncompensated care model is not a percentage add-on payment and therefore is not directly tied to Medicare payment rates. Instead, each disproportionate share hospital receives a fixed share of its uncompensated care costs from FFS Medicare, even if it treats very few Medicare patients.

In its March 2023 report to the Congress, the Commission recommended a redistribution of DSH and uncompensated care payment through the MSNI, adding $2 billion to the MSNI pool (for FFS and MA patients combined); scaling FFS MSNI payment in proportion to each hospital's MSNI; and paying commensurate MSNI amounts for services furnished to MA enrollees in a way that excludes such payments from MA benchmarks.

Shifting safety-net payments from the current DSH and uncompensated care payments to new MSNI-based payments would change the distribution of payments in three important ways. First, because hospitals' dependence on Medicare patients is a factor in computing the MSNI, hospitals with higher shares of Medicare patients would tend to receive higher add-on payments per case. These hospitals also would receive the MSNI add-on payment for a greater share of the services they furnish because Medicare is a large share of their patient mix. Second, because Medicare would no longer directly subsidize Medicaid patients, hospitals with few Medicare patients and large Medicaid patient loads would see a reduction in payments. Third, because under the MSNI policy Medicare's payments would be more closely tied to Medicare patients, those hospitals that previously received high levels of payments for DSH and uncompensated care but treated relatively few Medicare patients would tend to receive less funding. Overall, payments would shift toward hospitals serving high volumes of Medicare patients and, in particular, low-income Medicare patients.[12]

If Medicare hospital payments were redistributed using an MSNI model and an addition of $2 billion were added to the combined FFS/MA MSNI pool, the hospitals that would gain most would be smaller hospitals with higher shares of Medicare patients. On average, rural hospitals would receive higher MSNI add-on percentages than urban hospitals (13.7 percent vs. 9.3 percent, respectively) (Table 1). Rural hospitals in aggregate would see an increase in FFS Medicare payments of 3.3 percent. Such hospitals would benefit because they tend to have high shares of Medicare patients that are not factored into current DSH percentages or uncompensated care payments. Rural hospitals would also tend to benefit from removing the distortion in uncompensated care payments that directs payments to hospitals with high shares of MA patients.[13]

[12] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[13] Medicare Payment Advisory Commission. 2023, op cit.

**Table 1. Effect of redistributing current DSH and UC payments under the MSNI and adding $2 billion to the FFS/MA MSNI pool by type of hospital, 2019**

| Hospital characteristic | Simulated mean MSNI percentage add-on to FFS Medicare payments* | Simulated aggregate percentage change in: | |
|---|---|---|---|
| | | FFS Medicare revenue *(due to shifting from DSH/UC payments to the MSNI policy)* | (All-payer) total revenue *(due to the MSNI policy)* |
| All IPPS hospitals | 10.4% | 0.5% | 0.1% |
| Government (*n* = 349) | 14.0 | −1.5 | −0.6 |
| For profit (*n* = 592) | 11.6 | 2.3 | 0.8 |
| Nonprofit (*n* = 1,663) | 9.2 | 0.5 | 0.2 |
| Rural (*n* = 611) | 13.7 | 3.3 | 1.1 |
| Urban (*n* = 1,990) | 9.3 | 0.2 | 0.1 |
| Teaching (*n* = 1,568) | 10.1 | 0.1 | 0.0 |
| Nonteaching (*n* = 1,033) | 10.5 | 1.3 | 0.4 |
| MA share of stays | | | |
| < 25% (*n* = 1,308) | 9.7 | 0.7 | 0.2 |
| 25% to 50% (*n* = 949) | 10.2 | 0.5 | 0.2 |
| > 50% (*n* = 347) | 12.5 | −0.3 | −0.1 |

Note: DSH (disproportionate share hospital), UC (uncompensated care), MSNI (Medicare Safety-Net Index), FFS (fee-for-service), IPPS (inpatient prospective payment systems), MA (Medicare Advantage). The table presents unweighted mean values comparing payments that occurred in 2019 with what payments would have been under an MSNI distribution of safety-net dollars. Data include all IPPS hospitals in the United States (excluding territories) with more than 200 discharges and complete cost report data in 2019.
*Add-on adjustments are applied to inpatient and outpatient payments excluding Part B drugs.

Source: MedPAC analysis of cost report and claims data.

## MedPAC's recommended changes to the hospital wage index would address geographic inequities and improve the accuracy of payments

Medicare's prospective payment systems (PPSs) use wage indexes to adjust Medicare base payment rates for geographic differences in labor costs. For the inpatient prospective payment systems (IPPS), the Congress specified that the wage index should reflect the labor costs of hospitals in a geographic area relative to the national average hospital level. However, because of the limited data sources used, the use of broad labor market areas, and the number of wage index exceptions that the Congress and CMS have added over time, Medicare's IPPS wage index is inaccurate and inequitable.[14]

The Commission's key concerns with the current IPPS wage index are that it fails to accurately reflect differences in labor costs across geographic areas and creates inequities across hospitals. These inaccuracies and inequities stem from the data sources and definition of labor market areas used, and they are frequently exacerbated by the numerous wage index exceptions. While there are motivations for each IPPS wage index exception, collectively they detract from the core purpose of

[14] Medicare Payment Advisory Commission. 2023b. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

the wage index—accurately and equitably reflecting differences in labor costs across geographic areas—because most have either no or a flawed empirical basis, can be manipulated, and add administrative burden. Indeed, CMS has noted that the rural floor in particular is subject to wage index manipulation, as high-wage urban hospitals in certain states have reclassified to their state's rural area to increase the state's rural floor. Urban hospitals then receive the higher rural floor for their wage index, and rural hospitals can experience reductions in payments due to budget-neutrality adjustments that pay for increasing urban wage indexes up to the new "rural floor." In addition, the Commission remains concerned that the use of the initial hospital wage index by other provider types (such as skilled nursing facilities) is inaccurate and inequitable.

The share of hospitals receiving wage index exceptions has grown over time and the effects can be substantial. In fiscal year 2022, about two-thirds of IPPS hospitals benefited from at least one IPPS wage index exception, compared with about 40 percent of IPPS hospitals in 2007. Among the two-thirds of IPPS hospitals with a wage index value affected by at least one wage index exception in 2022, over a quarter received a more than 10 percent increase in their wage index value, and some received a substantially higher increase.

The most common wage index exceptions are budget neutral; thus, the increased payments made to the hospitals receiving these exceptions are paid for by reducing payments to all hospitals. In fiscal year 2022, increasing payments to hospitals that reclassified, benefited from the rural floor, and/or received the temporary low-wage exception resulted in a reduction in IPPS base rates to all hospitals of 2.2 percent (equal to about $2.2 billion in aggregate). That represented a significant decrease in payments to the one-third of IPPS hospitals that did not receive an exception.

To accurately reflect geographic differences in labor costs among IPPS hospitals and other types of providers and to be more equitable across providers, the Commission recommended in June 2023 that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.

Because all employers participate in the labor market and compete for similar types of workers, the wages and benefits used to construct a wage index should come from all employers of a given occupation. Using all-employer wage data also increases the number of employers with wage data in each area, therefore increasing reliability and decreasing the circularity that causes deviations between the labor costs reported by hospitals and broader labor market wages. Incorporating local (e.g., county) wage data would allow the wage indexes to recognize differences in labor costs within a broader labor market area and allow for a smoother and more equitable distribution of wage index values across adjacent local areas. Furthermore, eliminating all wage index exceptions would remove hospitals' opportunities for wage index manipulation and promote equity in how Medicare pays for hospital services.

Because of the large inaccuracies in the current wage index systems, implementing the Commission's recommended changes would have a material effect on many providers. Based on our illustrative models, we estimate that, once the changes were fully phased in, IPPS payments would fall by more than 5 percent for about 10 percent of hospitals and rise by more than 5 percent

for 18 percent of hospitals. Because of the significant redistributional effects, the Commission recommended implementing these changes gradually over multiple years or managing them through a stop-loss policy so that no provider would experience increases or decreases in Medicare payments of more than a specified percentage in any one year due to the transition to the new wage index system. However, once fully implemented, these revisions would result in more equitable and accurate payments across regions and across types of providers.

The Commission developed an illustrative wage index consistent with its recommendation and modeled the effects. Because of the large inaccuracies in the current IPPS wage index, moving to the Commission's illustrative IPPS wage index would have a material effect on many IPPS hospitals. While the effects varied within types of hospitals, the Commission estimated that, in aggregate, rural hospitals' IPPS payments would increase if Congress were to move from the current wage index to the alternative approach recommended by the Commission.

**MedPAC has recommended aligning payment rates across ambulatory settings for certain services**

The Committee also requested comments on policies to lower patient costs by equalizing payments for identical care provided in different settings of care. In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. If the same service can be safely and appropriately provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. This principle suggests that—for services that are safe and appropriate to provide in a lower-cost setting—Medicare should more closely align FFS payment rates across ambulatory settings. However, Medicare should be selective about which services should have payment rates aligned across settings, as many ambulatory services cannot be safely or appropriately provided in freestanding offices in most circumstances. Such services are typically complex procedures or services related to emergency care. In these instances, discretion should be used and the payment rates in each of the ambulatory settings should be left unchanged to ensure that hospitals are adequately reimbursed to maintain access to those services.

Because of the payment rate differences across clinician offices, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs), hospitals have an incentive to acquire physician practices and then bill for the same services under the outpatient prospective payment system (OPPS), thereby increasing revenue without a meaningful change in the site of care. Indeed, billing for many ambulatory services has been shifting from the physician fee schedule (PFS) to the OPPS. Analysis of data from the American Medical Association's Physician Practice Benchmark Surveys indicates that the share of physicians who were either in practices at least partially owned by hospitals or that were employees of hospitals increased from 29.0 percent in 2012 to 40.9 percent in 2022.[15]

As hospitals acquire more physician practices and more physicians become employed by hospitals, service billing shifts from the PFS to the OPPS—with its usually higher payment rates—even if there is no actual change to the physical setting in which the service is provided or in the delivery of the service itself. Among evaluation and management (E&M) office visits, echocardiograms, nuclear cardiology, and chemotherapy administration services, for example, the share of the total volume of services billed under the OPPS increased from 2012 to 2021 (Table 2). As billing of

[15] Kane, C. 2023. *Policy research perspectives: Recent changes in physician practice arrangements: Shifts away from private practice and towards larger practice size continue through 2022*. Chicago, IL: American Medical Association.

services shifts from the PFS to the OPPS, program spending and beneficiary cost sharing increase without significant changes in patient care.

**Table 2. Billing of important ambulatory services has shifted from the PFS to the OPPS**

| Service | Share billed under OPPS | |
|---|---|---|
| | 2012 | 2021 |
| Office visits | 9.6% | 12.8% |
| Chemotherapy administration | 35.2 | 51.9 |
| Cardiac imaging | 33.9 | 47.6 |
| Echocardiography | 31.6 | 43.1 |

Note: PFS (physician fee schedule), OPPS (outpatient prospective payment system).

Source: MedPAC analysis of standard analytic claims files, 2012 and 2021.

The incentive for hospitals to acquire physician practices was mitigated (but not eliminated) by the Bipartisan Budget Act (BBA) of 2015, through which the Congress directed CMS to develop a limited system that more closely aligns payment rates between HOPDs and freestanding offices. CMS satisfied this mandate in 2017 by implementing payment rates that approximate PFS rates for services provided in off-campus provider-based departments (PBDs) of hospitals that were not providing services when the Congress enacted the BBA of 2015 on November 2, 2015.[16] However, the off-campus PBDs not subject to the BBA of 2015 site-neutral payments have no restrictions on expanding the range of services they provide. Therefore, when a hospital acquires a physician practice and adds it to an existing off-campus PBD that is excepted from the BBA of 2015, the services furnished by that practice are paid at full OPPS rates (with the exception of office visits). In 2022, 86 percent of the services provided in off-campus PBDs were provided in excepted facilities. This high percentage of services in excepted PBDs suggests that a strong majority of the off-campus PBDs were excepted from BBA of 2015.

Based on the recent growth in hospital acquisition of physician practices and our own empirical analysis, in June 2023 the Commission recommended that the Congress more closely align payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings and when doing so does not pose a risk to access.

In general, Medicare statute requires that CMS implement changes within a payment system budget neutrally. Without an explicit provision of law, in implementing an alignment of payment rates across ambulatory settings, CMS would be required to increase payment rates for the services that were not aligned to ensure that there would be no aggregate effect on payments within the payment system. Similarly, MedPAC's June 2023 recommendation would have no direct effect on Medicare program spending because, unless otherwise directed, CMS would apply budget-neutral increases to the OPPS payment rates of the nonaligned services to offset the effects of the lower aligned payment rates. However, the recommendation would have differing effects across hospitals, as some would see Medicare revenue gains while others would experience revenue losses. Despite the potential losses for some hospitals, the Commission does not expect this recommendation to affect beneficiaries' access to these services, as we do not expect hospitals to

[16] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2016. Medicare program: hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs. *Federal Register* 81, no. 219 (November 14): 79562–79892.

change what services they offer. Regardless, if one were concerned about certain categories of hospitals being adversely affected, these concerns should be addressed through targeted assistance to those hospitals—such as through the Commission's recommended safety-net policy—rather than maintaining higher-than-warranted OPPS payment rates for some services.

The impacts of payment alignment would differ across hospitals, with some seeing overall losses in OPPS revenue because they provide a disproportionately high share of the low-complexity site-neutral services relative to other hospitals. In contrast, other hospitals would see a rise in revenue because they provide a disproportionately high share of the more-complex services for which payment rates would increase under the budget-neutrality adjustment. Though the Commission estimated that rural hospitals would experience a reduction in Medicare payments of roughly 2.5 percent under a budget-neutral, redistributive site-neutral policy, it does not believe that this reduction in Medicare revenue would have a substantial adverse effect on rural beneficiaries because:

- Rural hospitals have better financial performance than urban hospitals under Medicare FFS payment systems;
- Critical access hospitals are not paid under the OPPS, so they would be unaffected by payment rate alignment; and
- OPPS payment rates for services provided in rural sole community hospitals are 7.1 percent higher than standard OPPS payment rates. This adjustment would apply to the aligned payment rates.

In considering an alternative to an across-the-board budget-neutrality adjustment, we also evaluated a stop-loss policy that would be a temporary, narrowly focused approach to ensure access to care among low-income beneficiaries who rely on safety-net hospitals. Such a policy would require congressional action because current law requires CMS to make payment policy changes budget neutral. Under the stop-loss policy the Commission modeled in 2022, about 23 percent of hospitals would have reductions in overall Medicare revenue capped at 4.1 percent, and the other 77 percent of hospitals would receive no benefits from the stop-loss policy.

The Commission asserts that concerns about specific types of hospitals being adversely affected due to payment alignment should be addressed through targeted assistance to those hospitals rather than paying all hospitals higher-than-warranted rates for certain services—for example, through the MSNI policy we previously discussed.

## Conclusion

We appreciate the opportunity to provide feedback on these very important issues related to access to health care for beneficiaries in rural and underserved areas. Please consider us a resource for any issue related to the Medicare program. If you have any questions regarding our comments or wish to discuss the Commission's work in greater detail, please contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael Chernew, Ph.D.
Chair