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March 18, 2024

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

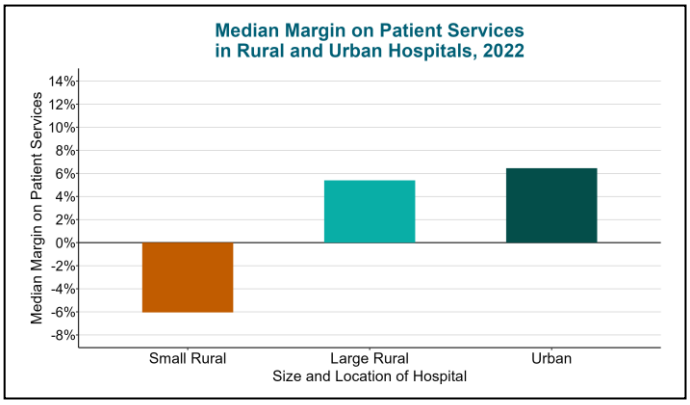
RE: Comments on MedPAC March 7 Meeting Discussion and Recommendations for MedPAC's Workplan for Rural Hospital and Clinician Payment Policy

Dear Dr. Chernew:

As the Commission and staff finalize your workplan for reviewing rural payment policies, I urge you to incorporate the following components and considerations:

Examine Small Rural Hospitals Separately From Larger Rural Hospitals

The Commission's analyses typically examine "rural hospitals" as a single category, or disaggregate them solely based on whether they are IPPS hospitals vs. Critical Access Hospitals or whether they are inside or outside micropolitan areas. Our research has shown that *small* rural hospitals (those with annual expenses below the median for all rural hospitals) are very different from larger rural hospitals, and failure to examine them separately leads to inaccurate or misleading conclusions.



Higher costs have had a negative impact on profit margins at every hospital in the country. But in most cases, urban hospitals and even large rural hospitals have continued to make profits on patient services. In contrast, most *small* rural hospitals have been *losing* money on patient services for several years, including prior to the pandemic. For them, "lower margins" means even bigger losses, and the bigger the losses, the sooner the hospital will run out of money and be forced to close. **Most of the rural hospitals that are at risk of closing are small rural hospitals, not larger rural hospitals.**

There are over 1,000 small rural hospitals in the U.S., representing more than one-fourth of the short-term general hospitals in the country. Small rural hospitals deliver not only traditional hospital services such as emergency care, inpatient care, and laboratory testing, but most of them

also deliver primary care and inpatient rehabilitation services, and many are also the only source of long term care for Medicare beneficiaries. Most of the communities served by small rural hospitals are a half-hour drive or more from the nearest alternative hospital. In many cases, there are no other sources of health care in their community, so if the hospital closes or is forced to cut back on services due to financial challenges, the residents of the community will lose access to essential services.

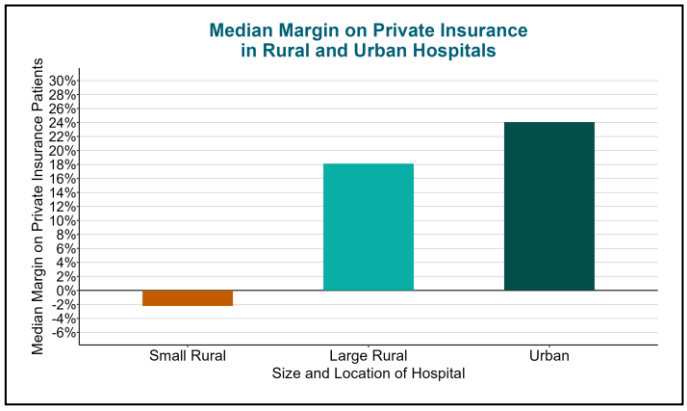
Don't Ignore the Problems Facing Critical Access Hospitals

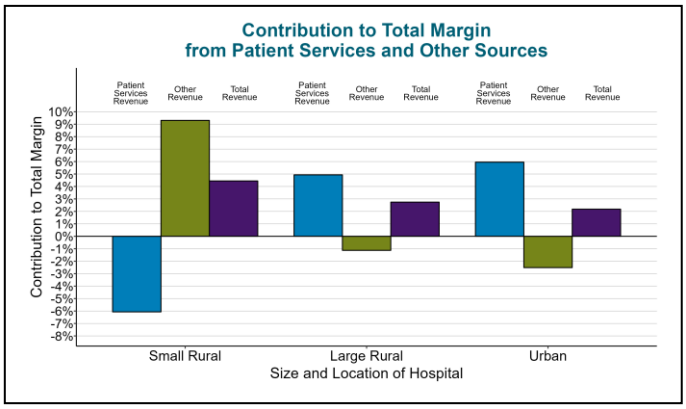
The chapter on Hospital Inpatient and Outpatient Services in the Commission's March 2024 Report to Congress focuses solely on IPPS hospitals and ignores Critical Access Hospitals, even though 70% of rural hospitals are Critical Access Hospitals. Moreover, over 80% of *small* rural hospitals are Critical Access Hospitals, whereas the majority of rural IPPS hospitals are *not* small hospitals, so the Commission's analyses have been biased against the nation's smallest rural communities.

It is very misleading for Commission staff to say that Medicare pays Critical Access Hospitals 101% of their costs and to imply that Medicare payments are adequate to cover the cost of delivering care at those hospitals. Due to sequestration, Critical Access Hospitals are paid only 99% of their costs, and not all of their costs are eligible for cost-based payment. No business in any other industry would survive if it could only be paid 99% of the costs it incurred to produce its products or deliver its services, yet that is exactly what the Medicare program expects Critical Access Hospitals to do.

Don't Assume That Private Payers Pay Small Rural Hospitals More Than Medicare

The Commission's analyses implicitly assume that it's acceptable for Medicare to pay a hospital less than its costs because the hospital can offset the loss with profits on patients with private insurance. However, our analyses show that Critical Access Hospitals and other small rural hospitals cannot offset losses on Medicare and Medicaid patients because private payers pay them less than the cost of delivering patient services and far less than those private payers pay larger rural hospitals and urban hospitals.





Because of low payments from private insurance plans, Medicare, and Medicaid, most small rural hospitals lose money on patient services overall. Many are only able to continue operating because of subsidies they receive from the taxpayers in their community. This means that many Medicare beneficiaries in rural areas are paying taxes to subsidize insurance plans in addition to

the cost-sharing amounts they pay for individual services.

Consider the Impact of Medicare Cost-Sharing Policies on Private Payer Payments

We were happy to hear that the Commission will be examining the problematic policy requiring Medicare beneficiaries to pay cost-sharing at Critical Access Hospitals based on the hospital's charges for its services. As part of your analysis, it is important to understand that many private health plans pay rural hospitals for services based on a discount on the hospital's charges. A hospital that sets its charges at amounts close to the cost of services could end up losing significant amounts of money if a private health insurance company pays the hospital only a small fraction of those charges. Critical Access Hospitals face a no-win situation – if they charge higher amounts to private insurance plans in order to make up for losses on Medicare and Medicaid patients, they will penalize their Medicare patients with higher cost-sharing amounts. It would make more sense to charge Medicare beneficiaries cost-sharing based on the amount Medicare pays the hospital, or ideally, based on the amount Medicare beneficiaries would pay at IPPS hospitals.

Examine the Problems Medicare Advantage Plans Are Creating for Small Rural Hospitals

We were also happy to hear that the Commission intends to examine the problems that Medicare Advantage (MA) plans are creating for rural hospitals. In doing so, it is important that you distinguish between small rural hospitals and larger rural hospitals, and that you specifically examine the impacts MA plans are having on small Critical Access Hospitals as well as small IPPS hospitals.

We urge that the Commission examine all of the following issues carefully:

- How often MA plans have failed to contract with the rural hospital that is located closest to where enrolled Medicare beneficiaries live. Small rural hospitals have told us that MA plans use the CMS network adequacy standards as justification for contracting only with hospitals located an hour or more away.
- How often MA plans require a beneficiary to travel to a different community for a service that the small rural hospital is able and willing to deliver. Small rural hospitals tell us that even if the hospital has a contract with the plan, the plan will only authorize specific services if they are delivered in distant communities.
- How much MA plans pay small rural hospitals for services compared to the amount the hospitals would receive for the same services from Original Medicare. Critical Access Hospitals have told us that MA plans refuse to pay the cost-based payment amounts the hospital would have received from Original Medicare.
- How often MA plans deny claims from small rural hospitals for services that they have already delivered and that would have been paid for by Original Medicare. Small rural hospitals tell us that even if the MA plan has agreed to pay the same amount as Original Medicare, only a fraction of the claims submitted are actually paid.
- How long it takes MA plans to pay claims. Small rural hospitals tell us that long delays in receiving payments from MA plans create significant cash flow problems for the hospitals.

The only way to obtain accurate information on how MA plans' policies and practices are harming rural hospitals is to ask the hospitals, not the MA plans. Small rural hospitals with limited staff and financial problems will not have adequate staff to assemble this information on their own, so we urge you to allocate sufficient resources to help them do so.

Recommend Changes in the Methods Medicare Uses to Pay for Rural Hospital and Rural Health Clinic Services

The methods Medicare currently uses to pay rural hospitals do not provide adequate support for essential rural healthcare services. Rural hospitals should not be forced to eliminate services their communities need in order to receive higher payments, as is required under the Rural Emergency Hospital program. Instead, Medicare should pay small rural hospitals **Standby Capacity Payments** to support the minimum fixed costs of essential services in addition to Service-Based Fees when individual services are delivered. More details on this approach are available in CHQPR's report *A Better Way to Pay Rural Hospitals*.

In addition, the method Medicare uses to pay Rural Health Clinics (RHCs) fails to support high-quality primary care and other essential medical services in rural communities. Basing payments on the number of visits to the clinic does not enable RHCs to deliver effective preventive care or proactive care for chronic conditions. Instead, RHCs should receive a combination of monthly payments for care management and fees for acute needs. (More detail on this approach is available here.) Moreover, CMS should eliminate the difference in productivity standards for physicians working in RHCs compared to nurse practitioners and physician assistants. The current standards make it more difficult for RHCs to hire physicians, and that makes it more difficult for the RHC and hospital to provide services such as obstetric care that require the use of physicians.

We urge that you carefully analyze the problems that current payment systems are causing for rural hospitals and clinics and that you thoroughly examine the benefits of the alternative payment methods described above.

I would be happy to answer any questions you have about the recommendations above and to provide assistance to you in analyzing the needs of rural hospitals and clinics and the solutions for addressing them. You can contact me by email at Miller.Harold@CHQPR.org or by telephone at
(412) 803-3650.

Sincerely,

Harold D. Miller
President and CEO