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

Dear Chairman Chernew and members of the Commission,

The National Rural Health Association (NRHA) thanks the Commission for the opportunity to offer comments on the issues discussed during MedPAC's March 7 – 8, 2024 meeting.

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 (CAHs), Rural Health Clinics (RHCs), long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

**Rural payment policies**

NRHA thanks MedPAC for a robust discussion and focus on rural provider payments. We appreciate the attention to rural providers and rural beneficiary access; however, we want to provide some additional context for some of the more misleading comments made during the meeting.

As explained in a 2011 MedPAC study:[1]

> "CAHs receive cost-based reimbursement for inpatient acute, swing-bed, and outpatient services delivered to Medicare beneficiaries. Medicare patients at CAHs owe coinsurance on outpatient services on the basis of 20 percent of applicable Part B charges. Under the outpatient prospective payment system (OPPS), coinsurance is based on 20 percent of the OPPS price under the fee schedule for Ambulatory Patient Classification (APC) units. Because the fee schedule is generally much lower than charges, an unintended consequence of cost-based reimbursement … is that beneficiaries receiving care at a CAH may have a higher coinsurance burden than those going to PPS hospitals…
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> Any reduction in the way that coinsurance is computed will change the amounts due from patients or their secondary insurers (including Medicaid) on the Medicare cost report. Under cost-based reimbursement, Medicare pays 101 percent of all Part B allowable costs net of deductibles, coinsurance, and primary payer amounts. Any reduction in coinsurance therefore results in additional outlays for the Medicare program… If Medicare wants to avoid penalizing beneficiaries with high rates of coinsurance when CAHs set their charges well above cost, then there is a need to adjust the CAH coinsurance policy."

NRHA agrees that charge-based coinsurance at CAHs and RHCs may place an undue burden on rural beneficiaries because the 20% coinsurance is applied to an amount that may be higher than FFS

[1] Freeman, S., Dalton, K., 2011. Medicare Copayments for Critical Access Hospital Outpatient Services- 2009 update. Retrieved April 2, 2024 from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/Dec11_Copayments_CriticalAccessHospitals_CONTRACTOR_JS.pdf



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rates. However, we caution MedPAC against conflating issues with charge-based coinsurance with cost-based reimbursement as a whole. While hypothetically "providers can set charges freely", given that the majority of CAH Medicare payments are limited to 101% of costs (minus sequestration) there is limited incentive to set inflated charges. We'd also call attention to the last sentence of the above 2011 MedPAC report to highlight the need to figure out how to adjust CAH payments to make up the disparity in loss of coinsurance. While cost-based reimbursement in theory results in zero profits, in reality it actually creates operating losses on Medicare services for CAHs due to sequestration and non-allowable expenses.[2] NRHA encourages MedPAC to consider solutions that are both equitable for rural beneficaries, while protecting the viability of rural providers.

NRHA also highlights a comment made on the complexity of rural hospital payment designations. It is important to remember the hundreds of rural hospitals that closed following the adoption of Medicare prospective payment system (PPS) in the 1980's and 1990's due to the untenability of the PPS when applied to low-volume and/or rural hospitals. Since then, a myriad of designations have been created to address the historical payment inequities facing rural providers. Each Medicare designation is designed to alleviate a particular challenge for a subset of rural hospitals. For example, low-volume hospitals (LVH) receive a payment adjustment to account for extremely low patient volumes. Medicare Dependent Hospitals (MDHs) were created to support small hospitals that have a significant Medicare patient volume.

While further change is needed to address rural health care financing challenges, elimination of the current framework of designations, including cost-based methodologies, without clearly defined and tested alternatives may likely result in a collapse of the nation's rural health care infrastructure. NRHA encourages MedPAC to consider solutions that protect short-term rural provider viability, while looking towards payment design focused on value that maintains sufficient revenue to cover fixed costs.

The March meeting also discovered Rural Health Clinic (RHC) payment. While the Consolidated Appropriations Act (CCA) of 2021 made necessary increases in payment for independent or "freestanding" 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. Many CAHs allocate overhead costs to their provider-based RHCs through the cost-report stepdown methodology. This required allocation methodology may dilute otherwise reimbursable costs of the CAH if the RHC all-inclusive payment rate (AIR) is limited or capped as it was in the CAA 2021. Even with the historically uncapped AIR, data suggests that CAHs with provider-based RHCs perform less well financially than CAHs without provider-based RHCs. Due to the CAA 2021 policy change, hospitals and systems considering establishing new services are re-evaluating the feasibility of investing in new provider-based RHCs, leading to potential access concerns for individuals living in rural, low-volume areas.

One alternative payment structure for provider-based RHCs would be voluntary participation in a quality reporting program in exchange for enhanced reimbursement. While the statement by one commission that "RHCs are exempt from quality reporting" is true; we have seen the number of Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) with an RHC

[2] Besler. Non-Allowable Expense on the Medicare Cost Report [POD-CAST]. January 26, 2022.https://www.besler.com/insights/non-allowable-expense-podcast/.AccessedDecember11,2022.



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presence grow rapidly with 1,643 RHCs participating as of January 2022.[3] The primary reason for underrepresentation of RHCs in quality reporting programs is that RHCs are ineligible to participate in CMS quality reporting programs such as the Physician Quality Reporting System and the Electronic Health Record Incentive Payment Program and were exempted from mandatory participation in the Merit-Based Incentive Payment System (MIPS).[4] Implementing a voluntary quality measure reporting program would provide valuable data on RHCs that has historically been unavailable and work to improve population health while the enhanced payments would encourage RHCs to take up the reporting. Conceptually, the Rural Health Fairness in Competition Act from the 117th Congress[5] provides a framework for this kind of model.

**Medicare Advantage**

NRHA supports MedPAC's proposal to study the implications of Medicare Advantage (MA) growth on rural providers, particularly around payment, administrative burden, and rural hospital bypass, which are some of the most common concerns we hear from our members. We also encourage the Commission to look at the impacts on beneficiary access to care related to network adequacy and travel times to care, prior authorization denials, and care delivery.

NRHA agrees with the stated concern by Commissioners about post-acute care and MA. NRHA members frequently note that MA plans drive patients away from swing beds in CAHs and into skilled nursing facilities (SNFs). This practice can take beneficiaries out of their local communities and ultimately bypass rural hospitals. We encourage the Commission to look at how MA plans drive discharge to certain settings in rural areas and the impacts on both patients and providers.

NRHA encourages MedPAC to look beyond the Henke, et al.[6] study referenced during the discussion. The authors of the study found that MA penetration was associated with improved financial performance by rural hospitals. As the Commissioners noted, this is a case of correlation and not causation and needs to be studied further. NRHA would like to highlight several points for consideration by the Commission to consider before relying on the study broadly.

It is likely only possible to understand the impact of MA plans on rural hospital finances by analyzing the claims paid by plans against the facility contract and then compare the ratio of cost to charges. The author's conclusion that "Medicare Advantage penetration was associated with increased financial stability and reduced risk of closure" may not be true for all rural hospitals across the country. There are many variables at play when looking at rural hospital finances, viability, and closures and MA is just one, albeit growing, factor in the mix.

There are several related issues surrounding MA payment to rural facilities, the most significant of which is the impact of MA payments to rural cost-based providers. We often hear that the payment rates are lower than what these providers would receive from traditional Medicare, eroding the

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[3] Centers for Medicare and Medicaid Services. Shared Savings Program Fact Facts as January 2022.Available at https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf. Accessed April 2, 2024.

[4] Gale JA, Croll Z, Coburn AF. Rural Health Clinic Participation in the Merit-Based Incentive System and Other Quality Reporting Initiatives: Challenges and Opportunities. Portland, ME: University of Southern Maine, Muskie School, Maine Rural Health Research Center; July 2018. PB-70.

[5] Rural Health Fairness in Competition Act, H.R. 5883, 117th Cong. § 2 (2021) https://www.congress.gov/bill/117th-congress/house-bill/5883/text.

[6] Rachel Mosher Henke, et al., *Medicare Advantage in Rural Areas: Implications for Hospital Sustainability*, 29 AM. J. MANAGED CARE 594 (2023) https://www.ajmc.com/view/medicare-advantage-in-rural-areas-implications-for-hospital-sustainability.



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Congressional intent of these designations. When payment rates are on par with traditional Medicare, it becomes a question of whether the MA plans will pay reimbursement correctly and in a timely manner. Many rural providers face challenges with prior authorization, claims denials, and downgrades (for example, from inpatient to observation). These issues require expert billing staff to not only catch such denials and downgrades, but to successfully challenge them. In general, rural hospitals have fewer FTE and may struggle to train and retain billing and finance staff, meaning that dealing with the administrative challenges from MA plans is incredibly difficult.

NRHA thanks MedPAC for its work to ensure rural provider stability. If you have any questions, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley (amckinley@ruralhealth.us).

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association



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