CHAPTER 7

Reducing beneficiary cost sharing for outpatient services at critical access hospitals

RECOMMENDATION

For fee-for-service Medicare beneficiaries, 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 hospitals' outpatient coinsurance equal to the inpatient deductible.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 7

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Chapter summary

Critical access hospitals (CAHs) are small rural hospitals with 25 or fewer acute care beds that receive cost-based reimbursement for most of the care they provide to Medicare beneficiaries, rather than the prospective payment system (PPS) rates received by other hospitals. For many CAHs, the higher rates associated with cost-based payments are necessary to remain financially viable. The Commission estimates that Medicare's cost-based fee-for-service (FFS) payments to CAHs averaged about $4 million more per CAH than would have been paid under the inpatient and outpatient PPSs in 2022. The additional $4 million in payments was about 10 percent of the average CAH's $40 million in all-payer revenue and far higher than the average CAH's net profit of about $1 million. If CAHs had been paid standard PPS rates, many would have incurred significant losses.

However, FFS beneficiaries pay substantially more coinsurance at CAHs than they do for the same services at PPS hospitals. For most outpatient services, CAH coinsurance is set at 20 percent of charges. Charges are the list prices that hospitals set for their services, and they typically far exceed most hospitals' reported costs of providing those services. Charges can be seen as arbitrary and not a good proxy for cost or value. The Commission's analysis of outpatient cost-sharing liabilities at CAHs found

In this chapter

that cost sharing averaged 52 percent of total FFS Medicare payments for CAH outpatient services in 2022; however, cost sharing varied widely across services and CAHs. This variation reflects a wide difference in markups (the ratio of charges to costs) across CAHs and across services within CAHs. For some services, cost-sharing liability was less than 30 percent of the total payment, while in other cases (where charges were highest relative to costs) cost sharing was equal to 100 percent of the total payment. This variation among CAHs creates inequities in cost sharing paid by beneficiaries depending on whether they receive services at a CAH with high or low markups and may subject CAH patients to cost sharing that is much higher than what they would be liable for if they had received care at a hospital where coinsurance equals 20 percent of Medicare's payment rate for the service at that specific hospital.

FFS beneficiaries who receive outpatient services in hospitals paid under Medicare's outpatient PPS (OPPS) also receive financial protection in the form of a cap on coinsurance. Under the OPPS, coinsurance for an outpatient procedure (e.g., a drug, CT scan, emergency department visit, or surgery) provided at most hospitals cannot be greater than Medicare's inpatient hospital deductible ($1,676 in 2025). However, there is no cap on cost sharing for FFS beneficiaries who receive outpatient services at CAHs. We found that, in 2022, about 200,000 CAH outpatient line items (out of 26 million line items) had coinsurance that exceeded the OPPS cap. The most common services with coinsurance above the inpatient deductible were orthopedic surgeries (e.g., knee replacements) and Part B drug injections (e.g., pembrolizumab for cancer, infliximab for arthritis). If Medicare had imposed a cap on CAH coinsurance for each line item in 2022, the coinsurance on the 200,000 claims would have been reduced by an average of about $2,000 per line item.

In a majority of cases, CAH coinsurance for beneficiaries in FFS Medicare is paid for by the beneficiary's supplemental insurer. However, we estimate that about 16 percent of rural FFS beneficiaries do not have supplemental insurance and are directly billed 20 percent of charges when they receive outpatient services at a CAH. And, even when a beneficiary has supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on in the form of higher premiums in states with CAHs. The higher supplemental insurance premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs.

The Commission recommends that CAH coinsurance for outpatient services received by FFS beneficiaries be set at 20 percent of the outpatient payment

amount (rather than 20 percent of charges) and subject to a cap per service equal to the inpatient deductible. This change would protect beneficiaries from excessive coinsurance and would make CAH cost sharing more consistent with Medicare cost sharing for outpatient services in other hospitals.

If beneficiary coinsurance for outpatient services provided at CAHs had been set at 20 percent of the payment amount in 2022, with the amount per line item capped at the level of the inpatient deductible, beneficiary cost-sharing liability would have been about $2.1 billion lower (60 percent lower), assuming no change in care patterns. Assuming that CAHs would retain their current level of cost-based reimbursement, the $2.1 billion reduction in beneficiary cost sharing would have resulted in a $2.1 billion annual increase in FFS Medicare program payments, which would have been funded by taxpayers and beneficiaries who pay Part B premiums. The benefits of this policy change would accrue primarily to FFS beneficiaries without supplemental coverage who receive outpatient services at CAHs, as well as purchasers of supplemental policies in states with CAHs. ■

Most rural communities in the U.S. have low population density and experience longer travel times for services, both of which can pose challenges for delivery of and access to medical care.[1] To help address these challenges, the Congress enacted the critical access hospital (CAH) program in 1997. The program provides cost-based Medicare payments to certain rural hospitals with 25 or fewer beds that provide care to beneficiaries in fee-for-service (FFS) Medicare. The cost-based outpatient rates are far higher than payments under Medicare's prospective payments systems and help CAHs remain financially viable. However, beneficiary cost-sharing liability for most FFS Medicare outpatient CAH services is also higher than at other hospitals since it is set at 20 percent of charges rather than 20 percent of the Medicare payment amount. Charges are the list prices that hospitals set for their services, and they typically exceed most hospitals' reported costs of providing those services; these charges can be seen as arbitrary and not a good proxy for cost or value.

In this chapter, we explain how CAH cost sharing works and recommend a new method of setting cost sharing based on allowable payment amounts. While this chapter focuses on CAHs, rural health clinics (RHCs) also have charge-based coinsurance. Similar to findings on charge-based coinsurance at CAHs, we found that beneficiary coinsurance at RHCs is often high and varies considerably across them. To provide a more complete picture of cost-based coinsurance in rural areas, information on RHCs is provided as an appendix to this chapter (pp. 360–367).

Given the wide array of Medicare's payment policies for rural hospitals, there may be more efficient ways to distribute additional funding to isolated rural hospitals in need of support and opportunities to harmonize or consolidate the large number of special rural payments. The Commission's recommendation in this chapter to modify cost-sharing liability for FFS beneficiaries who use CAHs does not preclude larger efforts to reform rural payments in the future.

Background

In rural areas, population density is often too low to support the provision of certain health care services, creating challenges for both rural residents and their health care providers. The Commission has a long history of monitoring rural beneficiaries' access to care and developing recommendations designed to preserve or improve that access (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2001). In 2012, the Commission established a set of principles designed to guide expectations and policies with respect to rural access, quality, and payment. The Commission determined that rural payment adjustments should be designed to preserve access rather than to preserve all hospitals, be empirically justified, maintain incentives for cost control, and have low-volume adjustments limited to the isolated providers that are needed to preserve access to care (see text box on the Commission's principles concerning special payments, p. 346).

Medicare's approach to preserving rural beneficiaries' access to hospital care has historically focused on increasing payments for services furnished by rural hospitals. Currently, Medicare's special inpatient and outpatient payments for rural hospitals fit into three conceptual models. A majority of rural hospitals are designated CAHs and paid under a cost-based model, with beneficiary cost sharing for outpatient hospital services based on the hospital's charges. Most other rural hospitals receive add-on payments to their prospective payment rates or a combination of a monthly fixed payment and prospective payment rates.

Low population density poses challenges for rural hospitals

Rural communities across the U.S. are diverse in terms of income and demographics. For example, though residents of rural areas have lower average incomes relative to the national average, the range of rural incomes across the country is wide, and some rural areas have average incomes that exceed national averages.[2] What most rural areas have in common is low population density, resulting in low patient volumes for local health care providers. Population density is often too low to support certain specialized services, meaning that rural beneficiaries must travel farther for some types of care, especially for subspecialized services. In our annual focus groups, beneficiaries residing in rural areas largely accepted having to choose between a rural way of life and the

The Commission's principles for rural special payments

The Medicare program has a long history of using special payments to support rural hospitals. In our 2012 report on rural Medicare payment policy, we created a series of principles to guide our payment policies (Medicare Payment Advisory Commission 2012). The Commission established that payment adjustments for rural providers should:

- be designed to preserve access rather than preserve all providers,
- be empirically justified,
- have incentives for cost control, and
- limit low-volume adjustments to isolated providers.

The overarching objective of these principles is to preserve equitable access to high-quality care for rural beneficiaries in a fiscally prudent manner. To promote efficient use of Medicare's resources, rural payment adjusters should be empirically justified and designed in a way that encourages cost control (Medicare Payment Advisory Commission 2012). In the case of low-volume adjusters, special payments should be limited to isolated providers since maintaining two low-volume hospitals in neighboring communities could be costly and raise quality concerns due to the volume–outcomes relationship observed at rural hospitals (Joynt et al. 2015, Joynt et al. 2013, Medicare Payment Advisory Commission 2012, Moscovice and Casey 2011, Silber et al. 2010). ■

desire to have quick access to a wide range of health services (Campanella et al. 2023).

While rural and urban beneficiaries use similar levels of care, on average, beneficiaries who reside in rural areas travel farther to receive health care services for two reasons (Medicare Payment Advisory Commission 2021). First, certain services are not available in some rural areas. Second, rural FFS beneficiaries often bypass their local rural hospital and instead choose to receive nonemergency service at a larger, more urban hospital (Medicare Payment Advisory Commission 2021). These two phenomena make it difficult for rural hospitals to create economies of scale, which results in higher cost per unit of service. Higher unit costs make it more difficult for hospitals to turn a profit, increasing the likelihood of closure. In prior work, we examined the 40 rural hospitals that closed between 2015 and 2019 to determine whether common factors contributed to closure. We found that the closed hospitals experienced a 54 percent decline in admissions, on average, and about a 10 percent decline in outpatient services during the decade prior to closure (Medicare Payment Advisory Commission 2021). Volume declined primarily due to increased bypass of local hospitals for low-complexity admissions.[3]

FFS Medicare programs that support rural hospitals

To preserve isolated rural beneficiaries' access to emergency, outpatient, and, in some cases, inpatient care, the Congress has instituted several enhancements to Medicare payment rates for rural hospitals. Medicare's current special inpatient and outpatient payments for rural hospitals fit into three conceptual models (Table 7-1, pp. 348–349). (Note that about 150 rural hospitals (6 percent) do not receive special rural payment adjustments.)

- **Add-ons to prospective payment rates.** One model increases prospective payment rates to rural hospitals. Examples of this approach include sole community hospitals (SCHs), Medicare-dependent hospitals (MDHs), and designated low-volume hospitals. These hospital types receive payments for inpatient services that are based in part on

standard rates paid under the inpatient prospective payment systems (IPPS). An SCH receives inpatient operating payments equal to the higher of standard IPPS rates or the hospital's costs per stay in a base year updated to the current year and adjusted for the current-year case mix. (An SCH also receives a 7.1 percent add-on to its outpatient prospective payment system (OPPS) rates.) An MDH's inpatient operating payments are equal to the higher of standard IPPS rates or a blend of standard IPPS rates (25 percent) and the hospital's historical costs updated to the current year and adjusted for changes in case mix (75 percent). A hospital that is designated low volume receives up to a 25 percent increase to its IPPS payments (including geographic- and case-mix-adjusted operating and capital base payments, plus any additional payments such as payments for uncompensated care, outliers, and disproportionate-share hospitals).

- **Payments based on current costs.** Under this model, CAHs receive cost-based reimbursement for inpatient, outpatient, and lab services and for post-acute care provided in swing beds. More detail on cost-based payments made to CAHs is provided below.
- **Fixed payments combined with per service payments based on prospective payment rates.** Under this model, rural emergency hospitals (REHs), which are small, outpatient-only hospitals with 24/7 emergency departments, receive fixed monthly payments to help cover emergency standby costs in addition to payments that are set at 105 percent of standard OPPS rates for each outpatient service provided. (For more information on REHs, see our March 2024 report to the Congress.)

Given the wide array of rural hospital payment policies, there may be more efficient ways to distribute additional funding to isolated rural hospitals in need of support and opportunities to harmonize or consolidate the large number of rural special payments. However, in this chapter, we focus specifically on potential improvements to the largest rural hospital program, the CAH program, and within that program we will focus on the issue of cost sharing. In the appendix at the end of the chapter, we also discuss coinsurance at rural health clinics (RHCs) because of the similarity of the issues.

A majority of rural hospitals receiving special payments are designated critical access hospitals

A majority of rural hospitals receiving special payments are designated CAHs and paid under a cost-based model, with beneficiary cost sharing based on hospital charges.[4] The Congress created the CAH category in the Balanced Budget Act of 1997. To qualify for the CAH program, a hospital had to be at least 35 miles by primary road or 15 miles by secondary road from the nearest hospital or be declared a "necessary provider" by the state. Because states could waive the distance requirement, the CAH program became an option for almost all small rural hospitals, rather than being limited to isolated hospitals. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) eliminated states' ability to declare additional hospitals "necessary providers" starting in January 2006. However, existing CAHs retained their CAH status even if they did not meet the distance criteria. CMS has authorized a modest number of additional CAHs since 2006 because most hospitals that meet the distance and size criteria had already converted to CAH status by 2006.[5] In 2025, there are about 1,370 CAHs nationwide.

CAHs are limited to 25 beds and must have an average acute care length of stay of no more than four days.[6] But CAHs' capabilities vary widely: Some small CAHs offer no surgical services and have less than one acute care discharge a week, while larger CAHs may employ orthopedic surgeons and radiologists, have an average daily inpatient census of over 15 patients, and offer a wide variety of services, including MRI imaging and dialysis.

As noted above, CAHs are paid for FFS Medicare patients on the basis of their costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory, and therapy services, as well as post-acute care in the hospital's swing beds.[7] The cost of treating Medicare patients is estimated using cost-accounting data from Medicare cost reports. CMS's cost-accounting methodology allocates costs among patients based on a combination of factors such as the number of days a patient stays in the hospital and the dollar value of charges the patient incurs for ancillary

TABLE 7–1 **Rural-focused hospital payment models (cont. next page)**

Program	Primary eligibility requirements	Payment adjustment methods	Annual FFS cost, 2022[a] (in billions)	Outpatient cost sharing
Payments based on IPPS rates				
Sole community hospital (can also be low volume) (*n* ≈ 450)[b]	35 miles or more from an IPPS hospital or at least 15 miles from IPPS hospitals and must meet other criteria	Inpatient operating payments based on the higher of IPPS rates or historical costs trended forward from 1982, 1987, 1996, or 2006; outpatient add-on of 7.1%; 60% of SCHs also received the low-volume adjustment in 2022	$1.5[c] (includes LVH add-ons for SCHs)	20% of SCH payment amount
Medicare-dependent hospital (can also be low volume) (*n* ≈ 170)[b]	Rural or reclassified as rural, 100 or fewer beds, and 60% of days or discharges were for Medicare beneficiaries	Inpatient operating payments equal to the higher of IPPS rates or 25% of the IPPS rate plus 75% of historical costs trended forward; historical costs are based on 1982, 1987, or 2002 cost reports; 59% of SCHs also received the low-volume adjustment in 2022	0.2 (includes LVH add-ons for MDHs)	20% of standard OPPS payment amount
Low-volume hospital (*n* ≈ 230 hospitals have only LVH status)[b]	Under 3,800 total discharges and more than 15 miles from another IPPS hospital (it can be next to a CAH)	Increases IPPS payments for inpatient care by up to 25% (linear decline between 500 and 3,799 discharges); hospitals can receive low-volume adjustments and either SCH or MDH adjustments	0.1 (for non-SCHs/ non-MDHs)	20% of standard OPPS payment amount
Payments based on current costs				
Critical access hospital (*n* ≈ 1,350)	25 or fewer beds, designated a "necessary provider" by the state before 2006, or meets certain criteria for being isolated from other hospitals (e.g., 35+ miles by primary road from other hospitals)	Paid approximate cost for inpatient, outpatient, and post-acute swing services; lab and therapy services; on-call costs; an extra add-on for physician payments	≈ 5[d]	20% of charges

services. Outpatient interim payments are computed by multiplying the charges on a claim by the facility's average outpatient cost-to-charge ratio across all cost centers, and inpatient interim payments are made on a per diem basis. After the end of the fiscal year, during cost-report settlement, final payments are determined by multiplying charges on each claim by the cost-to-charge ratio for the relevant cost center. For example, the payment for a lab service will be computed by multiplying the charge for the lab test by the cost-to-charge ratio for the laboratory cost center. Beneficiaries pay the standard hospital deductible for inpatient services ($1,676 in 2025) and cost sharing equal to 20 percent of charges (not costs) for outpatient services.

Medicare's cost-based payments to CAHs (including beneficiary cost sharing) were $12 billion in 2022, representing 6 percent of all Medicare inpatient

TABLE 7–1 **Rural-focused hospital payment models (cont.)**

Program	Primary eligibility requirements	Payment adjustment methods	Annual FFS cost, 2022[a] (in billions)	Outpatient cost sharing
Fixed payments in addition to OPPS payments				
Rural emergency hospital ($n \approx 40$)	CAH or small rural hospital that ceases to provide inpatient services	Paid a fixed monthly payment (equivalent to $3.4 million per year in 2025) plus 105% of OPPS rates for outpatient care	N/A (program started in 2023)	20% of standard OPPS payment amount
Hospitals that do not have special inpatient or outpatient payments				
IPPS rural hospitals without special inpatient or outpatient payments ($n \approx 150$)	Too large or too close to other hospitals to qualify for the low-volume adjustment	Standard PPS	No extra payments	20% of standard OPPS payment amount

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), SCH (sole community hospital), LVH (low-volume hospital), MDH (Medicare-dependent hospital), CAH (critical access hospital), OPPS (outpatient prospective payment system), N/A (not applicable). Eligibility requirements are current as of February 2025.
[a] The costs shown in this table are FFS costs. They have the secondary effect of increasing Medicare Advantage benchmarks in rural areas. Therefore, the total cost for the taxpayer will be higher than the figures shown.
[b] Among the 450 SCHs, 60 percent also received the LVH adjustment. Among 170 MDHs, 59 percent also received the LVH adjustment.
[c] The cost of SCH special payments is a combination of about $500 million from the 7.1 percent outpatient add-on to program payments plus approximately $1 billion in the combined value of low-volume- and SCH-specific inpatient payments. The count of SCHs includes SCHs that choose the standard PPS rate plus SCHs that choose historical costs trended forward. The count also includes SCHs that now are considered to be in urban areas but have been reclassified to rural areas. Similarly, the MDH payments include the combined value of the low-volume- and MDH-specific inpatient payments, and the count includes all currently designated MDHs.
[d] This figure represents a rough estimate of the difference between cost-based payments and what payments (including cost sharing) would have been if CAHs were paid PPS rates. The largest difference is the approximately $3 billion in additional payments that CAHs received in 2022 for outpatient services because of cost-based reimbursement and higher beneficiary coinsurance. The second-largest difference is payments for post-acute swing-bed services, which are about $1.5 billion higher than PPS rates due to cost-based reimbursement. These post-acute swing-bed payments are fully funded by the Medicare program.

Source: MedPAC analysis of IPPS final rules. MedPAC analysis of inpatient and outpatient CAH claims and hospital cost reports.

and outpatient payments to hospitals. The average Medicare payment per CAH for acute inpatient, post-acute swing-bed, and outpatient services was $9 million in 2022.

Cost-based FFS Medicare payments provide significant financial support to CAHs

CAHs are willing to accept restrictions on their number of beds and lengths of stay because their cost-based payments are substantially higher than what their payments would be under Medicare's PPSs. Higher cost-based payments for many of the services CAHs provide to Medicare beneficiaries are funded in part by taxpayers through higher program payments and in part by beneficiaries and their supplemental insurers through higher cost sharing.

CAHs' financial health often depends on receiving these higher-than-PPS payment rates. The extra FFS Medicare payments that CAHs receive are considerably higher than all-payer profits at most CAHs. In addition, findings from our site visits suggest that, because Medicare Advantage (MA) plans reportedly have rates that are based on Medicare's cost-based payments, CAH status also increases these facilities' MA payments above standard PPS rates (even with greater numbers of claims denials).

Medicare's cost-based payments are about equal to the cost of providing care to FFS Medicare patients, and

Medicaid rates, too, are often close to the cost of care. As a result, CAHs often operate at close to breakeven on their patients with public insurance. Because these hospitals are breaking even on patients with government insurance, their profitability often hinges on making enough profit on commercial patients, local government support, donations, and the 340B program to cover losses incurred when providing care to patients without insurance.[8]

While there is a wide range of revenue and profitability at CAHs, on average in 2022 CAHs had about $40 million of revenue from all payers and about $1 million of profit.[9] In 2022, FFS Medicare accounted for about $10 million, or 25 percent, of CAH revenue, on average, compared with an average of about 16 percent in other acute care hospitals.[10] CAHs' FFS revenue included about $5 million in outpatient revenue, about $2 million in acute inpatient revenue, almost $2 million in post-acute swing-bed revenue, and about $1 million in other FFS Medicare revenue. On our site visits (discussed below), most CAHs reported that MA revenue in aggregate was slightly below FFS revenue because MA represents a slightly smaller share of patients than FFS and because of more denials of claims from MA.

Cost-based FFS payments help CAHs remain viable

To estimate the average increase in Medicare payments that CAHs receive from cost-based payments relative to what they would have received under PPS rates, we repriced CAH claims using standard PPS payment rates. We found that CAHs' outpatient cost-based payments were about double what they would have been under OPPS rates.[11] The post-acute swing-bed payment rate was about 400 percent of post-acute swing-bed rates at PPS hospitals. By contrast, CAH payment rates for acute inpatient services were similar to IPPS payment rates. On average, we estimate that FFS Medicare revenues per CAH would have been about $4 million (or 40 percent) lower if CAHs had been paid PPS rates, reducing CAH all-payer revenue by 10 percent, all else equal.

Rural hospitals report that CAH status raises MA payment rates

For many years, MedPAC has conducted site visits to rural communities to meet with rural clinicians and hospital administrators. In 2023 and 2024, we conducted eight site visits to rural hospitals in three states and telephone interviews with four administrators in other communities that we could not visit in person. The objective was to hear the perceptions and concerns of those running PPS hospitals, CAHs, REHs, RHCs, and rural ambulance services.

As part of our site visits, we interviewed hospital administrators and financial officers about how MA plans pay for in-network and out-of-network patients. All our interviewees reported that MA plans typically base rates on CAHs' reported costs. While there are some claim denials and payment delays, CAH executives we interviewed stated that MA payment rates are usually close to FFS rates. A recent report by the American Hospital Association asserts that CAHs' payment-to-cost ratios for MA patients averaged 95 percent of CAHs' payment-to-cost ratios for FFS patients in 2023 (American Hospital Association 2025). This finding is consistent with past research suggesting that MA plans often base payment rates on FFS Medicare rates—in part due to the governing statute requiring the MA plan to pay FFS rates if a patient receives necessary care at a CAH that the plan does not contract with (Berenson et al. 2015, Mason et al. 2005).[12] But actual collections can be below FFS rates due to claims denials.

According to our site visit and telephone interviews, Medicare administrative contractors (MACs) periodically provide CAHs with a "rate letter" that sets out the preliminary payment rates that the CAH will receive for Medicare FFS claims based on estimates of how much services will cost. The CAHs we interviewed forward their rate letters to the MA plans that they contract with. MA plans then update their rates (after a potential delay) to reflect a per diem payment for inpatient services and a discount-to-charge rate for outpatient services that matches the interim payment rates in the letter from the MAC.[13] Consequently, the CAHs we spoke with have contracts with MA plans that set rates close to CAH FFS rates for MA patients. While our site visits were limited to the experience of eight CAHs, those eight responses are consistent with the literature and a past CAH survey that found hospitals often contracted for payment rates from MA plans that were close to FFS rates (Baker et al. 2016, Berenson et al. 2015, Chen et al. 2018, Maeda and Nelson 2017, Mason et al. 2005). While the contracted price is similar to the FFS price, the CAH administrators

we interviewed reported that in some cases, MA plans apply payment reductions or deny payment when the plan determines that the service lacked medical necessity. CAH administrators told us that claim denials and delays can result in the CAH receiving less, on average, for services covered under MA than for services covered under FFS (Zionts 2025). Despite the claim denials and delays, our site visits suggest that the net rates MA plans pay CAHs (even after denials) are still generally higher than traditional PPS rates for outpatient care. Rates for inpatient care appear to be similar to FFS rates, though MA rates paid for post-acute swing-bed care are less well-documented.

Beneficiaries pay substantially more coinsurance for CAH outpatient services

When the Congress established the payment mechanism for outpatient services provided by CAHs, it chose a formula that was the standard for hospital outpatient payment in the early years of the Medicare program. Before the implementation of the OPPS, Medicare paid all hospitals the lesser of either costs or charges for many outpatient services (Medicare Payment Advisory Commission 1999).[14] The program paid 80 percent of the allowed amount, and beneficiaries paid coinsurance equal to 20 percent of charges.[15] Charges are the list prices that hospitals set for their services, which typically exceed their reported costs of providing those services. Charges can be seen as arbitrary and not a good proxy for cost or value. For CAHs, payment is set at 101 percent of the provider's allowable FFS Medicare costs, split into the program payment and the beneficiary's cost-sharing liability. After the beneficiaries' Part B annual deductible is met, beneficiary coinsurance for CAH services equals 20 percent of charges (with no limit), with the Medicare program paying the remainder of the outpatient payment:

Medicare's CAH program payment = 101 percent of costs − 20 percent of charges billed as coinsurance

Thus, although the total payment received by the CAH cannot exceed 101 percent of allowable costs, the beneficiary's portion of the total payment is greater than 20 percent for any service for which charges exceed costs. Because charges vary widely across hospitals and services, both for the same services and across services, beneficiary cost-sharing liability for CAH services also varies—and can far exceed 20 percent of the total payment amount. We found that cost-sharing liability at CAHs averaged about half of total Medicare payments for CAH outpatient services in 2022 and varied widely, reflecting wide differences in markups (ratio of charges to costs) across CAHs and across services within CAHs. By contrast, beneficiary cost-sharing liability for outpatient services at most other hospitals that are paid under the OPPS is set at 20 percent of the hospitals' payment rate. Further, there is no cap on CAH coinsurance for outpatient services, which is not the case for services paid under the OPPS. The variation in beneficiaries' cost-sharing liability raises concerns about equity within and across CAHs.

In most cases, CAH coinsurance for beneficiaries in FFS Medicare is paid by the beneficiary's supplemental insurer. However, about 16 percent of rural FFS beneficiaries do not have supplemental insurance and are billed 20 percent of charges when they receive outpatient services at a CAH (Medicare Payment Advisory Commission 2024a). Further, even when beneficiaries have supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on to beneficiaries in the form of higher Medigap premiums in states with CAHs; those higher premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs.

MedPAC's predecessor commission, the Prospective Payment Assessment Commission (ProPAC), identified this problem when it considered Medicare's former cost-based payment system for the hospital outpatient services in 1995 (Prospective Payment Assessment Commission 1995):

> *Because payments for these services were not prospective and thus not known until annual cost reports are settled, copayments are calculated as 20 percent of charges, rather than 20 percent of payments. Historically, payments and charges were similar, so the beneficiary's share was not excessive. Over time, however, charges have grown significantly*

faster than Medicare payments, resulting in an increasing portion of payments coming from the beneficiary.

Concerned that the beneficiary's share of hospital-provided outpatient payments had become excessive, ProPAC recommended that beneficiary coinsurance for these services be reduced from 20 percent of charges to 20 percent of payments (Prospective Payment Assessment Commission 1995). In the Balanced Budget Act (BBA) of 1997, the Congress made changes to beneficiary cost-sharing liability for outpatient services that were consistent with ProPAC's recommendation (Medicare Payment Advisory Commission 1999). CMS implemented this change by freezing copayment amounts if they were larger than 20 percent of the total payment. Eventually, as the allowed amounts for each outpatient service increased, the coinsurance percentage across outpatient services declined to 20 percent.

From 2012 to 2022, coinsurance increased from 48 percent to 52 percent of CAH outpatient payments

Previously, the Commission contracted with RTI to evaluate the level of CAH cost sharing. RTI found that, because charges at CAHs were far higher than costs, beneficiaries and their supplemental insurers paid coinsurance that averaged 48 percent of estimated total payments for Medicare-covered outpatient services in 2012 (Freeman 2016). The Inspector General of the Department of Health and Human Services also noted the high cost sharing and encouraged "CMS to seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs" (Office of Inspector General 2014).

To update RTI's work, we examined cost sharing at CAHs from 2018 to 2022. We estimated not only coinsurance levels but whether that coinsurance was paid by beneficiaries, paid by supplemental insurance, or went unpaid (resulting in bad debt).

In 2022, about 1.9 million unique beneficiaries received 26 million CAH outpatient services for which coinsurance was set at 20 percent of charges.[16] We found that beneficiaries' coinsurance liability for these services was $3.3 billion, about 52 percent of the total payment—higher than the 48 percent share reported by RTI for 2012 because charges at CAHs rose slightly faster than costs from 2012 to 2022.

Because hospitals' charges vary widely, so does the share of the total payment billed to the beneficiary (or their supplemental insurer). For the 10 percent of CAHs with the lowest markups over costs, less than 33 percent of the total payment was billed to beneficiaries. In contrast, for the 10 percent of CAHs with the highest markups, more than 79 percent of the payment was charged to the beneficiary. To illustrate how markups affect coinsurance, in Table 7-2 we show the actual distribution of markups at CAHs in 2022 applied to a hypothetical service that cost $600 at three different hospitals. For this hypothetical service, a low-markup hospital (with a markup at approximately the 10th percentile of the distribution among all CAHs) would charge about $1,000 and have coinsurance of $200. In contrast, a high-markup hospital (at approximately the 90th percentile of the markup distribution) would charge $2,400 for a service that cost it $600 to deliver. The result would be coinsurance of $480. Thus, coinsurance billing could vary substantially depending on whether the beneficiary lived near a low-markup or a high-markup CAH.

Hospitals in smaller towns tend to have smaller markups

To see how beneficiary cost-sharing liability varied across rural markets, we examined differences across Rural–Urban Commuting Areas (RUCAs) (a census tract–based classification), which categorize areas based on the size of the town in which people in the county commute to work. Among CAHs located in RUCAs categorized as the most rural (an area without a town of more than 2,500 people), the average beneficiary coinsurance amount equaled 44 percent of payments. CAHs in larger rural towns (2,500 to 24,999 people) had an average beneficiary coinsurance amount of 53 percent of payments. In micropolitan and metropolitan areas, the average beneficiary coinsurance amount was approximately 60 percent of payments.[17] (Note that, because the payment rate for CAHs is set at 101 percent of costs, an average beneficiary coinsurance amount of 60 percent of payments is equal to about 60 percent of costs.) The high level of coinsurance reflects high charges, which were set at about 300 percent of costs, on average, in these communities.

During MedPAC site visits and interviews, small rural hospitals reported that their commercial payment

TABLE 7–2 How CAH markups affect coinsurance and program payments: Illustrative example

	Low-markup CAH (10th percentile)	Median-markup CAH (50th percentile)	High-markup CAH (90th percentile)
Approximate ratio of CAH's charges to costs	167%	250%	400%
Cost of hypothetical line item	$600	$600	$600
Charges	$1,000	$1,500	$2,400
Coinsurance (20% of charges)	$200	$300	$480
Program payments (101% of costs less coinsurance) × 98% (due to sequester)	$398	$300	$124
Share of payment paid by coinsurance	33%	50%	79%

Note: CAH (critical access hospital). The payment assumes that the CAH receives 20 percent of the cost as coinsurance. The program payment is equal to 101 percent of cost, less coinsurance, all reduced by 2 percent due the assumption that the sequester is in place. The 10th, 50th, and 90th percentiles represent rounded numbers from the actual distribution of CAH markups.

Source: MedPAC analysis of fee-for-service claims and cost-report data.

rates are often set at a discount to charges, which creates incentives to increase charges. However, during our site visits to hospitals in very small towns, administrators also reported that they felt social pressure to restrain markups because "everyone in the town knows everyone else." This phenomenon could partially explain why markups tend to be lower in RUCAs anchored by towns with fewer than 2,500 people than in micropolitan and metropolitan areas where the core town has 25,000 or more people.

At the extreme, beneficiaries can pay more than 100 percent of the total payment

Our analysis found that a few CAHs charged as much as or greater than five times estimated costs on average. For beneficiaries receiving outpatient services in these CAHs, their cost-sharing liability was equal to or more than the total allowed payment amount (101 percent of costs), resulting in the beneficiary being responsible for the entire payment. When a beneficiary (or a supplemental insurer on the beneficiary's behalf) pays coinsurance that is more than 100 percent of the allowed amount, the CAH must return a portion of those funds back to the Medicare program at cost-report settlement. In such cases, because the Medicare program did not make any payment for the service, and the program received a portion of the funds paid by (or on behalf of) the beneficiary at cost-report settlement (bringing the payment down to the allowed amount), the Medicare program realizes net negative spending for the service. In 2022, for about 1 million outpatient line items (4 percent of all CAH outpatient line items with coinsurance), the beneficiary was responsible for 100 percent or more of the total allowed amount for the line item on the claim. The average amount paid by the beneficiary or their supplemental insurer for these services was $226 per line item; the aggregate amount of these line items in 2022 was $243 million.

No cap on coinsurance for beneficiaries who receive care in CAHs, unlike the coinsurance cap for care received at OPPS hospitals

Under the OPPS, beneficiary cost-sharing liability for a single line item (e.g., a drug, CT scan, emergency department visit, or surgery) is capped at the inpatient deductible ($1,676 in 2025).[18] However, no such limit on cost sharing applies to outpatient services provided

by CAHs. In 2022, about 200,000 CAH outpatient line items (out of 26 million line items) had coinsurance that exceeded the inpatient deductible that year. The most common services with coinsurance above the cap were orthopedic surgeries (e.g., knee replacements) and Part B drug injections (e.g., pembrolizumab for cancer, infliximab for arthritis). If a line-item cap on CAH coinsurance had been in effect in 2022, the coinsurance on the 200,000 line items would have been reduced by an average of about $2,000 per line item, resulting in roughly $400 million less in beneficiary liability.

Most, but not all, coinsurance liabilities are paid by supplemental insurance

About 84 percent of rural beneficiaries in FFS Medicare have supplemental insurance, such as Medigap, Medicaid, or employer-sponsored coverage, that may cover beneficiaries' cost-sharing liability.[19] However, even when beneficiaries have supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on to beneficiaries in the form of higher premiums in states with CAHs; those higher premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs.

About 16 percent of rural FFS Medicare beneficiaries do not have supplemental insurance and are billed directly for coinsurance if they receive outpatient services in a CAH (Medicare Payment Advisory Commission 2024a). Ideally, we would analyze the outpatient CAH claims for this 16 percent of beneficiaries to better understand the financial liability they face. However, we do not have patient-level data on supplemental insurance that can be linked to claims. Instead, we rely on other sources to create upper-, midrange-, and lower-bound estimates of the number of beneficiaries without supplemental insurance who receive outpatient care in CAHs and the total amount of coinsurance billed to them.

An upper-bound estimate of CAH use among beneficiaries without supplemental insurance

About 1.9 million beneficiaries used 26 million CAH outpatient services in 2022, and about 16 percent of rural beneficiaries did not have supplemental insurance. If we assume that rural beneficiaries without supplemental coverage are as likely to use outpatient CAH services as other rural beneficiaries, then about 300,000 (16 percent of 1.9 million) FFS beneficiaries who received a CAH outpatient service in 2022 would have received cost-sharing bills equal to 20 percent of charges. This finding implies that about 300,000 beneficiaries would have been billed 20 percent of charges for about 4 million line items (16 percent of 26 million total CAH FFS line items). On average, $126 in coinsurance was billed for each line item; therefore, the upper-bound estimate of coinsurance billed to patients without supplemental insurance is about $500 million (4 million × $126). As we show below in our discussion of bad debts, at least $106 million of that coinsurance was not paid by beneficiaries.

A midrange estimate of CAH use among beneficiaries without supplemental insurance

Research suggests, however, that beneficiaries without supplemental insurance use about 25 percent fewer outpatient services (Medicare Payment Advisory Commission 2012).[20] Using this assumption would reduce the estimate of 4 million CAH line items to about 3 million line items on outpatient claims (a 25 percent reduction). Given that CAH coinsurance per service averaged $126 in 2022, those beneficiaries without supplemental insurance would have been billed about $380 million in coinsurance ($126 × 3 million services).[21] If rural beneficiaries without supplemental insurance were 25 percent less likely to use a CAH at all, there would have been 225,000 beneficiaries without supplemental insurance using a CAH for outpatient services (300,000 × 0.75).[22]

A lower-bound estimate of CAH use among beneficiaries without supplemental insurance

For a lower-bound estimate, we used hospital-reported data on bad debt to estimate the number of FFS beneficiaries without supplemental insurance who were billed for, but did not pay, CAH coinsurance. In 2022, CAHs reported $106 million in bad-debt expenses for outpatient services to FFS patients who were not dually eligible for Medicare and Medicaid. There was another $147 million in cost sharing not paid by Medicaid for dually eligible beneficiaries, resulting in a total bad debt of $253 million.[23] Because some CAHs do not claim bad debts (due to Medicare bad-debt expenses being lower than the expected administrative costs of collecting Medicare bad-debt payments), the $106 million in bad debt is a

lower bound on the amount of coinsurance that was billed by CAHs for FFS Medicare service and was not paid by the beneficiary. The average coinsurance billed to beneficiaries was $1,750 during 2022, implying that over 60,000 beneficiaries were billed outpatient coinsurance, did not have Medigap or other supplemental insurance, and did not pay the coinsurance bill ($106,000,000 / $1,750).

Setting CAH outpatient cost sharing at 20 percent of Medicare's payment

To prevent beneficiaries from being liable for charge-based coinsurance, CAH coinsurance could be set at 20 percent of the payment amount (rather than 20 percent of charges) and be subject to a cap per service that is equal to the inpatient deductible. The cap would be identical to the cap used in the OPPS: For high-cost services where 20 percent of the payment amount exceeds the inpatient deductible ($1,676 in 2025), coinsurance would be set at the amount of the deductible. This cost-sharing policy would be more equitable for beneficiaries and would reduce incentives to bypass CAHs.

In 2022, CAHs provided 26 million outpatient services for which cost sharing was set at 20 percent of charges. Beneficiary coinsurance for these services was about $3.3 billion, Medicare program payments were about $3.2 billion, and total payments were almost $6.5 billion.[24] To estimate the effects of setting coinsurance equal to 20 percent of payments, assuming the total payments to CAHs remain constant, we consider the effects of the new coinsurance policy on:

- FFS beneficiary coinsurance for CAH services,
- Medicare FFS program spending,
- Medicare bad-debt payments to CAHs,
- Part B premiums for all beneficiaries, and
- FFS beneficiary Medigap premiums.

These estimates assume no change in care patterns, and the effects may be higher or lower depending on how providers and beneficiaries respond to changes in financial incentives.

FFS beneficiary coinsurance for CAH outpatient services would be reduced by about 60 percent

In 2022, shifting CAH coinsurance for outpatient services from 20 percent of charges to 20 percent of payments would have reduced beneficiary (including supplemental insurers') cost-sharing liability by about 60 percent—from an average of 52 percent of payments to 20 percent of payments. Implementing the cap on coinsurance equal to the inpatient deductible would have reduced coinsurance by another $55 million or about 1 percent of payments. On net, coinsurance billed to CAH patients and their supplemental insurers would have been about $1.2 billion or 19 percent of total payments in 2022, equal to a $2.1 billion reduction.

While adding a coinsurance cap would have decreased coinsurance liability by an additional $55 million in 2022, the total estimate of reduced cost-sharing liability would still round to $2.1 billion. Because costs are lower than charges, the cap would have been binding on fewer cases under payment-based coinsurance. The number of services that would have been affected if a cap had been applied to CAH coinsurance would have been about 50,000 line items (out of 26 million), down from approximately 200,000 line items under charge-based coinsurance. In future years, the cap could be binding on more services if more high-cost drugs or services are provided in CAH outpatient departments.

FFS program spending would increase

If the allowed cost-based amount paid to CAHs did not change, then a $2.1 billion reduction in beneficiary cost sharing in 2022 would imply an offsetting increase in FFS program payments of almost $2.1 billion (Table 7-3, p. 356).[25]

Because Medicare's payments to MA plans are based on benchmarks that are linked to per beneficiary FFS program spending, increases in FFS spending will cause increases in payment to MA plans. We estimate that this increase would have been about $1.3 billion if the policy had been implemented in 2022.[26] The combined initial direct effect of the policy on FFS and MA program spending would have been about $3.4 billion in 2022 ($2.1 billion in FFS spending and $1.3 billion in MA spending). For an in-depth discussion of MA benchmarks and bids, see our March 2024

TABLE 7–3

Estimated net increase in 2022 Medicare program spending due to changing coinsurance to 20 percent of the payment amount

Financial effect in 2022	Government spending (in billions)	Part B premiums (in billions)	Taxpayer + beneficiary spending (in billions)
Additional FFS program payments to CAHs	$1.6	$0.5	$2.1
Increased program payments to Medicare Advantage plans	1.0	0.3	1.3
Change in Medicare payments to CAHs for bad debts	−0.15	−0.05	−0.20
Estimated cost in 2022	**2.5**	**0.8**	**3.2**

Note: FFS (fee-for-service), CAH (critical access hospital). The cost estimate in this table does not include the potential additional costs of shifting volume. Components may not sum to totals due to rounding.

Source: MedPAC analysis of FFS claims, cost-report data, and Medicare Advantage enrollment data.

report to the Congress (Medicare Payment Advisory Commission 2024b).

CAHs would see a reduction in bad debts

This estimated $3.4 billion in increased FFS and MA spending in 2022 would have been partly offset by lower FFS Medicare payments for bad debt. FFS Medicare pays hospitals 65 percent of cost-sharing amounts that are billed to beneficiaries or their supplemental insurers (including Medicaid) but not paid.[27] For the 1,320 CAHs for which we have 2022 cost-report data, 1,162 sought bad-debt reimbursement. (Some CAHs do not claim bad debt if they believe the value of such payments is less than the administrative cost of attempting to collect unpaid coinsurance.) In aggregate, CAHs reported $253 million in Medicare outpatient bad debts in 2022 and received $164 million in bad-debt payments (65 percent of bad debts) from FFS Medicare. If CAH coinsurance had been 20 percent of Medicare payments in 2022 (down 62 percent from our current estimate of 52 percent of Medicare payments), we estimate that the amount of bad-debt payments would have declined by $102 million ($164 million × 0.62).

In counties with one or more CAHs in 2022, 48 percent of beneficiaries with both Part A and Part B coverage were enrolled in an MA plan. Therefore, we expect that the effect on MA benchmarks of reduced FFS bad-debt payments would have been about 92 percent (48 percent / 52 percent) of $102 million, or almost $94 million.[28] Adding the effect of lower FFS bad-debt payments ($102 million) and associated lower MA benchmarks (almost $94 million), we estimate a reduction in spending of about $0.2 billion in 2022 under the alternative coinsurance plan (Table 7-3).

Federal spending on Part B services would increase

Medicare Part B is funded through a combination of beneficiary premiums (25 percent) and general revenues (75 percent); therefore, any changes in Part B spending affect beneficiary premium amounts and the amount required from federal general revenues (taxes). We estimate that the modified CAH coinsurance policy's direct financial impact on government spending in 2022 net of reduced bad-debt payments would have been about $3.2 billion (Table 7-3). Of that amount, about $2.5 billion would have been funded through general revenues, and beneficiaries or their supplemental insurers (including Medicaid) would have paid about 25 percent of the $3.2 billion cost, or $0.8 billion, in higher Part B premiums. There were about 60 million beneficiaries with Part B coverage in 2022 (Boards of Trustees 2023). Therefore, we estimate that annual Part B premiums for each Medicare beneficiary (both in FFS Medicare and in MA) would have increased by about $13 per beneficiary in 2022 ($3.2 billion × 25 percent / 60 million) if the alternative policy had been in effect.

We examined growth in coinsurance for outpatient services at CAHs from 2018 to 2022 and found that the amount grew 7.4 percent per year on average between 2018 and 2022. Therefore, we expect that the increased program spending associated with reducing CAH coinsurance to 20 percent of cost-based payments will continue to grow over time.

FFS Medigap premiums would decrease

Table 7-3 presents the aggregate increase in spending by the program. We now shift focus to how the stakeholders would benefit from a policy that sets coinsurance for outpatient CAH services at 20 percent of the payment amount. Beneficiaries who purchase Medigap policies in rural states or have other supplemental insurance, such as through an employer, would benefit because those policies would be liable for reduced coinsurance amounts, which would ultimately result in lower premiums for Medigap and other forms of supplemental coverage. As noted above, we estimated that beneficiary coinsurance for CAHs would have declined by $2.1 billion in 2022 if coinsurance had been set at 20 percent of Medicare payments rather than 20 percent of charges. CMS reported that 34.3 million FFS beneficiaries had Part B coverage in June 2022, meaning the $2.1 billion is the equivalent of decreasing FFS cost sharing by about $61 per year per person on average ($2.1 billion / 34.3 million FFS beneficiaries). For modeling purposes, we assumed that Medigap premiums decline by $1 for every $1 reduction in coinsurance costs borne by the Medigap plan. For Medigap Plan G, which had an average premium in 2022 of $137 per month for a 70-year-old (Medicare Supplement 2024), we estimate an average premium reduction of $5 per month, or about 4 percent.[29] Given the shares of rural Medicare beneficiaries with some type of supplemental coverage, we estimate that the $2.1 billion reduction in beneficiaries' coinsurance liability would have resulted in (1) about $0.6 billion less spending for employer-sponsored supplemental insurers (about 27 percent of rural FFS beneficiaries) in 2022, (2) about $0.9 billion in reduced Medigap premiums (44 percent of rural FFS beneficiaries), (3) about $0.3 billion in lower billings to Medicaid (some of which is not paid), and (4) about $0.3 billion in reduced cost sharing billed to those without supplemental insurance (some of which is not paid). We estimate that the cost sharing paid by beneficiaries without Medicaid, Medigap, or another form of supplemental insurance would be reduced to closer to $200 million because a material portion of these coinsurance bills are not paid (Table 7-4, p. 358).

Effects on Medigap premiums vary by state

In examining Medigap plan premiums in counties with CAHs, we found that rates are often set statewide. Therefore, if CAH coinsurance were reduced to 20 percent of payments, we would expect to see larger reductions in Medigap premiums in states where more beneficiaries use CAHs. In states without CAHs, Medigap premiums should not be affected. In states where CAH services represent a material share of hospital spending, there would be a material decrease in Medigap premiums. For example, we estimate that monthly Medigap premiums in Iowa and Kansas would have been $10 to $20 lower in 2022 if CAH coinsurance had been set at 20 percent of payments. Given current Medigap costs in Iowa and Kansas, this difference would imply about a 10 percent reduction in Medigap premiums (Blue Cross Blue Shield of Kansas 2024, Wellmark Blue Cross Blue Shield 2024). Both rural and urban beneficiaries who purchase Medigap plans in those states would realize the savings.

Little effect on CAHs' finances

The proposed policy is designed to maintain the payment rates CAHs currently receive for services provided to FFS beneficiaries. However, while payment rates would not change, there are two largely offsetting secondary effects on CAHs' revenue. CAHs reported $253 million in outpatient bad debts from FFS Medicare patients in 2022. (About 200 CAHs did not report Medicare bad debts; therefore, the amount of bad debts may be a bit higher than $253 million.) We estimate that about $89 million of reported bad debts were not paid by the program (35 percent of $253 million). If cost sharing were reduced by 62 percent (from 52 percent of costs to 20 percent of costs), then we would expect unreimbursed bad debts to decline by about $55 million (62 percent of $89 million). However, that $55 million in reduced bad debts would largely be offset by the effects of the sequester, which reduces Medicare program payments by 2 percent. The sequester would not reduce cost-sharing payments paid by the beneficiaries and their supplemental insurers. Therefore, shifting payments from the beneficiary to the program slightly

TABLE 7–4

Groups and entities affected by the estimated $3.2 billion in additional program spending in 2022

Affected group	Financial implication	Amount (in billions)
FFS beneficiaries/employers	Reduced Medigap and retiree premiums	$1.5
State Medicaid programs	Reduced cost sharing for Medicare beneficiaries who are also eligible for Medicaid	0.3
FFS beneficiaries without supplemental insurance	Reduced cost sharing paid to CAHs*	0.2
CAHs	Change in bad debts; additional payments subject to the sequester	0.0
MA plans and their beneficiaries	Increased payments to MA plans for Part A and Part B spending and supplemental benefits**	1.3
Total effect in 2022 *(funded by taxpayers and Part B premiums)*		**3.2**

Note: FFS (fee-for-service), CAH (critical access hospital), MA (Medicare Advantage). The initial effects do not include the potential effects of shifting volume. Components may not sum to totals due to rounding.
* Beneficiaries would have paid $0.2 billion less in coinsurance; this result does not include the psychological benefit of not receiving a bill that the beneficiary cannot or will not pay.
** The MA plan would receive a higher benchmark. Past research suggests this increase would result in both higher bids for the Part A and Part B benefit (which could be used to expand networks and/or increase profits, within limits) and more supplemental benefits for MA beneficiaries. It is uncertain how much of the higher benchmark would result in higher bids as opposed to additional benefits (see the section on "Effect on MA plan benefits" above).

Source: MedPAC analysis of fee-for-service CAH claims, cost-report data, MA enrollment data, and Medicare Current Beneficiary Survey data on supplemental insurance.

reduces the combined cost-sharing and program payments the CAH would receive. The net effect on CAHs' revenue would be close to zero: The effects of lower bad debts (+$55 million) would be offset by the effects of the sequester adjustment on the additional program payments (–$42 million), resulting in a net increase in CAH payments of only $13 million (less than $1,000 per CAH).

Effect on beneficiary site-of-service decisions

When cost sharing changes, beneficiaries may make different decisions about where they receive care. We discussed the direction of volume changes on program costs, but we did not estimate the magnitude of these effects.

To the extent that reduced CAH coinsurance resulted in a shift of FFS volume to CAHs, the Medicare program would incur additional costs. The increased cost would be partially (but not fully) offset by the effect of increasing volume on reported CAH costs per outpatient service provided. Increasing volume would reduce CAHs' costs per visit and payment per visit, but because less than 30 percent of CAHs' outpatient charges are for FFS Medicare beneficiaries, increased volume would have a small effect on reported Medicare costs for other services, and net Medicare program costs would increase.[30] While a volume shift to CAHs could theoretically increase program costs above the rough estimate shown in Table 7-3 (p. 356), we expect that the magnitude of this effect would be small because FFS coinsurance is expected to have a small effect on site-of-care decisions, as discussed above.

Recommendation

Most rural communities in the U.S. have low population density and longer travel times for services, both of which can pose challenges for delivery of and access

to medical care. In 1997, the Congress enacted the CAH program to help address these challenges. CAHs receive cost-based payments for services provided to FFS Medicare beneficiaries, a policy that helps the facilities remain financially viable. But because coinsurance in CAHs is based on charges, beneficiaries who use CAHs face much higher cost-sharing liability than beneficiaries who use other hospitals.

RECOMMENDATION

For fee-for-service Medicare beneficiaries, 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 hospitals' outpatient coinsurance equal to the inpatient deductible.**

RATIONALE

Basing coinsurance on CAH charges results in substantially higher beneficiary cost sharing than cost sharing for the same services provided in other hospitals, and that cost sharing varies widely across CAHs and services. About 16 percent of rural FFS beneficiaries do not have supplemental insurance and are billed 20 percent of charges when they receive outpatient services at a CAH. Even when beneficiaries have supplemental insurance that directly shields them from high coinsurance amounts, the cost of that coverage may be passed on to beneficiaries in the form of higher premiums in states with CAHs; those higher premiums are borne by all policyholders, whether or not they receive outpatient services at CAHs. Setting coinsurance at 20 percent of the CAH payment amount, with the amount per line item capped at the level of the inpatient deductible, would reduce liability for FFS beneficiaries who lack supplemental insurance and make CAH coinsurance more equitable for all FFS beneficiaries who receive care at CAHs.

IMPLICATIONS

Spending

- This recommendation would increase spending relative to current law by between $2 billion and $5 billion over one year and by between $25 billion and $50 billion over five years.

Beneficiary and provider

- The recommendation would reduce cost-sharing liability for beneficiaries who use CAH services, reduce premiums for supplemental insurance for all FFS beneficiaries in states with CAHs, and increase Part B premiums for all beneficiaries in both FFS Medicare and MA. We do not expect this recommendation to have a material impact on CAHs' revenues or their willingness or ability to treat beneficiaries. ■

APPENDIX 7–A

Charge-based coinsurance at rural health clinics

Rural health clinics (RHCs) were established under the Rural Health Clinics Services Act in 1977 to increase access to health care in rural areas by providing direct reimbursement for services furnished by nurse practitioners and physician assistants (General Accounting Office 1982). An RHC is an outpatient clinic that must initially be located in a nonurbanized area that qualifies as a primary care health professional shortage area, medically underserved area, or governor-designated shortage area. In 2022, fee-for-service (FFS) Medicare beneficiaries had about 9.5 million visits at 4,800 RHCs. Most visits include evaluation and management services, such as office visits or visits to beneficiaries in nursing homes. Historically, RHCs have predominantly furnished primary care, but because of changes finalized in December 2024, they now have the flexibility to furnish more specialty care.[31] As with critical access hospitals (CAHs), beneficiary coinsurance at RHCs is based on charges. The Commission has found that beneficiary coinsurance at RHCs is often high and varies considerably across them, leaving beneficiaries vulnerable. We also found that charge-based coinsurance may undermine recent payment reforms.

Medicare's payment system for RHCs

Medicare's RHC payment system generally bundles all professional services furnished in a single day into one payment. Medicare pays RHCs a facility-specific cost-based all-inclusive rate (AIR), subject to the limits described below, for each visit.[32] A facility's AIR is calculated annually by dividing the facility's total allowable costs by the total number of visits for all its patients, subject to certain conditions.[33] The AIR is not adjusted for the mix of services furnished or patients' case mix. The AIR is subject to limits that vary based on whether an RHC is independent or provider based, whether a provider-based RHC is part of a hospital with fewer than 50 beds, and when the RHC enrolled in Medicare. FFS Medicare pays 80 percent of the AIR, subject to payment limits.

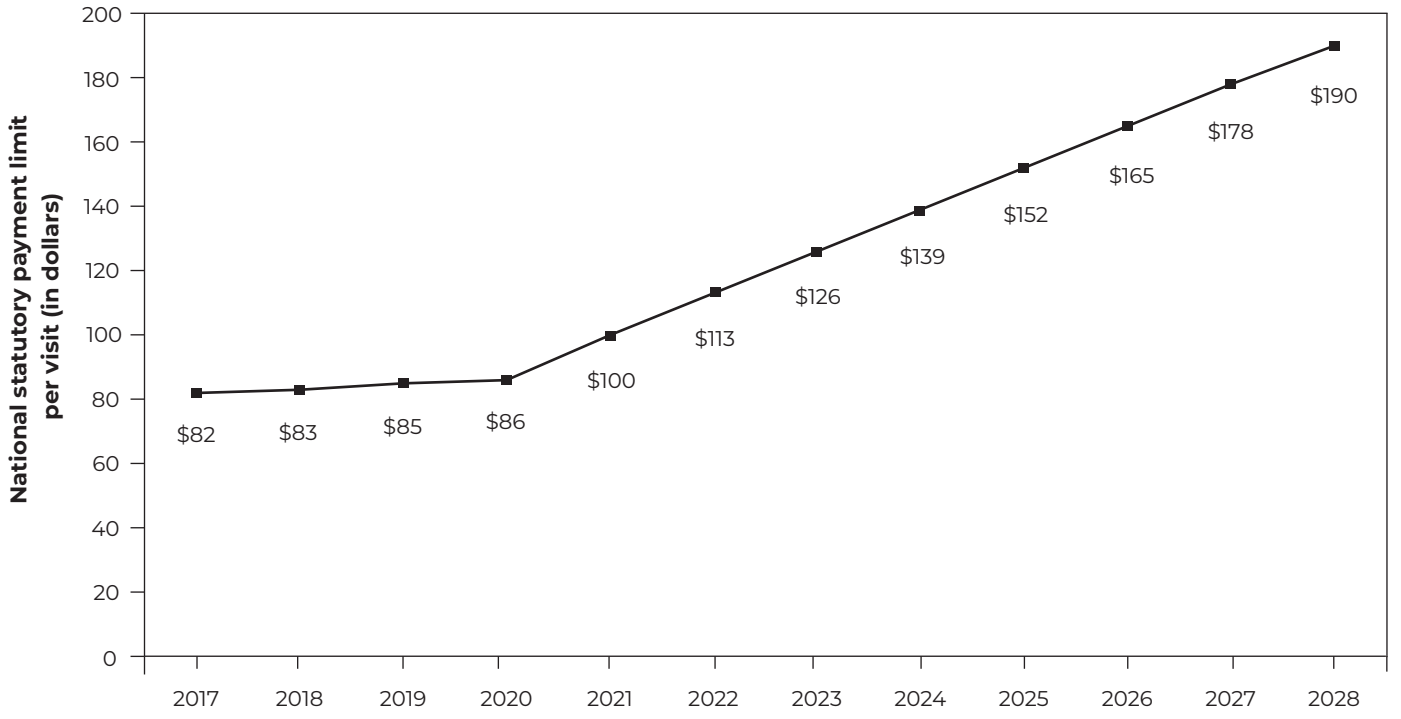
The AIRs for independent RHCs, provider-based RHCs that are part of a hospital with 50 or more beds, and RHCs of any type that enrolled in Medicare after December 31, 2020, are subject to the national statutory payment limit. The Consolidated Appropriations Act (CAA), 2021, instituted large increases in the national statutory payment limit. Beginning in April 2021, the national statutory payment limit increased by 14 percent to $100 per visit and will increase incrementally until it reaches $190 per visit in 2028 (Figure 7-A1, p. 362). Cumulatively, from 2020 to 2028, the national statutory payment limit will increase by 120 percent. In 2029 and beyond, the payment limit will be increased annually based on growth in the Medicare Economic Index (MEI).

Historically, provider-based RHCs that were part of a hospital with fewer than 50 beds were not subject to payment limits. However, beginning April 1, 2021, the CAA, 2021, implemented a payment limit per visit for RHCs that were part of a hospital with fewer than 50 beds and were enrolled as of December 31, 2020. These limits are equal to the greater of their 2020 AIR, increased annually by MEI growth, or the national statutory payment limit.[34] These RHCs are referred to as "specified" provider–based RHCs. We estimate that, as of 2020, the average AIR for specified provider–based RHCs was $255 per visit. Unlike the national statutory payment limit, the limits for specified provider–based RHCs vary substantially: For example, one RHC might have a payment limit of $200 per visit while another might have a limit of $400 per visit. The variation in payment limits per visit is largely due to substantial variation in costs per visit that predated the CAA, 2021. However, by using 2020 as the permanent base year for payment limits—when costs per visit increased because the number of visits temporarily declined due to the coronavirus public health emergency (PHE)—the law locked in higher payment limits, and RHCs with greater declines in volume generally benefited more.[35]

In the few years before the CAA, 2021, the total number of RHCs billing FFS Medicare increased moderately. All of that growth resulted from increases in provider-based RHCs since the number of independent RHCs billing FFS Medicare was declining. After the payment limits were raised per the CAA, 2021, growth in the total number of RHCs billing FFS Medicare accelerated, driven by continued growth in the number of provider-based RHCs and new growth in independent RHCs. For example, the number of independent RHCs billing FFS Medicare declined from 1,327 to 1,273 (4 percent) from

FIGURE 7–A1

Rural health clinics' national statutory payment limit per visit increased rapidly beginning in 2021



Note: Figures rounded to the nearest dollar. In 2021, the payment limit was $87.52 through March. Beginning in April 2021, the national statutory payment limit increased to $100. Medicare's rural health clinic 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.

2018 to 2020 (prior to the law's passage) but increased from 1,273 to 1,484 (17 percent) from 2020 to 2022 (after the law's passage) (Table 7-A1). The entry of new independent RHCs suggests that operators, including some owned by private-equity (PE) firms, find the new RHC payment limits enacted under the CAA, 2021, to be attractive.

Charge-based coinsurance for RHC services

As noted above, FFS Medicare pays 80 percent of the RHC's AIR, subject to payment limits. However, beneficiary cost sharing for RHC services is equal to 20 percent of RHC charges, not 20 percent of the AIR amount.[36,37] RHCs set their own charges, and their charges are not limited based on their AIRs or payment limits.[38] As with CAHs, charge-based beneficiary coinsurance can subject beneficiaries to substantially different coinsurance amounts for similar services furnished by different RHCs. However, in contrast to Medicare's payment formula for CAHs, in which higher beneficiary coinsurance lowers program payments, Medicare's payment formula for RHCs holds the program's payment constant even as beneficiary coinsurance increases. As a result, the RHC's total payment (program payments plus beneficiary coinsurance) increases as charges increase, and total payments may exceed the AIR and payment limits. This

TABLE 7–A1

Number of independent RHCs billing FFS Medicare increased after implementation of higher payment limits in 2021

	RHC type		
Year	Independent	Provider based	Total
2018	1,327	2,645	3,972
2019	1,288	2,778	4,066
2020	1,273	2,968	4,241
2021	1,295	3,154	4,449
2022	1,484	3,270	4,754

Note: RHC (rural health clinic), FFS (fee-for-service). Counts of RHCs are based on unique CMS Certification Numbers that billed at least one Medicare FFS claim in a given year after excluding certain claims, such as those with payments equal to zero. These totals exclude RHCs that did not bill FFS Medicare; RHCs excluded from this table may include CMS–certified RHCs that specialize in pediatrics.

Source: MedPAC analysis of RHC claims for FFS beneficiaries.

payment formula gives RHCs an incentive to increase their charges and subjects beneficiaries to high and variable cost-sharing liability.

Table 7-A2 provides an illustrative example of beneficiary cost-sharing liability and total payments for three independent RHCs with different levels of charges, highlighting the impact of charge-based beneficiary coinsurance and a payment formula that holds program payments constant. RHC 1's charges are equal to the 2025 national statutory payment limit of $152. RHC 1 thus receives a total payment equal to $152: Medicare pays 80 percent of the payment limit, or $121.60 ($152 × 0.80), and the beneficiary pays 20 percent of charges, or $30.40 ($152 × 0.20). If an RHC has higher charges, both the beneficiary's coinsurance and the total payment for the same service will increase. For example, RHC 3, which has charges equal to $225, will receive a total payment per visit of $166.60: Medicare pays 80 percent of the payment limit, or

TABLE 7–A2

Illustrative example of how higher charges result in higher FFS Medicare beneficiary coinsurance and total payments to rural health clinics, 2025

RHC	RHC AIR (subject to payment limits)	RHC charge per visit	FFS Medicare payment per visit (80% of AIR, subject to payment limits)	Beneficiary coinsurance per visit (20% of RHC charges)	Total per visit payment to RHC (Medicare payment + beneficiary coinsurance)
1	$152.00	$152.00	$121.60	$30.40	$152.00
2	152.00	175.00	121.60	35.00	156.60
3	152.00	225.00	121.60	45.00	166.60

Note: FFS (fee-for-service), RHC (rural health clinic), AIR (all-inclusive rate). 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 CMS regulations.

TABLE 7–A3

FFS Medicare beneficiary coinsurance exceeded 20 percent of the average estimated interim AIR per visit at independent RHCs in 2022

RHC type	Visits (in millions)	Average estimated interim AIR per visit	Average Medicare payment per visit	Average beneficiary coinsurance per visit	Average beneficiary coinsurance per visit as a percent of estimated interim AIR	Total payment per visit (Medicare payment + beneficiary coinsurance)
Independent	1.7	$111	$88	$38	34%	$126
Nonspecified provider based	0.4	113	89	43	38	132
Specified provider based	4.5	259	205	44	17	249

Note: FFS (fee-for-service), AIR (all-inclusive rate), RHC (rural health clinic). "Provider–based" RHCs are those owned by and operated as an integral part of another Medicare-certified facility, such as a hospital. "Specified provider based" RHCs are those that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020 (or had submitted an application for enrollment that was received no later than December 31, 2020); all other provider-based RHCs are "nonspecified." Independent RHCs are freestanding clinics that do not qualify for, or have not sought, provider–based status. Specified provider–based RHCs are generally subject to higher payment limits than other RHCs. 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. "Visits" represent unique claims. Claims were limited to those paid on an AIR basis where full beneficiary coinsurance was applicable. Outliers were trimmed. About 1 percent of claims were excluded because we could not classify provider-based RHCs as specified or not. Estimated interim AIRs are calculated by summing Medicare program payments on each claim and then dividing that total by 0.80, with an adjustment for sequestration. Numbers are rounded to the nearest dollar or percent.

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

$121.60 ($152 × 0.80), but the beneficiary pays 20 percent of the higher charges, or $45.00 ($225 × 0.20).

To examine the extent to which basing coinsurance on RHC charges affects beneficiary coinsurance, we analyzed FFS Medicare RHC claims for 2022. We limited our analysis to claims paid on an AIR basis for which full beneficiary coinsurance was applicable.[39] To calculate beneficiary coinsurance, we summed actual beneficiary coinsurance per claim. To calculate each RHC's AIR, subject to payment limits, we used a claims-based proxy because actual AIRs are not calculated until cost-report reconciliation at year's end. Specifically, we summed Medicare program payments on each claim and then divided that total by 0.80, with an adjustment for sequestration. We call this proxy the "estimated interim AIR."[40] We then divided the beneficiary coinsurance by the estimated interim AIR to arrive at the share of the estimated interim AIR paid by beneficiaries. Then we analyzed the extent to which beneficiary coinsurance varied by type of RHC: independent, nonspecified provider based, and specified provider based.[41]

We found that, in aggregate, the beneficiary share of the estimated interim AIR in 2022 was higher at nonspecified provider–based RHCs (38 percent) and independent RHCs (34 percent) and lower at specified provider–based RHCs (17 percent) (Table 7-A3). Because FFS Medicare's program payments to RHCs do not change based on beneficiary coinsurance, the total payments per visit were higher than the estimated interim AIR for independent and nonspecified provider–based RHCs and lower than the estimated interim AIR for specified provider–based RHCs. For example, the average estimated interim AIR for independent RHCs was $111 per visit, but the total payment amount per visit (including both beneficiary and program payments) was $126 because independent RHCs' charges far exceeded the estimated interim AIR

(which results in coinsurance of more than 20 percent of the estimated interim AIR).

Relative to other RHCs, the beneficiary share of the estimated interim AIR was lower among specified provider–based RHCs in 2022, not because their charges or beneficiary coinsurance at these RHCs was lower but because the average estimated interim AIR per visit was higher. For example, the average beneficiary coinsurance per visit was slightly higher among specified provider–based RHCs ($44) compared with independent RHCs ($38).

These findings demonstrate that beneficiary coinsurance at RHCs is not limited by AIRs or payment limits. Instead, coinsurance varies based on RHCs' charges.

Next, we examined the variation in charges by RHC type. We found that RHC charges (and therefore beneficiary coinsurance) varied substantially across and within types of RHCs. For example, within independent RHCs, the RHC at the 25th percentile had charges per AIR visit of $140 compared with $235 at the 75th percentile and $345 at the 95th percentile (Figure 7-A2, p. 366). We observed similar variation among nonspecified provider–based RHCs and specified provider–based RHCs (Figure 7-A2). Because RHC charges are directly tied to beneficiary coinsurance, we also observed similar variation in beneficiary coinsurance (data not shown).

Some variation in charges could be due to the number or mix of services furnished per AIR visit. However, after controlling for the number and mix of services by limiting our analysis to revenue-center charges for the most common RHC service—an evaluation and management office visit for an established patient (Healthcare Common Procedure Coding System code 99214)—wide variation in charges persisted. For example, charges for this service at specified provider–based RHCs ranged from $185 at the 25th percentile to $284 at the 75th percentile and $384 at the 95th percentile (Figure 7-A2, p. 366).

One type of RHC with particularly high charges and beneficiary coinsurance was RHCs owned by a PE firm. There is no comprehensive source of PE ownership of RHCs. However, we identified a group of about 100 RHCs as owned by one PE firm based on their new participation in Medicare and information on the RHCs' public websites. Among these PE-owned RHCs, the median charge per AIR visit was about $326, which is far higher than other types of RHCs (Figure 7-A2, p. 366). These higher charges translated into higher beneficiary coinsurance: Beneficiaries at PE-owned RHCs paid about 70 percent more per visit in coinsurance compared with the average among independent RHCs in 2022 (data not shown).[42]

These data suggest that beneficiaries often face high cost sharing because their coinsurance is based on charges. In addition to being higher, RHC charges vary widely across facilities. This situation leaves beneficiaries vulnerable to very high cost sharing and could create inequities across beneficiaries. The charging behavior of new PE-owned RHCs further highlights that basing coinsurance on facility charges and allowing total payments to increase as charges increase creates an incentive to raise charges and does not protect beneficiaries from excessive cost sharing.

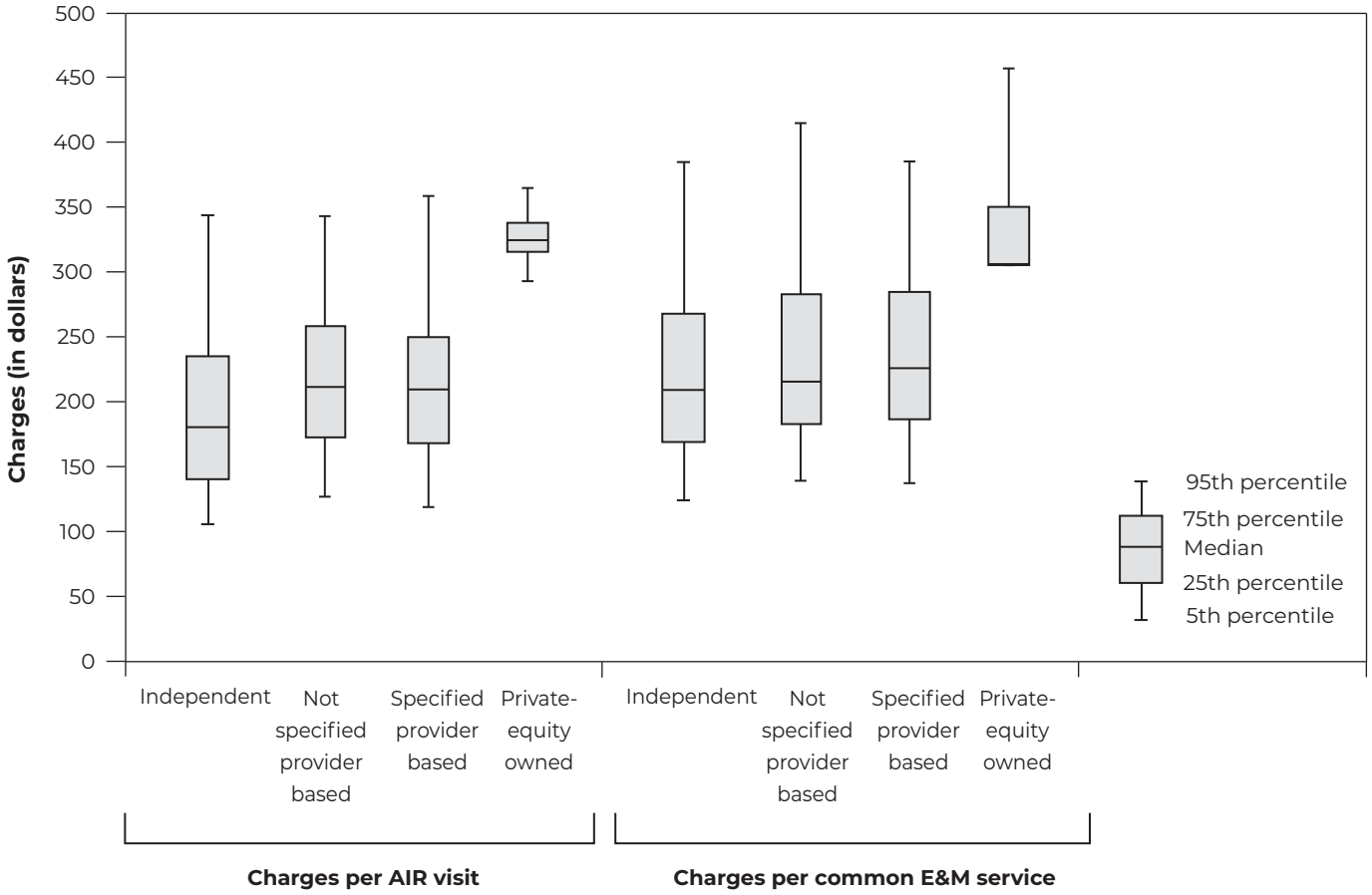
Charges are list prices and are often seen as arbitrary and not a good proxy for cost or value, which is one reason why most other Medicare payment systems have moved away from basing payments or beneficiary cost sharing on charges. Two other Medicare payment systems that pay for clinician services already limit beneficiary coinsurance to 20 percent of the payment amount. For example, the physician fee schedule (PFS) and the payment system for federally qualified health centers (FQHCs) both pay for clinician services furnished to rural beneficiaries. The PFS limits beneficiary coinsurance to 20 percent of the lesser of the payment rate or actual charges; beneficiary coinsurance at FQHCs is limited to 20 percent of the lesser of actual charges or the prospective payment amount.

An option to reduce beneficiary coinsurance for RHC services

To set more uniform and predictable coinsurance levels, beneficiary coinsurance could be capped at 20 percent of the lower of an RHC's AIR, subject to payment limits, or 20 percent of actual charges. Using 2022 claims, we simulated the effect of such a policy on two outcomes—beneficiary coinsurance and total

FIGURE 7–A2

Rural health clinics' charges per AIR visit and common office visit varied substantially, 2022



Note: AIR (all-inclusive rate), E&M (evaluation and management). "Provider-based" RHCs are those owned by and operated as an integral part of another Medicare-certified facility, such as a hospital. "Specified provider–based" RHCs are those that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020 (or had submitted an application for enrollment that was received no later than December 31, 2020); all other provider-based RHCs are "nonspecified." Independent RHCs are freestanding clinics that do not qualify for, or have not sought, provider-based status. 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. "Visits" represent unique claims. For the analysis of charges per AIR visit, claims were limited to those paid on an AIR basis in which full beneficiary coinsurance was applicable. Outliers were trimmed. About 1 percent of claims were excluded because we could not classify provider-based RHCs as specified or not. We also excluded RHCs with fewer than 100 AIR visits to reduce the appearance of variation that is based on relatively few claims. For the analysis of charges for a common E&M service, we analyzed all RHC revenue center lines with Healthcare Common Procedure Coding System Code 99214 after excluding claims with no payments. For private-equity-owned RHCs, charges per common E&M service was the same at the 5th percentile, 25th percentile, and median.

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

FFS Medicare payments received by RHCs (beneficiary coinsurance plus program payments).[43]

We estimate that such a cap would have reduced FFS beneficiary coinsurance in 2022 by 19 percent overall. The reduction in beneficiary coinsurance would have been much larger for services furnished at independent RHCs and nonspecified provider–based RHCs. We estimate that such a cap would have reduced FFS beneficiary coinsurance in 2022 by 43 percent at independent RHCs, 49 percent at nonspecified provider–based RHCs, and 8 percent at specified provider–based RHCs.

As for the effect on RHC revenues, we estimate that such a cap in 2022 would have reduced FFS Medicare

payments to RHCs by about 3.9 percent overall: 12.9 percent for independent RHCs, 15.8 percent at nonspecified provider–based RHCs, and 1.4 percent for specified provider–based RHCs. The effect on specified provider–based RHCs was small because such RHCs generally had significantly higher estimated interim AIRs (and similar charges) relative to other RHCs, and therefore beneficiary coinsurance was already frequently equal to or less than 20 percent of their estimated interim AIRs. As a result, about two-thirds of such RHCs were not impacted at all, and even among those that were impacted, the effect was often small (because beneficiary coinsurance was often just above 20 percent of their estimated interim AIRs). Across all types of RHCs, all of the decline was due to lower beneficiary coinsurance because Medicare program payments to RHCs remain the same regardless of the amount of the beneficiary's cost-sharing liability.

However, the effects on independent RHCs and nonspecified provider–based RHCs would likely be much smaller if such a policy were implemented because growth in the national statutory payment limit is likely to outpace growth in charges per visit over the next few years (thereby reducing the share of total payments attributed to beneficiary coinsurance). To estimate the effect on independent RHCs in 2026 and in 2028 (when the CAA, 2021, increases to the national statutory payment limit are fully phased in), we increased beneficiary coinsurance per visit based on the average growth in charges per visit from 2018 to 2022 (5 percent per year) and program payments per visit by amounts stipulated in the CAA, 2021.[44,45] We used 2022 volume for both simulations. For 2026 and 2028, we estimate that capping beneficiary coinsurance at 20 percent of the lower of an RHC's AIR, subject to payment limits, or 20 percent of actual charges would reduce independent RHCs' total FFS Medicare payments by 8.4 percent and 7.3 percent, respectively. Furthermore, these effects are for FFS Medicare only (so the effects on all-payer revenue will be smaller). Even if beneficiary coinsurance was capped in this manner, we would still expect rapid growth in FFS Medicare payments at independent RHCs because the 120 percent growth in the national statutory payment limit from 2020 to 2028 would more than outweigh the 7 percent or 8 percent decrease in payments due to reduced cost sharing.

While we estimate that the effect of capping beneficiary coinsurance would have been small at specified provider–based RHCs in 2022 (1.4 percent), charge-based coinsurance could undermine the new payment limits that the CAA, 2021, implemented for these RHCs by allowing faster growth in beneficiary coinsurance to offset slower growth in payment limits. AIRs for these providers have historically grown based on the increase in costs per visit, which has been faster than growth in the MEI. Now that these RHCs' payment limits increase based on MEI growth, they could face pressure to reduce cost growth or increase charges. For example, if the MEI grew by 3 percent and an RHC's cost per visit grew by 5 percent, the RHC would have an incentive to increase charges. In this example, an RHC that had historically set its charges equal to its AIR (e.g., an AIR of $250 per visit and charges of $250 per visit) would need to increase their charges (and therefore beneficiary coinsurance) by 13 percent to offset the effects of the new MEI-based cap on total payments per visit. Such a response would undermine the payment limits (by allowing total payments per visit to exceed the limits and reduce the incentive to hold down cost growth) and shift the burden of the new payment limits to beneficiaries. ■

Endnotes

1 In this chapter, we follow the most common CMS definition of "rural" for payment-policy purposes, which comprises all counties outside of metropolitan areas. Because types of rural areas vary widely, we also subdivide these areas into distinct types, using rural–urban commuting areas. Further distinguishing rural areas allows us to compare rural areas with larger core areas (e.g., micropolitan areas with a city population between 25,000 and 50,000) and more remote areas where the largest town has fewer than 2,500 people.

2 Using survey data from 2013 through 2017, the Census Bureau found that the median household income in mostly urban counties was higher than that of mostly rural counties ($60,000 vs. $47,000); however, the range in median household incomes across mostly urban counties ($21,000 to $130,000) and mostly rural counties ($20,000 to $95,000) was wide (Guzman et al. 2018). (The Census Bureau defines an area as "mostly rural" if most of its census tracts are not in urban areas (Ratcliffe et al. 2016).) In a separate analysis, the Census Bureau found that median incomes for rural households in the Northeast and Midwest were actually higher than those of their urban counterparts; in contrast, median incomes for rural households in the South and West were lower compared with urban households in the same regions (Bishaw and Posey 2016). One caveat is that the incomes used by the Census Bureau are not adjusted for the cost of living. An earlier study that compared rural and urban poverty rates found that the poverty rates—prior to any adjustment for the cost of living—were higher in rural areas, but after adjusting for the cost of living, poverty rates were lower in rural areas (Jolliffe 2006). We are not aware of any updates to this dated finding that adjusts rural and urban incomes or poverty rates by the cost of living.

3 For each of the seven most common diagnosis-related groups at the closed small rural hospitals (pneumonia, heart failure, chronic obstructive pulmonary disease, nutritional and metabolic disorders, esophagitis and digestive disorders, kidney and urinary tract infections, and septicemia), volume declined by between 40 percent and 84 percent from 2005 to 2014.

4 CAHs must be in rural areas or reclassified by CMS as rural. States have the ability to declare areas rural, which allows CAHs to apply to CMS for rural reclassification (42 CFR Sec. 412, Prospective Payment Systems for Inpatient Hospital Services). Because all new CAHs must be more than 35 miles from another facility (or more than 15 miles on secondary roads or in mountainous terrain), almost all of them are located outside of metropolitan statistical areas.

5 For more details about the evolution of the CAH program, see MedPAC's June 2005 report to the Congress.

6 Most CAH beds are "swing beds," in which beneficiaries can receive acute or post-acute care. In some states, these beds can also be used for the long-term care of Medicaid or private-pay residents of the hospital. In addition to 25 acute care/swing beds, CAHs are allowed to have distinct-part skilled nursing facilities (SNFs), 10-bed psychiatric units, 10-bed rehabilitation units, and home health agencies (HHAs). However, these distinct-part departments of the CAH are paid through Medicare's prospective systems for SNFs, inpatient psychiatric facilities, inpatient rehabilitation facilities, and HHAs.

7 CAHs may not receive the full 101 percent of their costs under current law due to payment reductions imposed by a budget sequester on Medicare payments and limits on the share of hospital bad-debt payments that are reimbursable by Medicare.

8 CAHs vary widely in their financial resources and their level of profitability. CAHs with donations and government support can afford higher cost structures because cost-based payments act as a matching grant for donations and government support. For example, if a hospital uses $10 million in government support or donations to build a new facility and buy equipment, when that facility and equipment are depreciated over time, Medicare reimburses the CAH for Medicare's share of the facility's depreciation expense. This mechanism partially explains how communities with more favorable payer mixes and more outside support have been able to build new hospitals in recent years. However, not all communities have a significant amount of non-patient-care revenue. Among the approximately 1,350 CAHs in 2022, 25 percent had all-payer total profit margins below –2 percent, and 25 percent had all-payer total margins above 9 percent. There have been 13 CAH closures over the past five years (2020 to 2024).

9 These profits exclude COVID-19 relief funds and represent a profit margin of about 2.5 percent in 2022. In 2023, total (all-payer) margins increased to close to 5 percent for CAHs and IPPS hospitals.

10 This revenue excluded physician fees from hospital-owned physician practices.

11 This amount represents the difference between the CAH payment rate and what the rate would have been if the hospital had been paid basic OPPS rates in the county.

However, it may somewhat overstate the payment differential because if the hospital had not become a CAH, it may have engaged in other changes to increase its payment rates, such as reclassifying to a different area with a higher wage index. We do not have a precise counterfactual.

12 Section 1866(a)(1)(o) of the Social Security Act states that a CAH should "accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a Medicare+Choice organization under part C, with a PACE provider under section 1894 or 1934, or with an eligible organization with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967[596], or under section 222(a) of the Social Security Amendments of 1972[597], which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled." Sections 1886(d)(11) and 1886(h)(3)(D)) refer to payments for graduate medical education, which are paid directly by the Medicare program; the MA plan is not expected to make those payments.

13 This process may not represent the rate setting experience at all CAHs.

14 In some cases, outpatient care was paid based on a blend of costs and a fee schedule.

15 For inpatient services, cost sharing is set at a fixed deductible that does not vary with charges or local wages. The fixed inpatient deductible is the same for CAHs and PPS hospitals.

16 Other services such as lab tests and certain vaccines do not require coinsurance.

17 CAHs can be in a metropolitan area if the state declares the CAH's location as rural for some purpose.

18 The limit on outpatient coinsurance was enacted as part of the Balanced Budget Refinement Act in 1999, and the House Ways and Means Committee report stated that the rationale was to limit excessive outpatient coinsurance (U.S. House of Representatives 1999). A potential additional concern is that if a beneficiary does not have supplemental insurance, the hospital may have an incentive to shift the patient to inpatient status to avoid large losses on unpaid coinsurance.

19 In some cases, Medicaid will pay the cost sharing for dually eligible patients. However, if the Medicare program payment is higher than the Medicaid payment rate, then Medicaid may refuse to pay any cost sharing. The unpaid coinsurance is then deemed a bad debt, and the Medicare program pays the CAH 65 percent of the unpaid coinsurance as a "bad-debt payment."

20 The lower use could reflect less need for services or a greater deferral or delay of care due to not having supplemental insurance. In our examination of data from the 2021 Medicare Current Beneficiary Survey, we found that 10.6 percent of beneficiaries without supplemental coverage stated they had a health problem or condition about which they thought they should have seen a doctor or other health professional but did not. In contrast, 5.7 percent of those with Medigap coverage did not see a physician despite a concern that they needed medical attention.

21 This illustrative example is dependent on many assumptions about CAH use by beneficiaries without supplemental insurance and is not a precise estimate.

22 This estimate is by necessity imprecise. We assume that there was a 25 percent reduction in CAH users, while the research suggests a 25 percent reduction in overall use. Nevertheless, the 25 percent from the literature provides a rough estimate of the number of beneficiaries directly affected by charge-based coinsurance.

23 In some states, Medicaid pays the cost sharing for dual-eligible patients. However, in some states, Medicaid rates are set below 80 percent of rural hospitals' costs. In these cases, Medicaid can choose not to pay the cost sharing by stating that the Medicare program payments are already above what the Medicaid program views as a full payment. CAHs then often report the unpaid coinsurance as a bad debt for dual-eligible patients, and the Medicare program then pays the hospital 65 percent of this unpaid cost sharing as a bad-debt expense. The level of bad debt from dually eligible patients varies widely by state.

24 CMS estimates what the actual cost will be for each claim. It then pays the CAH the estimated costs less the beneficiary cost sharing. After the close of the cost-reporting year, CMS will estimate costs using cost-report data and then provide a final settlement so that total program payments will equal 101 percent of allowed costs, less beneficiary cost sharing, less 2 percent for the sequester.

25 The offsetting increase in program spending did not factor in the sequester, which is why we describe that offset as almost $2.1 billion. In 2022, the sequester was not in effect for the first three months of the year, partially in effect for three months of the year (a 1 percent reduction), and fully in effect for six months of the year (a 2 percent reduction). If we had

factored in the sequester using 2022 sequester data, the $2.1 billion increase in program spending would be reduced by about 1.25 percent, resulting in increased program spending of $2.07 billion rather than the $2.1 billion reported here.

26 The increased payments to MA plans would reflect increases in MA bids for providing standard Part A and Part B services (e.g., physician visits) and/or increased plan spending on supplemental benefits (e.g., vision benefits). Song and colleagues estimate that, for every dollar increase in MA benchmarks, MA plans' bids for standard Part A and Part B services increase by 50 cents and spending on supplemental benefits increases by 30 cents to 40 cents (Song et al. 2013). Using these estimates, we approximate that the $2.1 billion in additional FFS spending in 2022 due to the change in CAH coinsurance policy would have increased program payments to MA plans by about $1.3 billion (Table 7-3, p. 356).

27 Before 2013, CAHs were paid 100 percent of bad-debt expenses. At that point, high charges and high bad-debt payments did not affect CAHs' net revenue. That changed in 2013 when the Congress enacted reduced payments of bad-debt amounts.

28 The effect of the lower benchmark on program spending would be slightly less than $94 billion because of how benchmarks affect bids and supplemental benefits, as discussed above.

29 This example assumes that a $1 reduction in medical losses by the Medigap plan would reduce premiums by $1. It is possible that if the Medigap plan is already at the minimum medical loss ratio of 65 percent, it may have to reduce premiums by more than $1 if its cost of insurance declines by $1.

30 For example, assume a service costs $220 at the CAH with a fixed cost percentage of 50 percent, or $110, and 30 percent of outpatient charges are for FFS Medicare patients (these were the approximate averages in 2022). The cost per service to all payers would be reduced by $110 / V, where V is the volume. As a result, Medicare costs on existing services would be reduced by ($110 / V) × (V × 0.30), or 30 percent of $110, or $33. The net difference in payments to CAHs relative to payments to PPS hospitals was $110, or about half of the cost at the CAH. Thus, shifting one service from a PPS hospital to a CAH would directly cost about $110 on average and save about $33 through reduced unit costs at the CAH. On net, shifting volume to CAHs would further increase program costs ($110 in higher price paid less $33 in lower cost allocation across other services).

31 Historically, CMS enforced the standard that RHCs must be primarily engaged in providing primary care services. However, in a December 2024 final rule, CMS reinterpreted the Social Security Act to allow RHCs to furnish a higher share of specialty care services. Specifically, RHCs are now required to provide primary care, but CMS will no longer require that RHCs primarily engage in furnishing primary care services.

32 In certain cases, RHCs may receive multiple payments for services furnished on the same day, such as a qualified medical visit and a qualified mental health visit on the same day. Other services furnished at RHCs are not paid under the RHC AIR methodology, such as certain vaccines, laboratory tests, technical components of imaging services, telehealth services unrelated to behavioral health, and certain care-coordination services.

33 Historically, RHCs were subject to productivity standards, which effectively lowered RHCs' AIRs if clinicians did not furnish a minimum number of visits per year. However, CMS eliminated RHC productivity standards effective for cost-reporting periods ending after December 31, 2024.

34 To qualify for an AIR-based payment limit, an RHC must have been enrolled in Medicare as of December 31, 2020, or have submitted an application for enrollment that was received no later than December 31, 2020.

35 In 2020 (and broadly during the PHE), more RHCs received exemptions from productivity standards than in previous years. Such exemptions further allowed costs per visit to increase and to be permanently included in provider–based RHCs' payment limits.

36 Before meeting their outpatient deductible, beneficiary cost sharing is based on RHC charges.

37 The Medicare program also pays RHCs bad-debt payments equal to 65 percent of unpaid beneficiary cost sharing.

38 RHC coinsurance must not exceed 20 percent of the RHC's "reasonable customary charge" (Sec. 405.2410).

39 Based on these criteria, we excluded non–behavioral health telehealth services, virtual communications services, care-coordination services, telehealth originating-site fees, claims for which Medicare was a secondary payer, claims that were part of a demonstration, claims in the deductible phase of the benefit, preventive services for which cost sharing is not applicable, and claims for which cost sharing was waived during the coronavirus PHE. We also implemented outlier trims. After all exclusions and trims, our universe of claims included 6.7 million claims (or about 70 percent of all FFS Medicare RHC claims) and $1.4 billion in total spending (or about 73 percent of all FFS Medicare RHC spending).

40 Using claims data to estimate interim AIRs rather than information from cost reports produces different results for some RHCs. However, we used a claims-based approach for multiple reasons. Any limit on beneficiary coinsurance would likely be implemented using interim AIRs because that information is available at the point of care. In contrast, cost–report–based AIRs are not available until after reconciliation at year's end. We also expect the overall difference between interim and final AIRs, subject to payment limits, to be similar in the future because all AIRs are now subject to payment limits.

41 Provider-based RHCs are those owned by and operated as an integral part of another Medicare-certified facility, such as a hospital. "Specified" provider–based RHCs are those that are part of a hospital with fewer than 50 beds and were enrolled in Medicare as of December 31, 2020 (or had submitted an application for enrollment that was received no later than December 31, 2020); all other provider-based RHCs are "not specified." Independent RHCs are freestanding clinics that do not qualify for, or have not sought, provider-based status.

42 Since 2022, this PE firm has continued to increase the number of RHCs it owns. In addition, other PE firms purchased RHCs after 2022 (Business Wire 2024, MyTown Health 2024).

43 Simulations were limited to RHC claims paid on an AIR basis where full beneficiary coinsurance was applicable.

44 Because nonspecified provider–based RHCs are subject to the national statutory payment limit and their charges per visit grew at slightly slower rates compared with independent RHCs from 2018 to 2022, results of a similar simulation for these providers would be directionally consistent with the simulation for independent RHCs.

45 We also simulated the effect on reductions in beneficiary coinsurance. At independent RHCs, we estimate that beneficiary coinsurance would be reduced by 32 percent in 2026 and 29 percent in 2028.

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