MEDPAC

Advising the Congress on Medicare issues



Charge-based coinsurance at rural health clinics

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Context for today's presentation

- June 2025: The Commission recommended that Congress change coinsurance at CAHs from charge-based to being based on Medicare's payment amount
- Beneficiary coinsurance at RHCs is also based on provider charges
- Implications of moving away from charge-based coinsurance differ
  - CAHs: Would not affect the total revenue per FFS visit
  - RHCs: Would reduce RHCs' revenues per FFS visit
- A change to RHC coinsurance was not part of MedPAC's June 2025 recommendation

Note: CAH (critical access hospital), RHC (rural health clinic).

Presentation roadmap

1. Overview of Medicare's payment system for RHCs
2. Charge-based coinsurance at RHCs
3. Charge-based coinsurance for telehealth at RHCs
4. Alternative to charge-based coinsurance at RHCs
5. Discussion

Overview of rural health clinics (RHCs)

- RHCs were established by the Rural Health Clinics Services Act of 1977 to increase local access to care in rural areas
- RHCs must initially be located in a nonurbanized area that qualifies as a HPSA, MUA, or governor-designated shortage area
- Two types of RHCs:
  - Provider-based (PB): Owned by/operated as part of another facility, e.g., a hospital
  - Independent: Freestanding clinics that do not qualify for or have not sought PB status
- Historically, RHCs have furnished primary care but now have the flexibility to furnish more specialty care

Note: RHC (rural health clinic), HPSA (health professional shortage area), MUA (medically underserved area), PB (provider based).

FFS Medicare and RHCs, 2025

RHCs	5,200
Users	2.3 million
Visits	10.3 million
Payments	$2.3 billion

Note: FFS (fee-for-service), RHC (rural health clinic). The total number of RHCs is calculated as the number of unique provider numbers that billed FFS Medicare in 2025; figure is rounded to the nearest 100 RHCs. Number of RHCs excludes RHCs that did not bill FFS Medicare, such as those specializing in pediatrics or women's health. Spending figures do not include cost-report reconciliation payments or services paid under other payment systems (such as the technical component of imaging services and tests billed under the clinical laboratory fee schedule).

Source: MedPAC analysis of 2025 FFS Medicare RHC claims.

FFS Medicare's payment system for RHCs

- Bundles all professional services furnished in a single day into one payment: a facility-specific cost-based all-inclusive rate (AIR)
- Medicare program payment = 80% of the AIR, subject to payment limits
- Beneficiary coinsurance = 20% of RHC *charges*
- Other services furnished at RHCs are not paid under the AIR methodology (e.g., certain vaccines, lab tests, certain care management services, and non-mental health telehealth services)

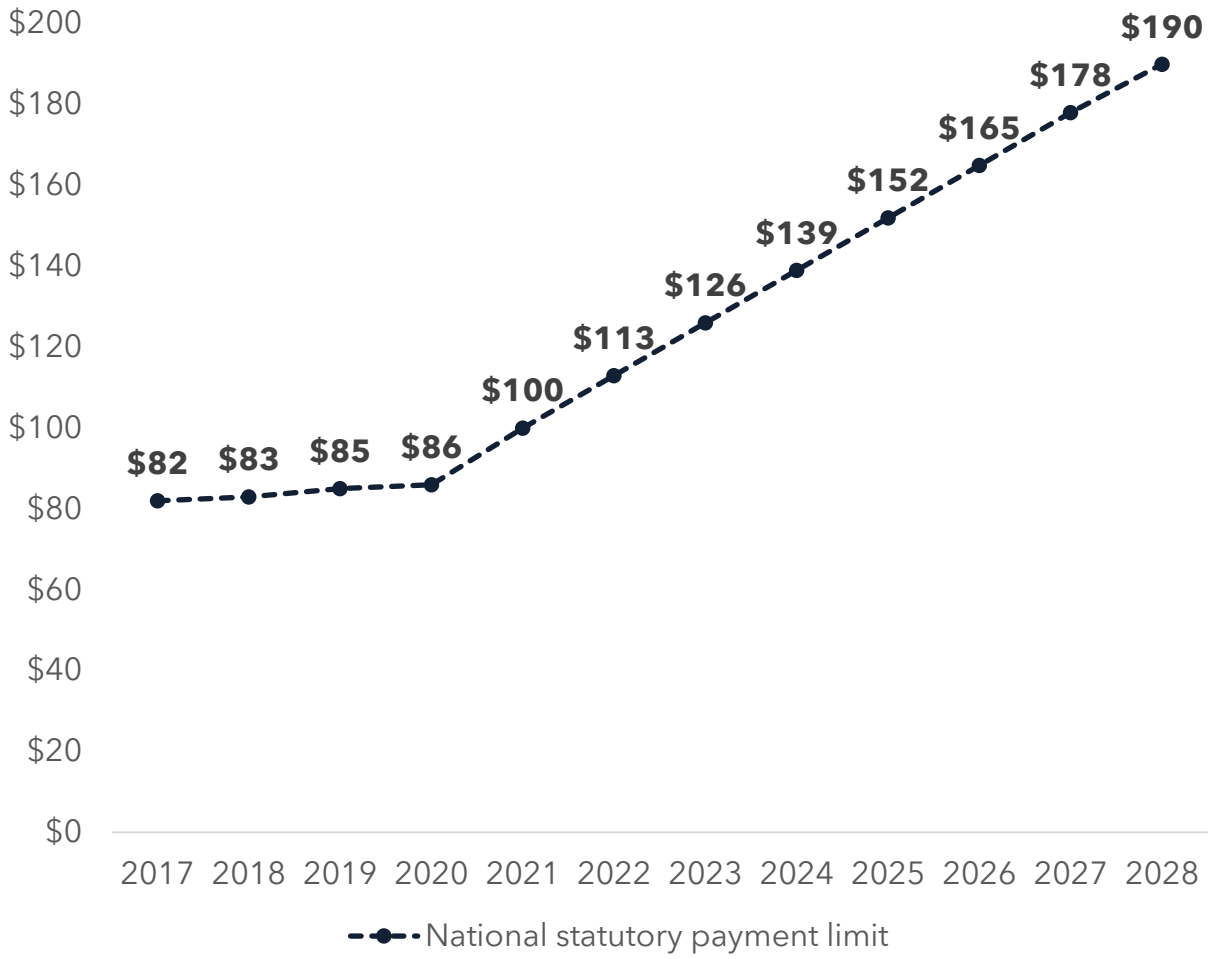
Note: RHC (rural health clinic), FFS (fee-for-service), AIR (all-inclusive rate). In certain cases, RHCs may receive multiple payments for services furnished on the same day, such as a qualified medical visit and a qualified mental health visit.

As of 2021, all RHC AIRs are subject to payment limits

- Prior to 2021:
  - AIRs subject to the national statutory payment limit for independent and for PB RHCs that were part of 50+ bed hospital
  - Other PB RHCs' AIRs were not subject to payment limits
- Starting in 2021:
  - Independent RHCs subject to increasing payment limits
  - Nonspecified PB RHCs subject to increasing payment limits
  - Specified PB RHCs—AIRs capped at greater of:
    - RHC's 2020 AIR (adjusted by MEI growth) or
    - National statutory payment limit

Note: RHC (rural health clinic), AIR (All-inclusive rate), PB (provider-based), MEI (Medicare economic index). Specified PB RHCs are those that are part of a hospital with less than 50 beds and that were enrolled in Medicare as of December 31, 2020. All other PB RHCs are nonspecified PB RHCs.

National statutory payment limit per visit increased rapidly beginning in 2021

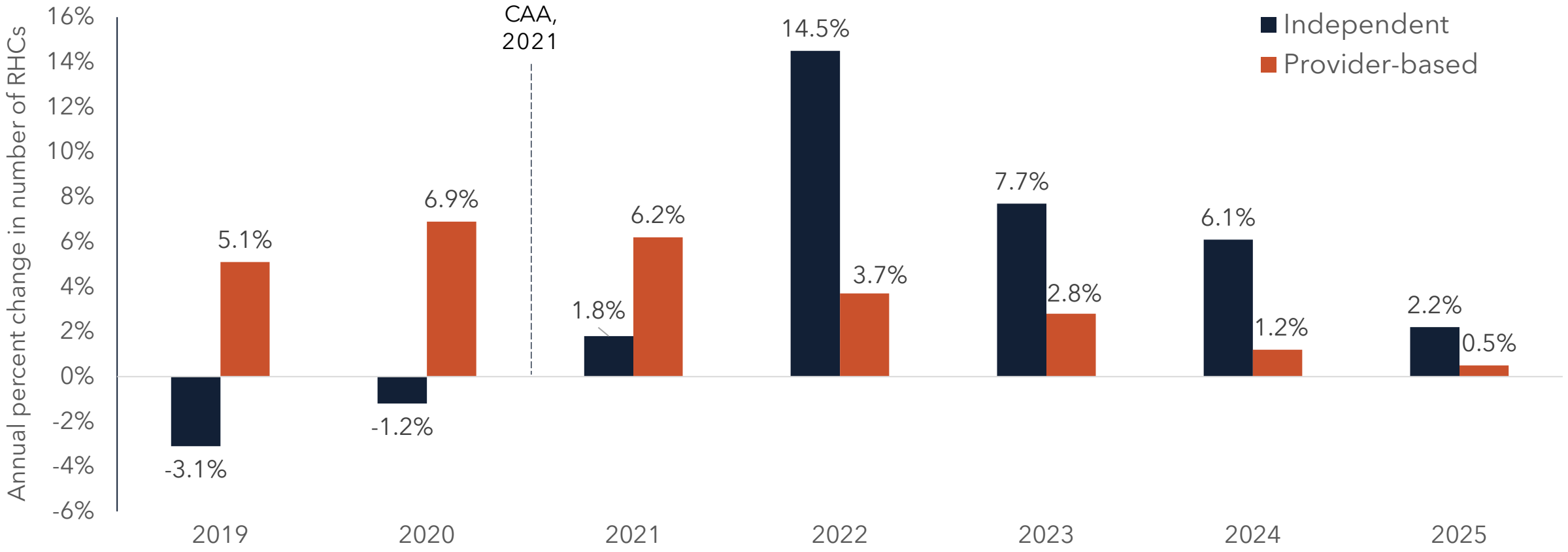


- From 2020 to 2028, the national statutory payment limit will increase by 120%
- Starting in 2029, the national statutory payment limit will increase annually based on MEI growth
- Specified PB RHCs' payment limits vary and are generally much higher than the national statutory payment limit

Note: MEI (Medicare economic index), PB (provider based), RHC (rural health clinic). 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 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. Specified PB RHCs are those that are part of a hospital with less than 50 beds and that were enrolled in Medicare as of December 31, 2020.

Source: MedPAC analysis of Medicare regulations.

Growth of independent RHCs billing FFS Medicare increased after higher payment limits began in 2021



Note: RHC (rural health clinic), FFS (fee-for-service), CAA (Consolidated Appropriations Act). Counts of RHCs are based on unique CMS Certification Numbers that billed at least one Medicare FFS claim in a given year. These totals exclude RHCs that did not bill FFS Medicare.

Source: MedPAC analysis of RHC claims for FFS beneficiaries.

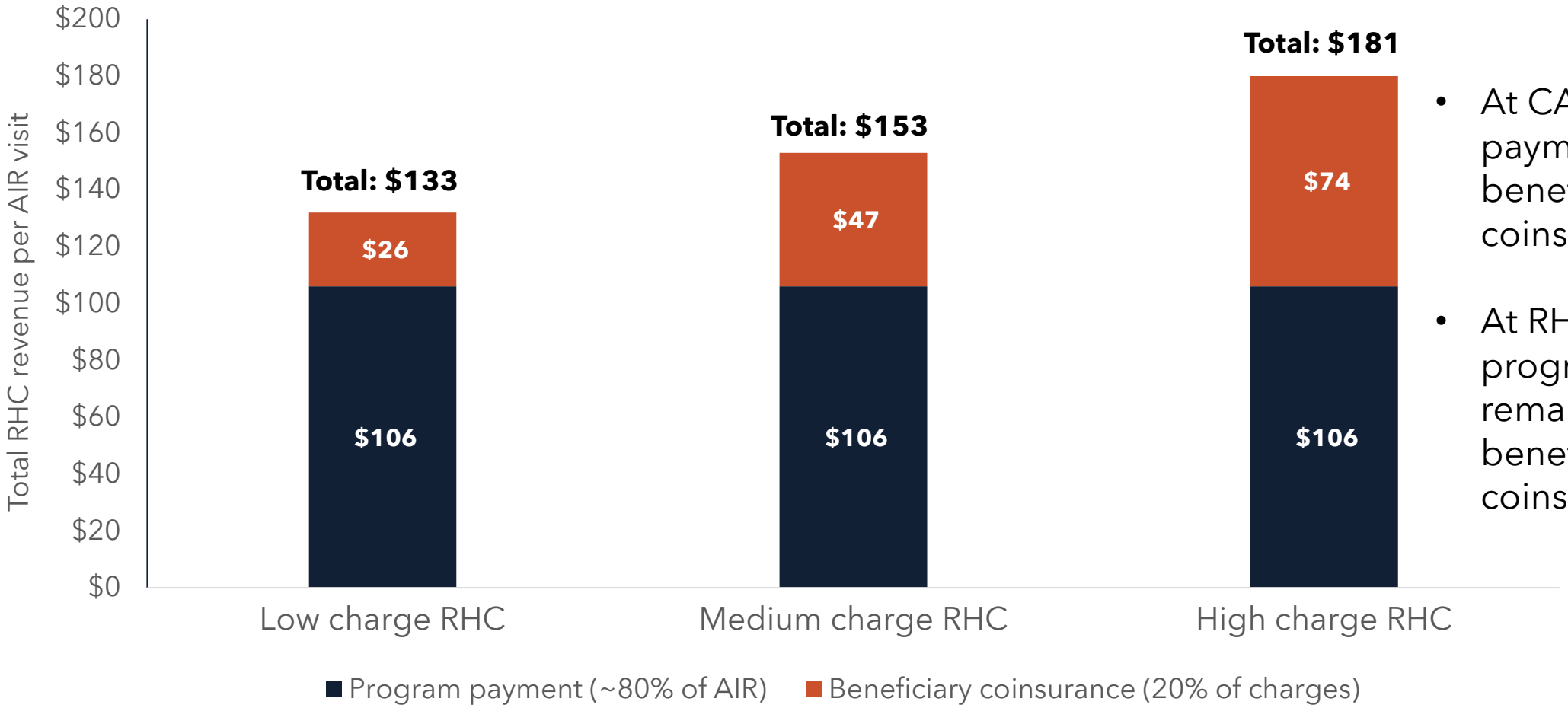
Change in number of RHCs suggests multiple underlying patterns

- Shift from declining to robust growth in independent RHCs suggests operators find new RHC payment limits attractive
- Some growth related to entry of PE-owned RHCs
- Entry of independent RHCs may be due to established clinician practices becoming RHCs as attractiveness of RHC payment system increases relative to the PFS

Note: RHC (rural health clinic), PE (private equity), PFS (physician fee schedule).

Charge-based coinsurance at RHCs

RHCs with higher charges receive higher total payments due to higher beneficiary coinsurance



- At CAHs, program payments decline as beneficiary coinsurance increases
- At RHCs, in contrast, program payments remain unchanged as beneficiary coinsurance increases

Note: AIR (all-inclusive rate), RHC (rural health clinic), CAH (critical access hospital). Results based on actual average program payments and beneficiary coinsurance for three independent RHCs in 2025 that had AIRs equal to $136. Program payments plus beneficiary coinsurance may not sum to total payments due to rounding.

Source: MedPAC analysis of RHC claims for FFS beneficiaries.

FFS beneficiary coinsurance often exceeded 20 percent of estimated AIRs, 2025

RHC type	Visits (millions)	Average estimated AIR per visit	Average Medicare payment per visit (~80% of AIR)	Average coinsurance per visit (20% of RHC charges)	Average coinsurance as a percent of estimated AIR	Total payment per visit (Medicare payment + beneficiary coinsurance)
Independent	2.1	$136	$106	$48	36%	$155
Nonspecified PB	0.7	149	117	52	35	169
Specified PB	4.7	277	217	54	20	272

Note: FFS (fee-for-service), RHC (rural health clinic), PB (provider based), AIR (all-inclusive rate). "Visits" represent services that were the main reason for a visit and cases with multiple paid services per claim. Services were limited to those paid on an AIR basis where full beneficiary coinsurance was applicable. Outliers were trimmed, and services were excluded if we could not classify provider-based RHCs as specified or not. Estimated AIRs are calculated by dividing Medicare program payments 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.

FFS beneficiary coinsurance as a share of estimated AIRs varied substantially within and across types of RHCs, 2025

Beneficiary coinsurance as a share of the estimated AIR							
RHC type	5th percentile	10th percentile	25th percentile	Median	75th percentile	90th percentile	95th percentile
Independent	19%	21%	25%	32%	42%	54%	60%
Nonspecified PB	19	21	26	32	41	49	54
Specified PB	10	12	15	19	25	31	36

Note: FFS (fee-for-service), AIR (all-inclusive rate), RHC (rural health clinic), PB (provider based). "Visits" represent services that were the main reason for a visit and cases with multiple paid services per claim. Services were limited to those paid on an AIR basis where full beneficiary coinsurance was applicable. Outliers were trimmed, and services were excluded if we could not classify provider-based RHCs as specified or not. Estimated AIRs are calculated by dividing Medicare program payments 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.

Beneficiary coinsurance is likely to increase faster than Medicare payments in the future

- Beneficiary coinsurance grows based on charges; payment limits are (or will be) updated by MEI growth
- From 2018 to 2025, average annual MEI growth was 2.8%, compared with average annual growth of RHC charges per AIR visit of:
  - Independent: 6.6%
  - Nonspecified PB RHCs: 4.4%
  - Specified PB: 6.3%
- Charge growth has been more rapid at independent RHCs at the same time that their payment limits have increased substantially

Note: RHC (rural health clinic), MEI (Medicare economic index), AIR (All-inclusive rate), PB (provider based).
Source: MedPAC analysis of FFS Medicare RHC claims and cost-report data.

Charge-based coinsurance for telehealth services at RHCs

Coverage and payment for telehealth services varies at RHCs by conditions treated

- RHC services were historically required to be face-to-face (in-person)
- In 2020, in response to the COVID-19 PHE, Congress temporarily authorized RHCs to furnish telehealth services, at a PFS-equivalent rate
- Beginning in 2022, for mental health services, telehealth flexibilities extended permanently; payment rate equal to standard RHC AIRs
- For non-mental health services, telehealth flexibilities temporarily extended through 2027
  - Paid at PFS-equivalent rate ($97 in 2025), which is lower than our estimate of standard AIRs (average of $136 for independent RHCs and $277 for specified PB RHCs)
  - CMS has solicited feedback on how to pay for these services at RHCs in the future

Note: RHC (rural health clinic), PHE (public health emergency), PFS (physician fee schedule), AIR (All-inclusive rate), PB (provider based). Beginning October 1, 2026, RHCs bill different health care common procedure coding system codes that correspond to specific services rather than a single code for all non-mental health telehealth services (G2025). This coding change does not affect the payment rate.

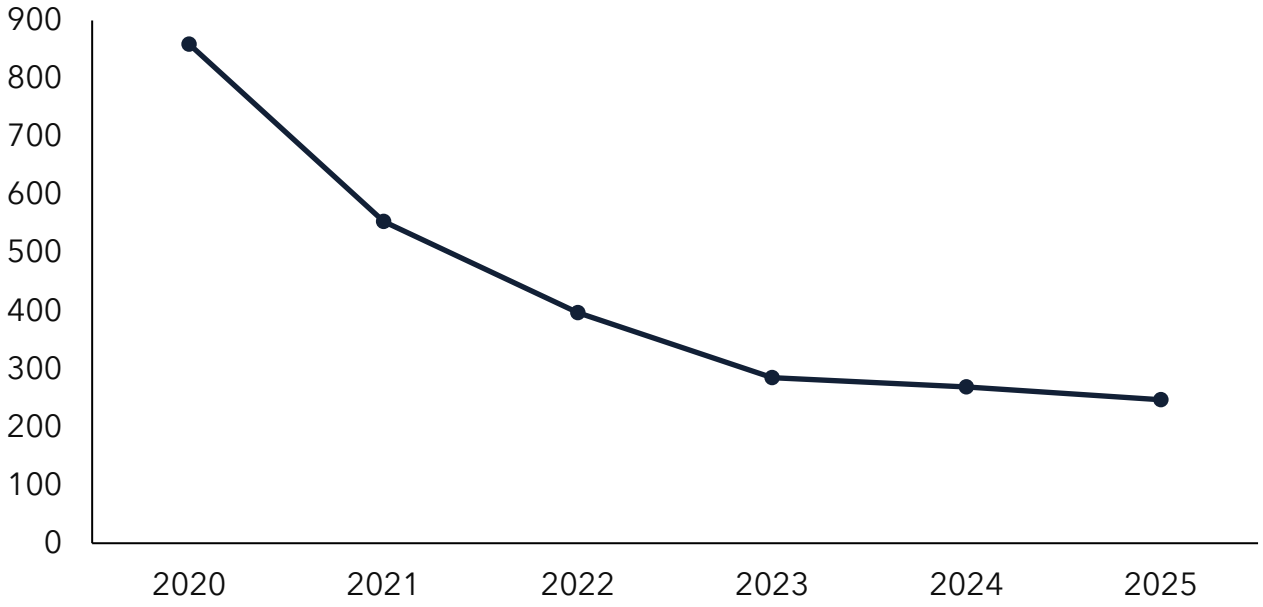
Summary of RHC telehealth coverage, payment rates, and coinsurance, 2026

Type of service	Duration of coverage	Payment rate	Beneficiary coinsurance
In-person visits and mental health telehealth	Permanent	Standard AIRs	Set equal to 20% of RHC charges
Non-mental health telehealth	Temporary (extended through 2027)	PFS-equivalent rate	Capped at 20% of PFS-equivalent rate

Note: RHC (rural health clinic), AIR (all-inclusive rate), PFS (physician fee schedule). Coinsurance for non-mental health telehealth services is 20% of the lesser of the PFS-equivalent rate or RHC charges. Beginning October 1, 2026, RHCs bill different health care common procedure coding system codes that correspond to specific services rather than a single code for all non-mental health telehealth services (G2025). This coding change does not affect the payment rate.

Use of telehealth at RHCs declined since 2020, with modest use in 2025

RHC telehealth claims (in thousands), 2020-2025



Note: RHC (rural health clinic), PFS (physician fee schedule). Telehealth use in the fourth quarter of 2025 was likely lower than it would have otherwise been because telehealth flexibilities lapsed and were subsequently extended on a retrospective basis.

Source: MedPAC analysis of FFS Medicare RHC claims.

- Telehealth use at RHCs peaked in 2020, declined rapidly from 2021 to 2023, and then declined slightly in 2024 and 2025
  - Similar to PFS telehealth visit trends
- 2025 telehealth use at RHCs
  - ~100,000 beneficiaries
  - ~250,000 telehealth visits
  - ~75% of telehealth visits were for non-mental health telehealth visits paid at the PFS-equivalent rate

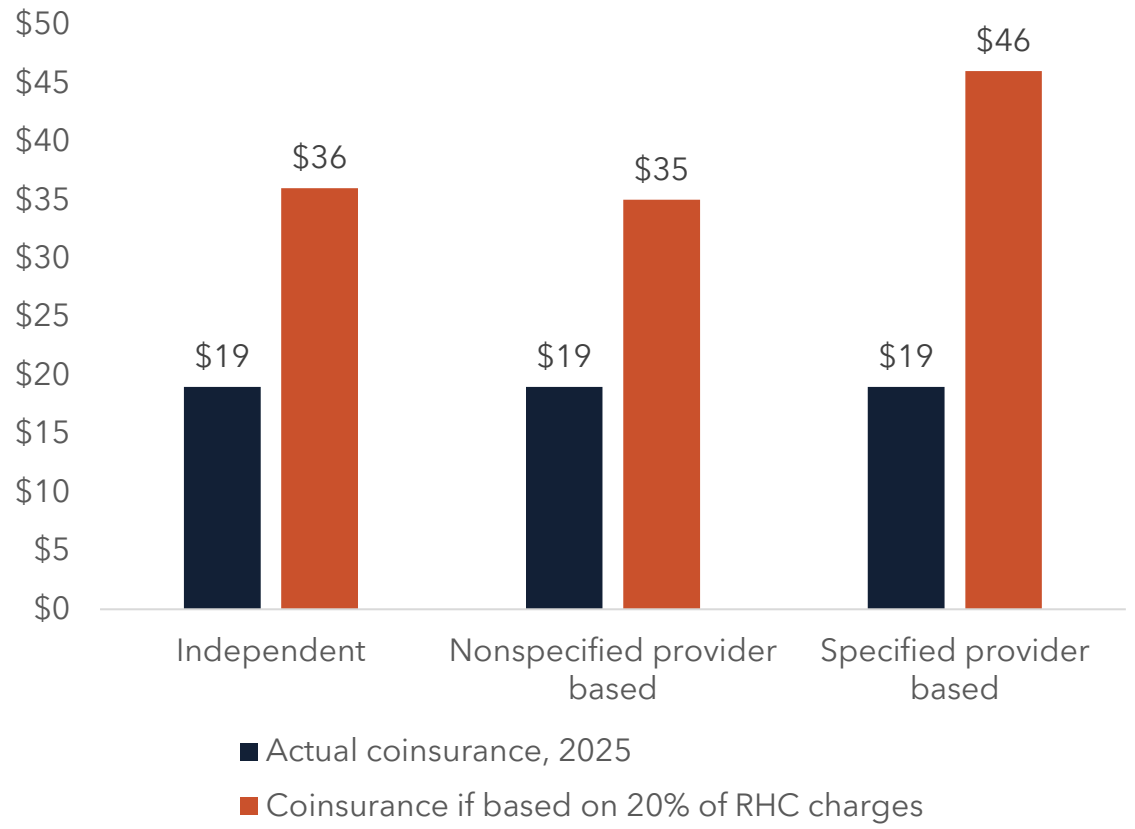
MedPAC has supported paying RHCs for telehealth services at PFS-equivalent rates (June 2023)

- Concerns about paying RHCs for telehealth services based on standard AIRs
  - Increases coinsurance and creates inequities between beneficiaries
  - Could discourage local in-person care
  - Could create adverse incentives to use RHCs to bill telehealth for populations outside of the communities typically served by RHCs

Note: RHC (rural health clinic), PFS (physician fee schedule), AIR (all-inclusive rate).
Source: MedPAC's June 2023 Report to the Congress.

Setting coinsurance for non-mental health telehealth visits at 20% of charges would have substantially increased beneficiary liability in 2025

- Shifting from a PFS-equivalent rate to standard AIRs for non-mental health telehealth visits would have increased beneficiary coinsurance per visit by:
  - Independent: $17 (92%)
  - Nonspecified PB: $16 (85%)
  - Specified PB: $27 (146%)
- Coinsurance based on charges would vary substantially for non-mental health telehealth visits
  - 10th percentile: $20 per visit
  - 90th percentile: $65 per visit



Note: PFS (physician fee schedule), AIR (all-inclusive rate), PB (provider based). Analysis limited to revenue centers with healthcare common procedure coding system code G2025 that is subject to full beneficiary coinsurance.

Source: MedPAC analysis of 2025 FFS Medicare RHC claims data.

Alternative to charge-based coinsurance at RHCs

Summary of RHC policy considerations

- Non-mental health telehealth services: paid PFS-equivalent rates
  - Beneficiary coinsurance is capped and equitable
  - MedPAC supported paying the PFS-equivalent rate (June 2023)
- Services paid standard AIRs, with charge-based coinsurance
  - Results in high, rapidly growing, and inequitable coinsurance
  - Commission could consider alternatives to charge-based coinsurance

Note: RHC (rural health clinic), PFS (physician fee schedule), AIR (all-inclusive rate).
Source: MedPAC's June 2023 Report to the Congress and analysis of FFS Medicare RHC claims and cost-report data.

Commissioners could consider alternative to charge-based coinsurance at RHCs

- Could set coinsurance at RHCs equal to 20% of the lesser of:
  - the AIR, subject to payment limits, or
  - 20% of RHC charges
- Alternative approach would align with Commission's 2025 CAH cost-sharing recommendation

Note: RHC (rural health clinic), AIR (all-inclusive rate), CAH (critical access hospital).

Estimated effects of capping beneficiary coinsurance at 20 percent of the lesser of AIRs, subject to payment limits, or charges in 2025

- Reduced FFS beneficiary coinsurance by an estimated 24% overall
  - 44% at independent RHCs
  - 43% at nonspecified PB RHCs
  - 13% at specified PB RHCs
- Substantially reduced variation in coinsurance
- Reduced total FFS Medicare payments to RHCs by 5%
  - 14% at independent RHCs
  - 13% at nonspecified PB RHCs
  - 3% at specified PB RHCs
- Program payments would not change, so all reductions in total revenues are due to declines in beneficiary coinsurance

Note: AIR (all-inclusive rate), FFS (fee-for-service), RHC (rural health clinic), PB (provider based).
Source: MedPAC analysis of FFS Medicare RHC claims and cost-report data.

Discussion

- Questions/comments on presentation
- Feedback on alternative to charge-based coinsurance at RHCs
- Direction on potential future analyses
  - Additional interviews with RHCs
  - Analysis of phase-in of potential alternatives
  - Analysis of options to mitigate potential effects on RHCs



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