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Advising the Congress on Medicare issues

Rural hospital and clinician payment policy: A work plan for 2024–2025

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Presentation roadmap

1. Existing rural payment policies
2. Critical access hospital and rural health clinic cost sharing
3. Medicare Advantage's effect on rural providers and access to care
4. Potential research topics for 2024–2025 cycle

Rural payment policies

MedPAC rural payment principles

- Target payment adjusters to preserve access
- Focus low-volume adjustments on isolated providers
- Empirically justify the magnitude of payment adjustments
- Maintain incentives for cost control

Source: MedPAC June 2012 report to the Congress.

Special FFS Medicare payments to preserve access to hospital care in rural areas

- Higher inpatient prospective payment rates (for SCHs, MDHs, LVHs)
- Cost-based payments (for CAHs)
- Fixed monthly payments and higher prospective payment rates per service (for REHs)
- About 95 percent of rural hospitals receive one of these five types of special payments
- These are all FFS programs; it is not clear how often Medicare Advantage plans also make these additional payments

Note: FFS (fee-for-service), SCH (sole community hospital), MDH (Medicare dependent hospital), LVH (low-volume hospital), CAH (critical access hospital), REH (rural emergency hospital).

Special FFS Medicare payments to hospitals result in higher Medicare margins in rural areas

Hospital type	FFS Medicare margins, 2022 (excluding provider relief funds)		
	25th percentile	Median	75th percentile
Rural IPPS hospitals	−24.0%	−7.8%	3.1%
Urban IPPS hospitals	−21.5	−10.4	0.7
Critical access hospitals	≈0	≈0	≈0

Note: FFS (fee-for-service), IPPS (inpatient prospective payment system).
Source: MedPAC analysis of Medicare cost report files.

Special FFS Medicare payments have not been large enough to result in higher all-payer margins at rural hospitals

Hospital type	All-payer operating margins, 2022 (excluding provider relief funds)		
	25th percentile	Median	75th percentile
Rural IPPS hospitals	−10.0%	−1.8%	5.2%
Urban IPPS hospitals	−6.5	0.9	9.8
Critical access hospitals	−5.7	0.9	7.6

Note: FFS (fee-for-service), IPPS (inpatient prospective payment system).
Source: MedPAC analysis of Medicare cost report files.

Special FFS Medicare payments to preserve access to clinician care in rural areas

- FFS Medicare special payments based on the physician fee schedule
  - CAH method II billing (15% add-on)
  - HPSA bonus (10% quarterly bonus)
  - GPCI floors (effects vary)
- Separate payment systems that have enhanced rates and are focused on primary care in rural and/or underserved areas
  - FQHCs
  - RHCs

Note: FFS (fee-for-service), CAH (critical access hospital), HPSA (health professional shortage area), GPCI (geographic practice cost index), FQHC (federally qualified health center), RHC (rural health clinic).

Special FFS Medicare payment rates for RHCs

Year	FFS rates per visit for independent RHCs
2020	$86
2021	100
2022	113
2023	126
2024	139
2025	152
2026	165
2027	178
2028	190

- Provider-based RHCs
  - Rates averaged ~$255 per visit in 2020 and increase annually by MEI thereafter
- Independent RHCs
  - FFS payment rates are set to more than double by 2028
- Rapid increases are likely to:
  - Maintain or increase access to clinicians in rural areas
  - Result in FFS Medicare paying much higher rates for primary care in many rural areas than in urban areas
- Commission will monitor effects of rate increases

Note: FFS (fee-for-service), RHC (rural health clinic), MEI (Medicare economic index). Payment rates for independent RHCs refer to the national statutory payment limit for RHCs' all-inclusive rates. Payment rates for provider-based RHCs refer to the RHC-specific all-inclusive rate caps for grandfathered RHCs. Provider-based RHCs that are part of a hospital with 50 or more beds or that is newly enrolled in Medicare after December 31, 2020, are subject to the same all-inclusive rate cap as independent RHCs.
Source: MedPAC analysis of Medicare cost report files and summary of regulations.

Coinsurance based on provider charges increases beneficiary cost-sharing liability

- Critical access hospitals (outpatient services)
  - Program pays 101% of costs minus coinsurance
  - Coinsurance = 20% of charges
  - Coinsurance often about 50% of payment for outpatient services
    - E.g., if charges are 250% of costs, coinsurance will be 50% of payments (250% x 20% =50%)
  - Coinsurance can be 100% or more of payments for high mark-up services
    - E.g., if charges are 500% of costs, coinsurance will be 100% of payments (500% x 20% =100%)
- Rural health clinics
  - Program pays 80% of RHC rate
  - Coinsurance = 20% of charges
  - Providers can get more than 100% of the RHC rate by increasing charges

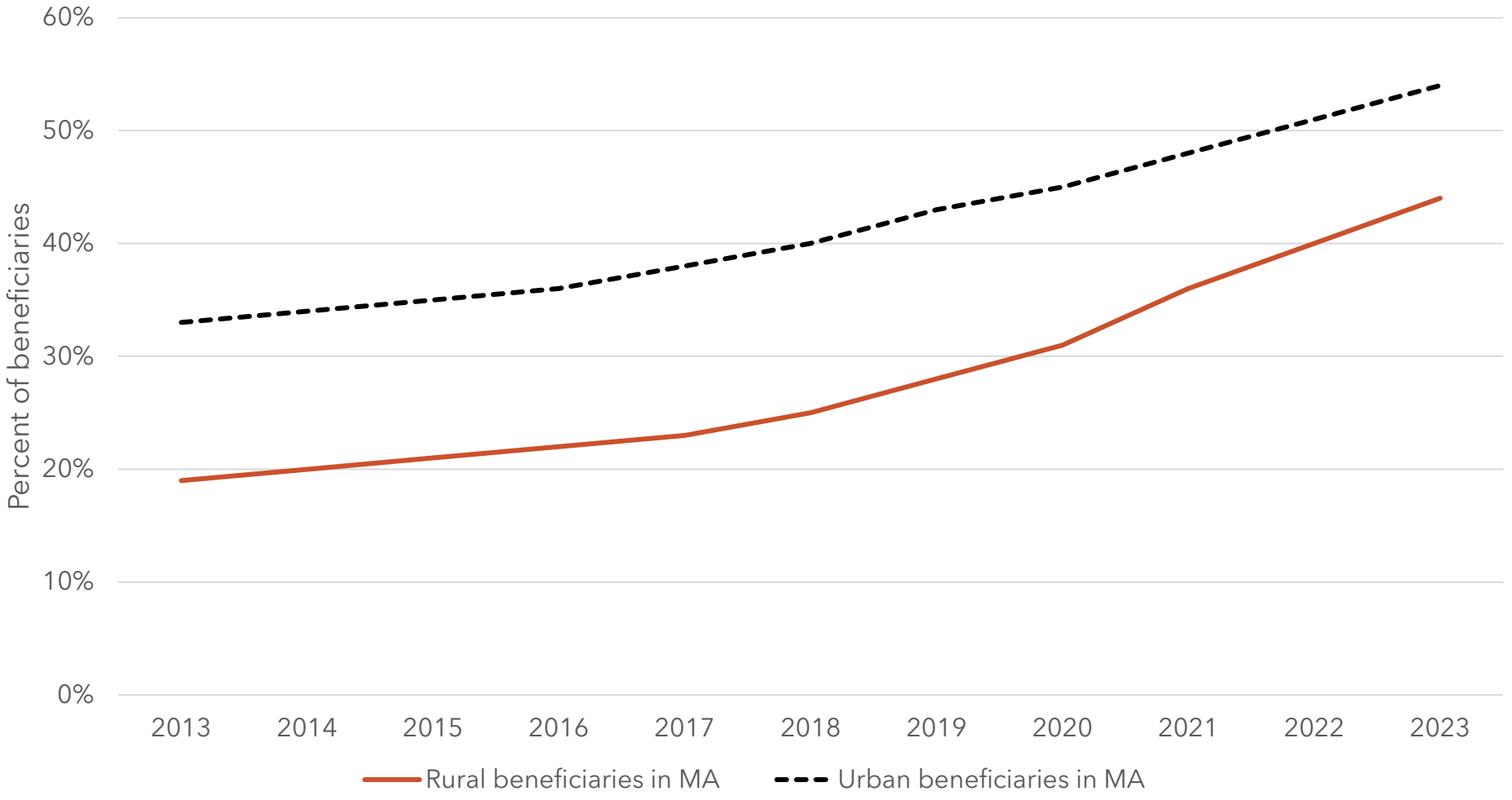
Note: RHC (rural health clinic). Examples do not include the effects of sequestration.

Medicare Advantage in rural areas

The growth of Medicare Advantage

- The Commission strongly supports the inclusion of private plans in the Medicare program
- Over 99% of Medicare beneficiaries live in counties where MA is an option
- Both rural and urban beneficiaries are increasingly choosing MA

Medicare Advantage enrollment, 2013–2023



Note: MA (Medicare Advantage). Medicare Advantage enrollment as a share of all Medicare beneficiaries with both Part A and Part B coverage.
Source: MedPAC analysis of Medicare enrollment files.

Why is MA enrollment growing?

- More beneficiaries enrolling in MA
  - Lower cost: Can obtain a maximum out-of-pocket limit without purchasing Medigap plan
  - Extra benefits can include dental, hearing, reduced Part D premiums, pre-paid debit cards for over-the-counter medications or groceries
- Fewer beneficiaries switching out of MA
  - May be difficult to obtain Medigap policies
  - MA plan spending on extra benefits doubled from 2018 to 2023

Sources: MedPAC focus groups, MedPAC analysis of Medicare enrollment files, MedPAC March 2024 report to the Congress.

Evaluating effects of MA on beneficiary travel time

- Compare FFS and MA beneficiaries' travel time for:
  - Primary care
  - Inpatient care
  - Pharmacy visits
- Examine shares of MA and FFS beneficiaries bypassing their local hospital

Note: MA (Medicare Advantage), FFS (fee-for-service).

Evaluating effects of MA on rural providers

Provider concerns about MA expressed during site visits:

- Difficulty getting prior authorization for admission and discharge to post-acute care
- Lower payment rates for MA patients than for FFS patients
  - Providers don't always receive full cost-based payments for MA CAH patients
  - Providers don't always receive full RHC rates for MA patients
- Extra administrative time in billing
  - Delayed payments
- Analyze effect on rural closures
  - Hospitals suggest MA increases financial risk
  - Henke (2023) suggests there are lower closure rates in areas with MA growth

Note: MA (Medicare Advantage), FFS (fee-for-service), CAH (critical access hospital).
Source: MedPAC site visits and interviews with rural providers.

Evaluating MA/FFS differences in hospitals' lengths of stay and use of observation beds

- Compare how care is provided and coded in MA and FFS
  - Length of stay
  - Ratio of observation stays to inpatient stays
- Examine differences across MA plans
  - Interview MA plans that are integrated with providers
  - Interview independent MA plans
  - Care patterns such as length of stay

Note: MA (Medicare Advantage), FFS (fee-for-service).

Preliminary finding: MA beneficiaries tend to have longer inpatient stays

	MA beneficiaries' length of stay minus FFS beneficiaries' length of stay, 2019-2021 (difference in days)	
	Rural	Urban
Total (All discharge destinations)	0. 4*	0.5*
Discharged to SNF	1.1*	1.2*
Discharged to home	0.2*	0.2*

*Indicates statistically significant at the P<.01 level of significance after adjusting for clustering of standard errors at the hospital level.

Potential impacts of longer lengths of stay

- Could increase hospital costs (without an increase in revenue if paid on a DRG basis)
- Could increase beneficiary cost-sharing

Note: MA (Medicare Advantage), FFS (fee-for-service), SNF (skilled nursing facility), DRG (diagnosis-related group). Length of stay is measured within severity adjusted DRGs within the same hospital. For the length of stay analysis, each combination of hospital and MS-DRG is considered an observation.
Source: MedPAC analysis of Medicare claims and encounter data.

Potential research topics for the 2024–2025 cycle

- Cost sharing
  - Charge-based cost sharing at RHCs and CAHs
  - Are reforms needed?
- Implications of MA growth for rural providers on:
  - Length of hospital stay and associated inpatient costs
  - Payment rates for hospitals and RHCs
  - Rural hospital bypass
  - Beneficiary travel times for primary care
- Combined effects of MA growth on rural hospitals' finances

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

Commissioner feedback

- Questions?
- Key issues we missed that should be added?
- Additional stakeholders that we should talk to?

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