

April 16, 2026

Michael Del Trecco
President & CEO
Vermont Association of Hospitals & Health Systems
148 Main St
Montpelier, VT 05602

Case: 7086118

Dear Mr. Del Trecco,

The Centers for Medicare & Medicaid Services (CMS) appreciates the Vermont Association of Hospitals and Health Systems (VAHHS) raising concerns regarding Medicare policy for Critical Access Hospitals (CAHs) and welcomes the opportunity to provide clarification. The Green Mountain Care Board (GMCB) has specifically highlighted the financial burden on Medicare beneficiaries receiving outpatient services at Vermont's CAHs. This concern stems from the fact that CAH outpatient coinsurance is based on chargemaster (billed) charges rather than actual Medicare payment rates, which can result in beneficiaries paying significantly more than they would at a Prospective Payment System (PPS) hospital.

As an initial matter, the beneficiary coinsurance applicable to CAH outpatient services is established by statute. Section 1834(g) of the Social Security Act provides that CAH outpatient services are reimbursed on a reasonable cost basis, and Section 1833 of the Act establishes the general Medicare Part B requirement that beneficiaries are responsible for 20 percent coinsurance. Implementing regulations at 42 C.F.R. §§ 410.152 and 410.160 further codify this cost-sharing requirement, and because CAH outpatient services are paid on a reasonable cost basis under 42 C.F.R. § 413.70, the application of these provisions results in beneficiary coinsurance that is effectively 20 percent of costs.

CMS operationalizes this statutory framework through the Medicare Claims Processing Manual (Pub. 100-04, Chapter 4, § 250.4), which instructs that coinsurance for CAH outpatient services is calculated based on charges associated with cost-based reimbursement. Accordingly, the CAH outpatient coinsurance policy reflects statutory requirements rather than discretionary policy. This is fundamentally different from PPS hospitals, where coinsurance is based on the Outpatient Prospective Payment System (OPPS) payment rate — a standardized, lower amount. Because charges are typically higher than costs, beneficiaries at CAHs often pay a significantly higher percentage of the actual cost of services.

With respect to hospital charges, CMS does not regulate the level of charges established by CAHs. While charges are used within the Medicare program for purposes such as determining beneficiary coinsurance and apportioning costs, CMS does not set or approve hospital charge structures, nor does it have a role in establishing or overseeing a provider's chargemaster. From a cost reporting perspective, CMS similarly does not dictate how providers set their charges.

However, under CMS regulations at 42 C.F.R. § 413.53, "charges" are defined as the regular rates for services that are billed to both beneficiaries and other patients. Implicit in the use of charges within the Medicare program is the expectation that such charges bear a reasonable relationship to the cost of furnishing services, as charges are used as a proxy for cost in various payment and cost apportionment methodologies.

The GMCB has expressed concern that high CAH chargemaster rates may violate Vermont law (18 V.S.A. § 9371(11)), which requires health care financing to be "sufficient, fair, predictable, transparent, sustainable, and shared equitably." However, in light of the statutory and regulatory framework described above, there are significant federal constraints on state action in this area.

The CAH coinsurance calculation methodology is mandated by federal statute (SSA § 1834(g)). Any change to the coinsurance calculation methodology would require congressional action because: (1) the method for calculating coinsurance is mandated by statute; and (2) aligning CAH coinsurance with OPSS-style rates would increase Medicare program expenditures, necessitating congressional approval.

While states may have policy interests related to affordability and equity, any efforts to require CAHs to alter their charges or billing practices in a manner that would effectively change Medicare beneficiary cost-sharing could raise concerns regarding consistency with federal statutory and regulatory requirements. If a state requires a CAH to modify its revenue cycle practices or charges for services provided to Medicare beneficiaries with the intent of influencing Medicare reimbursement or altering beneficiary cost-sharing amounts, those hospitals could face federal compliance risks, including:

- Altered Medicare cost-based reimbursement — Since CAH payments are tied to costs, artificially reducing charges could affect the cost report and reimbursement calculations under 42 C.F.R. § 413.70.
- Anti-Kickback Statute concerns — The OIG has warned that routine waiver or reduction of cost-sharing without individualized, good-faith financial hardship assessments may violate the Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)) and the Beneficiary Inducements Civil Monetary Penalty (CMP) law (SSA § 1128A(a)(5)).
- False Claims Act exposure — If charges are manipulated to influence federal program payments, it could implicate the False Claims Act (31 U.S.C. § 3729).

CAHs are required to bill Medicare beneficiaries the applicable copayment amounts as defined under federal Medicare law and do not have the authority to unilaterally modify, reduce, or otherwise alter these statutory cost-sharing obligations.

While state-mandated changes to Medicare cost-sharing are constrained by federal law, the following options are available to stakeholders:

1. Congressional/Legislative Action - The most direct path to reform is Congressional action at the Federal level to amend SSA § 1834(g) to align CAH outpatient coinsurance with OPSS-style rates. The Medicare Payment Advisory Commission (MedPAC) has previously recommended capping CAH outpatient coinsurance at the inpatient deductible level to reduce beneficiary burden. Vermont's Congressional delegation should be engaged to pursue statutory amendments aligning CAH coinsurance with OPSS rates, consistent with MedPAC recommendations.

2. Stakeholders may provide comment regarding the Medicare beneficiary coinsurance provisions for outpatient services at CAHs during the open comment period for the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule, published annually, typically in July.
3. Hospital Voluntary Action - Vermont CAHs may voluntarily:
 - Implement individualized financial hardship programs that comply with OIG guidance for waiving or reducing cost-sharing on a case-by-case basis.
 - Review and rationalize chargemaster rates for non-Medicare purposes, provided this is not done with the intent to manipulate Medicare reimbursement.
 - Enhance price transparency to help beneficiaries understand their cost-sharing obligations in advance.
4. Medicare Supplemental Insurance (Medigap) - Medigap plans typically cover CAH coinsurance, and ensuring robust Medigap enrollment among Vermont Medicare beneficiaries could mitigate individual financial burden.
5. State Medicaid and Low-Income Assistance Programs - Vermont may be able to use state Medicaid funds or other state programs to assist low-income Medicare beneficiaries with cost-sharing obligations, provided this is structured as a beneficiary assistance program rather than a direct modification of Medicare billing practices.

CMS appreciates the opportunity to provide this clarification on this issue. We hope this information is helpful. Please do not hesitate to reach out if you would like to discuss this information further.

Sincerely,



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