November 25, 2019

The Honorable Richard Neal
Chairman
Ways and Means Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Kevin Brady
Ranking Member
Ways and Means Committee
U.S. House of Representatives
Washington D.C. 20515

RE: Response to Request for Information on Priority Topics that Affect Health Status and Outcomes for the Rural and Underserved Communities Health Task Force

Dear Chairman and Ranking Member:

On behalf of the Rural Hospital Coalition (the Coalition), we appreciate the opportunity to provide feedback on the Committee's Request for Information (RFI) to help inform the work of the Rural and Underserved Communities Health Task Force (Task Force). We share your commitment to and focus on improving the delivery and financing of health care and related social determinants in urban and rural underserved areas and your effort to identify strategies to address the challenges that contribute to health inequities.

The Coalition is comprised of hospitals designated as Medicare-Dependent, Small Rural Hospitals (MDHs), Rural Referral Centers (RRCs) and Sole Community Hospitals (SCH) under the Medicare Program. The Coalition shares the common goal of ensuring that federal hospital payment policies recognize the unique and important role and contributions of these hospitals to the Medicare program and its beneficiaries. Consistent with this mission, the Coalition is pleased to provide a response highlighting some of these challenges and offering specific policies to

improve access to health care in rural and underserved communities. In order to avoid duplication in our response, we have one consolidated response below to following questions:

Q1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Q3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Q4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?
b. there is broader investment in primary care or public health?
c. the cause is related to a lack of flexibility in health care delivery or payment?

Q9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

Challenges Facing MDHs, RRCs, and SCHs

It is important to examine the challenges facing MDHs, RRCs, and SCHs that may impact the quality of, and access to essential health care services. First, many MDHs, RRCs, and SCHs are the sole source of care within and around a community. Many patients that live in rural and underserved communities depend on these facilities for a full complement of health care services, from primary care to sophisticated inpatient treatment. More and more rural hospitals are struggling and closing, causing access problems for residents of rural communities. When an MDH, RRC, or SCH closes, the consequences for the community may be more grave than otherwise.

Second, providers in rural and underserved communities treat more challenging and unique patient populations. For example, individuals who live in rural areas have higher rates of chronic or life-threatening diseases, such as diabetes and coronary heart disease.[1] Additionally, rural residents are more likely to face significant mental health issues including substance abuse and seasonal affective disorder.[2] By serving a disproportionate number of Medicare beneficiaries, MDHs also manage a challenging patient population: the elderly and aging. In 2018, the most recent year for which Medicare cost report data is available, Medicare patients (excluding Medicare Advantage patients) accounted for 54 percent of MDH patient days, significantly more

[1] O'Connor, A., & Wellenius, G. (2012, April 24). Rural-urban disparities in the prevalence of diabetes and coronary heart disease. The Royal Society for Public Health, 126(10), 813-820. doi:10.1016/j.puhe.2012.05.029.
[2] Health Status and Behaviors, Stanford Medicine, eCampus Rural Health.

than the 42 percent average at other rural hospitals, and the 34 percent average at urban hospitals.[3]

Third, providers in rural and underserved communities are increasingly confronting extremely difficult financial circumstances. Hospitals in these communities (including MDHs, RRCs, and SCHs) tend to have negative or very small operating margins, making them financially vulnerable. Additional Medicare reimbursement reductions impose further financial strain and compromise their ability to serve rural communities. These hospitals also often do not have the same flexibility as other hospitals to discontinue lower margin or unprofitable services, like mental health services. As mission driven organizations, and the only source of hospital services for their community, these hospitals often will continue to offer services, even at great financial loss, because there are no other providers offering those services. These hospitals also are struggling with dwindling federal support. Congress and the Centers for Medicare & Medicaid Services (CMS) have discontinued some of the benefits that these hospitals originally enjoyed.

While the deteriorating rural health safety net negatively affects patient care, it also significantly impacts local economies that often depend on these hospitals as large employers in the communities they serve.[4]

Policy Areas for Discussion and Consideration

Providing Predictability: Hospitals in rural and underserved communities need predictability in order to properly budget their resources. When policy and payment extensions are hanging in the balance every year or two, it is difficult for these hospitals to confidently budget. Even when programs are ultimately extended, without the predictability hospitals cannot use these extended resources to the maximum benefit. Ensuring predictability will allow for these hospitals to maximize the important relief they are given. By making permanent certain rural exceptions and policies, the Administration or Congress could easily take steps toward providing this predictability.

Extending SCH Exception to 340B Cuts: One example is the rural SCH exception to recent 340B payment cuts under the Medicare Outpatient Prospective Payment System (OPPS). Rural SCHs are excepted from the Medicare OPPS 340B payment cuts, but only on an annual basis. Urban SCHs and RRCs, however, are subject to the adjustment. CMS cited hospital operating margins, closure rates of rural hospitals, low-volume, and existing special payment designations among reasons for excepting rural SCHs, but not other rural safety net providers. Urban SCHs and RRCs share many of these same characteristics, and also should be protected while CMS examines the impact. The idea of implementing a significant policy change, and then examining the harm is potentially reckless given the known fragility of these providers.

Permanent Extension of MDH: The MDH designation should be made permanent. Because MDHs serve a disproportionate number of Medicare beneficiaries, MDHs rely on Medicare payments for delivering patient care to these beneficiaries and their broader communities. MDH status and the associated payment protections are critical to the continued viability of these

[3] Centers for Medicare & Medicaid Services. FY 2018 IPPS Impact File, September 29, 2017.
[4] Rural hospitals: The beating heart of a local economy, National Rural Health Association. January 18, 2018.

facilities. When Congress established the MDH program, it did so for only a limited period of time. Congress has consistently renewed and extended the MDH program, but always only for limited periods. The Bipartisan Budget Act of 2018 was the last such measure, extending the MDH program for five years (through October, 2022). Providing short-term extensions is not a long-term solution.

Data-Driven Policy: For policies impacting rural and underserved communities, it is essential to study and understand the consequences of any proposed changes before taking actions that may have negative consequences for providers in rural and underserved communities. To this end, there should be a reconsideration of exemptions to certain payment policies, as well as an examination of the impact of policies specifically on these hospitals.

Exempting MDHs, RRCs, and SCHs from Site Neutral: One example is the destabilizing site neutral payment reductions it finalized in the CY 2019 OPPS rule. Beginning in 2019, CMS pays for certain clinic visit services furnished by excepted (grandfathered) off-campus provider-based outpatient departments at the Physician Fee Schedule relativity adjuster rate, *i.e.,* the same payment amount used to pay for services furnished by non-excepted (non-grandfathered) off-campus provider-based outpatient departments. As previously stated, a large majority of hospitals in rural and underserved communities are already financially vulnerable due to a number of factors, including payment inadequacy and uncertainty. In proposing the policy change, the Administration cited concerns about hospitals purchasing additional physician practices to bill for physician services at OPPS payment rates as one reason for this change. There should not be the same concern with respect to MDHs, RRCs, and SCHs, where expanding services to underserved rural areas also is desirable, and perhaps trumps other concerns.

Updating MDHs and SCHs Base Year for Annual Payments: Another example of where policy could be update to reflect current data is related to how SCHs and MDHs are reimbursed by Medicare. MDHs and SCHs are currently reimbursed by Medicare for operating costs associated with inpatient services provided to program beneficiaries on the greater of the federal payment rate applicable to the hospital (*i.e.,* the payment that the hospital would otherwise receive under the inpatient PPS) or a cost-based payment, which is determined by adding together the federal payment rate applicable to the hospital and the amount that the federal payment rate is exceeded by a hospital-specific rate. These are based on the hospital's costs in fiscal year 1982, 1987, 1996 or 2006 trended forward, whichever is higher. MDHs can use 1982, 1987 or 2002 as a base year. A hospital that qualifies for MDH or SCH status will continue to be reimbursed under the PPS for as long as reimbursement under the PPS is more than reimbursement on a cost-basis; the hospital will be paid on a cost-basis if cost-based reimbursement is greater than reimbursement under the PPS. There are 451 SCHs; about 276 are paid based on the HSP. There are 169 MDHs; about 74 are paid based on the HSP.

The current base years were established by Congress in statute. CMS does not have the authority to add a new base year. Congress has added new base years from time-to-time. Congress last required an update more than decade ago (see, section 122 of Public Law 110-275, the Medicare Improvement for Patients and Providers Act of 2008). It is time for this program to reflect more current cost experience. We propose adding a more current base year (2016). This update will benefit some hospitals that do not currently receive hospital specific payments and boost

payments for certain other hospitals that currently use one of the older base years. We estimate that 244 hospitals in 45 states will benefit in one of these ways.

Inquiring on Annual MS-DRG Adjustments: The Task Force could also examine why the annual MS-DRG adjustments disadvantage RRCs and SCHs. CMS inpatient payment policy has been systematically disadvantaging RRCs and SCHs vis-à-vis their urban counterparts. According to CMS's own Impact Analysis of Proposed Changes (Table 1, 83 Fed. Reg. 20,603 et seq.), rural hospitals are disproportionately disadvantaged by the budget neutrality adjustments CMS uses when implementing and reconciling MS-DRG changes from year-to-year. For FY 2019, CMS estimates that this adjustment will be neutral for urban hospitals, but cause a 0.3 percentage point payment reduction for rural hospitals. The impact for certain categories of rural hospitals is even greater, including 0.4 percentage points for SCHs. As if this isn't troubling enough, as the table below reveals, this has been a consistent trend in recent years, serving to perpetuate the gap between urban and rural hospitals and further threatening the gap between urban and rural providers.

Weights and DRG Changes with Application of Recalibration Budget Neutrality Values Comparison Between Urban and Rural Hospitals From 2014 to 2020[5]

Year	Urban	Rural	RRC	SCH	MDH	SCH and RRC	MDH and RRC	Data source
2014	0	-0.4	-0.1	-0.6	-0.7	-0.3	-0.5	IPPS 2014 Final Rule
2015	0	-0.2	0	-0.2	-0.3	-0.3	-0.3	IPPS 2015 Final Rule Correction Notice
2016	0	-0.2	-0.1	-0.3	-0.3	-0.3	-0.3	IPPS 2016 Final Rule Correction
2017	0	-0.4	-0.1	-0.3	-0.6	-0.3	-0.6	IPPS 2017 Final Rule Correction
2018	0	0.1	0.1	-0.2		-0.1		IPPS 2018 Final Rule Correction
2019	0	-0.3	0	-0.5	-0.5	-0.2	-0.4	IPPS 2019 Final Rule
2020	0	-0.1	0	-0.3	-0.3	-0.3	-0.5	IPPS 2020 Final Rule
Total	**0**	**-1.5**	**-0.2**	**-2.4**	**-2.7**	**-1.8**	**-2.6**	

Avoiding Artificial Distinctions: The Coalition also encourages the Task Force to revisit the use of what we call "artificial" distinctions. Artificial, in that there is no apparent data analysis behind these distinctions. The primary example of this is the distinction CMS repeatedly makes between rural and urban SCHs when making policy decisions, such as in the application of the exception to the 340B payment cuts. CMS uses Metropolitan Statistical Areas (MSAs) to

[5] Inpatient Prospective Payment System Rules, Table 1 Impact Analysis (FY 2014 to 2020).

delineate between urban and rural areas. While we appreciate the need to distinguish urban and rural for a number of payment and policy mechanisms, and accept that MSAs provide a ready tool for this purpose, MSAs are not the most precise tool for characterizing urban and rural areas.

Given that MSAs use counties as building blocks, many "urban" areas are as rural as the most isolated frontier area. In fact, to be an urban SCH, a hospital has to be even further (35 miles) from another hospital to qualify. Currently, there are 78 urban SCHs in 38 states.[6] Some of these (36) have undergone urban-to-rural reclassification under the process described at 42 C.F.R. § 412.103 to retain rural status and access to these protections, but 42 have not sought or not been able to avail themselves of this process, and so remain urban and without these protections.

These issues reinforce the reasons there should be continued support for facilities in rural and underserved communities—especially MDHs, RRCs, and SCHs,—to ensure continued access to needed health care.

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We are hopeful that these suggestions are helpful to the Task Force.

The Coalition thanks you again for the opportunity to be part of this important discussion, and we look forward to serving as a resource.

Please do not hesitate to contact me at 202.204.1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman

CC: Representatives Danny Davis; Terri Sewell; Brad Wenstrup; Jodey Arrington

[6] Centers for Medicare & Medicaid Services. FY 2018 IPPS Impact File, September 29, 2017.