April 12, 2021

The Honorable Tina Smith
United States Senate
720 Hart Senate Office Building
Washington, DC 20510

The Honorable Mike Rounds
United States Senate
502 Hart Senate Office Building
Washington, DC 20510

The Honorable Deb Fischer
United States Senate
454 Russell Senate Office Building
Washington, DC 20510

The Honorable Tammy Baldwin
United States Senate
709 Hart Senate Office Building
Washington, DC 20510

Dear Senators Smith, Rounds, Fischer, and Baldwin:

The Rural Hospital Coalition supports the needs of rural communities across the country by advocating for hospitals with Rural Referral Center (RRC), Sole Community Hospital (SCH), and Medicare Dependent Hospital (MDH) designations under the Medicare program. We appreciate the opportunity to submit our policy priorities that will help promote rural infrastructure and rural economic development, and we share your belief that priorities for rural communities should be included in any infrastructure legislation that comes before Congress.

Our hospitals are as important to the sound infrastructure of rural communities as are the roads, schools, community centers, and the internet in these regions. In addition to ensuring public health and fulfilling important acute care needs, our rural hospitals are significant employers in their communities (often the largest employers), and they also make it possible for other employers to locate to our communities. Prospective employers looking to develop in a community generally look for: (1) an available, suitable work force; (2) transportation, including for finished goods; (3) access to materials; (4) schools; and (5) health care.

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 and, by extension, the overall rural infrastructure.

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.

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.[1]

These challenges have been compounded over the past 14 months, as the COVID-19 pandemic has placed an additional strain on the resources and capacities of our facilities, which, as noted above, were already operating on thin—often negative—margins and serving particularly vulnerable patient populations.

Policy Areas of Importance to the Infrastructure of Rural Communities

The Rural Hospital Coalition is largely focused on shoring up Medicare reimbursement for RRCs, SCHs, and MDHs, in order to help sustain these facilities, which, as noted above, are vital to the overall infrastructure and well-being of their rural communities. If Congress and the Administration can address and advance at least some of the proposals below, it can go a long way to shoring up our rural healthcare infrastructure.

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 CMS revisits this exception on an annual basis. Moreover, urban SCHs, MDHs and RRCs 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 CMS inexplicably did not find these considerations to be relevant or applicable to other rural safety net providers. CMS said that it would watch for negative impacts on other hospitals. Urban SCHs,

[1] Rural hospitals: The beating heart of a local economy, National Rural Health Association. January 18, 2018.

MDHs 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. Further, leaving rural SCHs uncertain from year-to-year whether CMS will maintain this exception makes it difficult to effectively plan and maximize available resources.

***Supporting RRCs and SCHs in the 340B Program*:** In 2010, Congress sought to make it easier for RRCs and SCHs—along with certain other hospital types, including Critical Access Hospitals—to participate in the 340B Program. However, many of these newly-eligible hospitals are being largely deprived of 340B Program benefits due to court decisions invalidating regulations and broadly interpreting a provision of the law excluding drugs with orphan designation from the program's drug discount requirements. Congress should clarify the 340B Program's orphan drug exclusion to explicitly limit the carve-out only to those uses for which the drug received orphan designation, by enacting **the Closing Loopholes for Orphan Drugs Act (H.R. 853)**. This effort will ensure that RRCs and SCHs (as well as other specified hospital types) benefit from the 340B Program to the extent that Congress intended, allowing these facilities to continue to provide rural communities with local access to important health care services.

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 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 September 2022).

A bipartisan House bill—**the Rural Hospital Support Act (H.R. 1887)**—would permanently extend the MDH program, among other provisions. There are currently 170 MDHs in 32 states that would benefit from this extension.

Exempting MDHs, RRCs, and SCHs from Site Neutral Payment Adjustments: 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 SCH and MDH Base Year for Annual Payments: Another policy that needs to be updated is related to how SCHs and MDHs are reimbursed by Medicare under the Inpatient Prospective Payment System. 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.

The current base years were established by Congress in statute, and CMS does not have the authority to add a new base year. Congress has occasionally added new base years, but it has been well over a decade since Congress last required an update (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, and the previously-mentioned **Rural Hospital Support Act (H.R. 1887)** would do just that by 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 331 hospitals in 47 states would benefit from the rebasing language in H.R. 1887.

Inquiring on Annual MS-DRG Adjustments: 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 (see table below, 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.

A House bill—**the Reviewing Urban and Rural Adjustment to Level Hospital Expenses and Lopsided Payments (RURAL HELP) Act (H.R. 1749)**—would help address these inequities by directing the Department of Health and Human Services (HHS) to conduct an evaluation of Medicare reimbursement rates received by both urban and rural hospitals and, depending on the results of the report, would require HHS to make necessary payment adjustments.

Weights and DRG Changes with Application of Recalibration Budget Neutrality Values Comparison Between Urban and Rural Hospitals From 2014 to 2020[2]								
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**	

******

The Coalition thanks you for your commitment to ensuring that the forthcoming infrastructure package includes provisions that will promote rural infrastructure and rural economic development. If we can provide you with additional information on any of the above proposals or answer any questions regarding the challenges that rural hospitals face, please do not hesitate to contact me at 202.204.1457 or ezimmerman@mcdermottplus.com.

Sincerely,

Eric Zimmerman

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