Congress Must Protect Rural Hospitals When Considering Site Neutral Payment Policy Changes

The Issue

As Congress examines Medicare outpatient payments across different sites of service, the unique circumstances of rural hospitals, particularly Sole Community Hospitals and Medicare Dependent Hospitals, must be considered and protected.

Background on SCHs, MDHs and the Financial Fragility of Rural Hospitals

Sole Community Hospitals (SCHs): Congress created the SCH program to maintain access to needed health services for Medicare beneficiaries in isolated communities. The SCH program ensures the viability of hospitals that are geographically isolated and thus play a critical role in providing access to care. Hospitals qualify for SCH status by demonstrating that because of distance or geographic boundaries between hospitals they are the sole source of hospital services available in a wide geographic area. There are a variety of ways in which hospitals can qualify for SCH status, but the majority qualify by being more than 35 miles from another provider.

Medicare Dependent Hospitals (MDHs): The MDH program was established by Congress with the intent of supporting small rural hospitals for which Medicare patients make up a significant percentage of inpatient days and discharges. Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare reimbursement to sustain hospital operations. Consequently, these hospitals are more vulnerable to inadequate Medicare payments than other hospitals because they are less able to cross-subsidize inadequate Medicare payments with more generous payments from private payers. Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment protections to buttress these hospitals. Congress recognized that if these hospitals were not financially viable and failed, Medicare beneficiaries would lose an important point of access to hospital services. To qualify as an MDH, a hospital must be (1) located in a rural area, (2) have no more than 100 beds, and (3) demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges.

Many patients that live in rural areas depend on SCHs and MDHs for a full complement of health care services, from primary care to sophisticated inpatient treatment. When one of these facilities closes, the consequences for the community may be more grave than in other areas.

Rural hospitals are more likely to have negative or very small operating margins, making them increasingly vulnerable to financial stress and closure. Rural hospitals often do not have the same flexibility as other hospitals to discontinue lower margin or unprofitable services. As mission driven organizations, rural hospitals often continue to offer unprofitable services, even at great financial loss, because there are no other providers to offer such services to their community.

When Considering Site Neutral Payment Policies, Congress Must Not Harm Rural Hospitals and the Communities They Serve

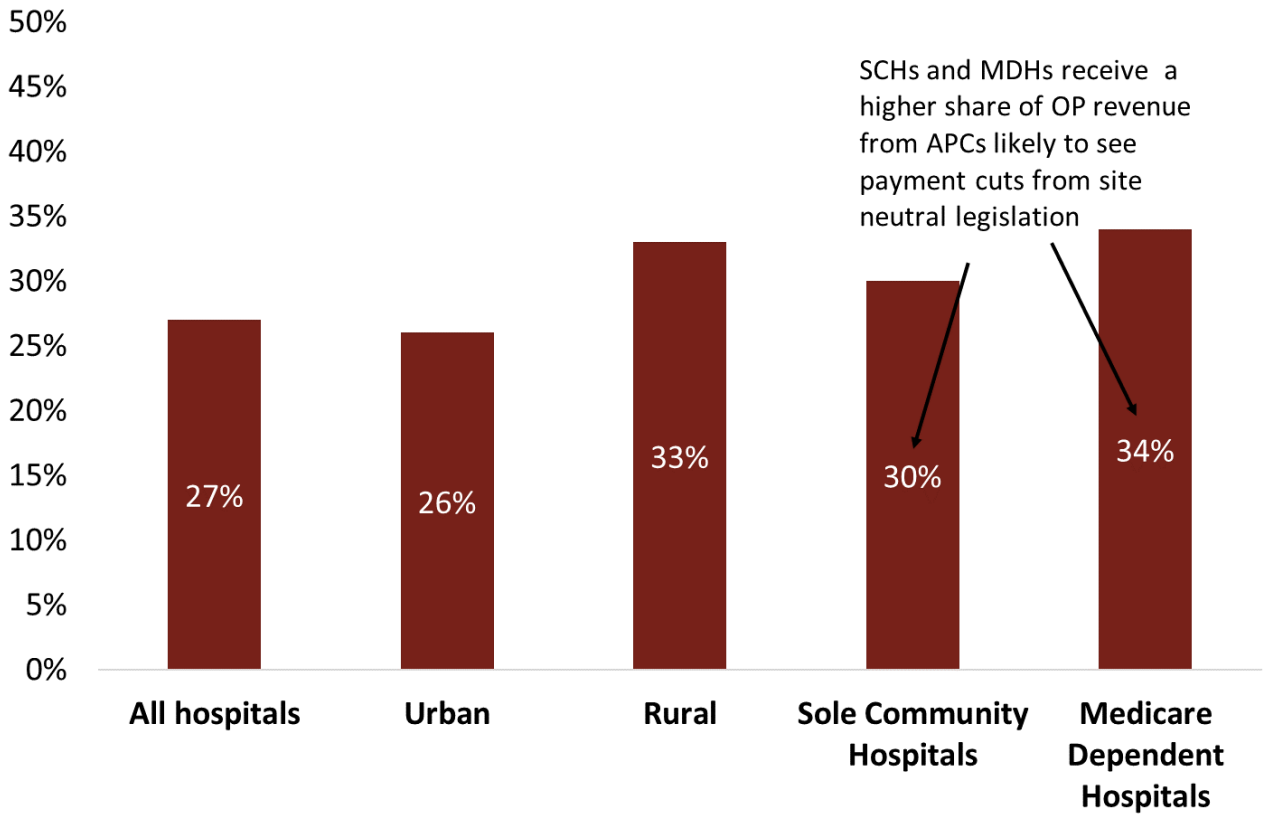
Congress has expressed an interest in legislation to align Medicare payments for commonly performed outpatient services across different sites of service—hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and physician office settings.

The Medicare Payment Advisory Commission (MedPAC) has advised that current payment variations—with HOPDs having higher payment rates for most services—encourage providers to furnish services in facility settings, which may not always be necessary, thereby increasing Medicare spending and beneficiary cost sharing. For services that can be safely provided in multiple settings, supporters of site neutral reforms assert that payment rates should be aligned across the three ambulatory settings.

The unique and fragile state of the rural health safety net needs to be carefully considered. Site neutral payment reforms could further strain rural hospitals and ultimately impact beneficiary access to care.

Rural hospitals, including SCH and MDHs receive a greater share of their outpatient revenue from services that are likely to be paid at a reduced rate through site neutral policies, further threatening their viability.

Percent of Outpatient Revenue from APCs Most Commonly Performed in Ambulatory Surgical Center or Physician Office Settings



Source: M+ analysis of 2024 IPPS Proposed Rule impacts file and 5% and 100% Medicare carrier and outpatient standard analytic files, results extrapolated for full Medicare fee-for-service population. Total HOPD spending limited to APCs paid through the outpatient prospective payment system, after removing APCs for emergency department, trauma, and critical care. Rural defined as any hospital not physically located in a metropolitan statistical area.

Site neutral payment reforms would be in part intended to motivate provider behavioral changes—i.e., services previously provided in more sophisticated, expensive HOPDs that can be safely performed in ASCs or physician offices *would migrate to* those settings when payments are aligned. Congress should not expect providers in rural areas to be able to respond as intended. For one, ASCs are largely located in urban areas. Rural areas typically lack the surgical specialists needed for ASCs, and the lower population density in rural areas makes them less attractive locations for ASCs.[1] MedPAC notes that, of ASCs that were open in 2021, 93.4% were located in urban areas, compared to just 6.6% in rural areas. As a result, beneficiaries who do not live near an ASC usually obtain ambulatory surgical services in HOPDs. Further, physician offices in rural areas are less likely to be built and equipped with the capacity to perform outpatient services likely to be subject to site neutral payment reforms, such as imaging procedures and nerve injections. If rural hospitals cannot migrate surgical procedures and other sophisticated services to ASCs or physician offices, they will endure payment cuts without being able to respond to the intended behavioral stimuli. SCHs and MDHs are particularly vulnerable to site neutral payment changes. These hospitals are often the sole source of care in their communities, and so cannot expect other hospitals to pick-up unprofitable services.

Stop Loss Provisions Must Protect Rural Hospitals

One proposed solution to lessen payment losses is to provide stop loss protections to hospitals with a disproportionate share patient percentage (DPP) that exceeds the national median, capping such hospitals' reductions in Medicare payments at a specified percentage over a specified period of time. Proposed DPP formulas would benefit hospitals that have a large share of Medicaid inpatients that are not covered through Medicare. This approach to protecting safety net hospitals would not work for MDHs.

MDHs are by definition required to have at least 60% of their inpatient days attributable to Medicare beneficiaries. The greater the share of inpatient days attributable to Medicare beneficiaries, the lower the possible share of inpatient days that can be attributable to Medicaid beneficiaries not covered through Medicare. Only 28% of MDHs are above the DPP median, compared to 50% of all hospitals.

Conclusion

SCHs and MDHs are in dire financial straits, and more payment cuts could force more closures. The Alliance for Rural Hospital Access encourages Congress, when working to refine payment policies to better align incentives and protect beneficiaries, to keep in mind the need to balance these policies with the need to protect beneficiaries' access to care in rural communities.

Payment policy changes that cause beneficiaries to lose access to hospital services will not serve beneficiary or taxpayer interests. To prevent such consequences, Congress should exempt certain rural hospitals, such as SCHs and MDHs, from proposed site neutral policy changes.

[1] https://www.medpac.gov/wp-content/uploads/2023/03/Ch5_Mar23_MedPAC_Report_To_Congress_SEC.pdf

ALLIANCE FOR RURAL HOSPITAL ACCESS

Congress must ensure that any legislative efforts to enact additional site neutral payment policies include appropriate exceptions that protect financially-vulnerable SCHs and MDHs, recognizing the unique role these facilities play in providing access to critical health care services in their communities.

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