September 28, 2023

Submitted via email: WMAccessRFI@mail.house.gov

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Re: Addressing Chronic Disparities in Access to Health Care in Rural and Underserved Communities

Dear Chairman Smith—

The Alliance for Rural Hospital Access (ARHA, or the Alliance) appreciates your commitment to improving rural health care and is pleased to submit this response to your request for information (RFI) on addressing chronic disparities in access to health care in rural and underserved communities. Our comments address the RFI topics pertaining to geographic payment differences, providing sustainable financing, improving the health care workforce, and aligning sites of service.

The Alliance is comprised of hospitals designated as Medicare-Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs) and Rural Referral Centers (RRCs) under the Medicare program. MDHs, SCHs and RRCs provide rural populations with local access to a wide range of health care services. In doing so, they localize care, minimize the need for further referrals and travel, and provide services at costs lower than their urban counterparts. These hospitals also commonly establish satellite sites and outreach clinics to provide primary and emergency care services to surrounding underserved communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close.

Background on Rural Hospital Designations

Medicare Dependent Hospitals: 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. As such, 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.

Sole Community Hospitals: 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.

Rural Referral Centers: Congress established the RRC program to support rural hospitals that treat a large number of complicated cases and function as regional referral centers. Generally, to be classified as an RRC, a hospital has to be physically located outside a Metropolitan Statistical Area (indicating an urban area) and either have at least 275 beds or meet certain case-mix or discharge criteria.

Challenges Facing MDHs, SCHs and RRCs

MDHs, SCHs and RRCs are often the sole source of care within and around a community. Many patients who live in rural 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, SCH or RRC closes, the consequences for the community may be graver than otherwise.

According to data on rural hospital closures compiled by the Cecil G. Sheps Center for Health Services Research (or Sheps Center), there have been 199 rural hospital closures and conversions since January 2005. This number includes 101 complete closures, 10 rural emergency hospital (REH) conversions, and 88 converted closures (defined as facilities no longer providing inpatient services but continuing to provide some health care services such as primary care or long-term care). Many more are paring unsustainable service lines, like obstetrics. The US Government Accountability Office (GAO) found that when rural hospitals close, people living in areas who receive care from them must travel farther to get the same services—about 20 miles farther for common services like inpatient care, and about 40 miles for less common services like alcohol or drug abuse treatment. Further, according to 2023 data from the Center for Healthcare Quality & Payment reform, more than 600 rural hospitals—nearly 30% of all rural hospitals in the country—are at risk of closing because of the serious financial problems they are experiencing.

Hospitals in rural communities often confront extremely difficult financial circumstances and tend to have negative or very small operating margins, making them increasingly vulnerable. Additional Medicare reimbursement reductions impose further financial strain, compromising rural hospitals' ability to serve their 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, rural hospitals often will continue to offer services, even at great financial loss, because there are no other providers offering those services.

In addition to negatively affecting patient care, the deteriorating rural health safety net also impacts the local economies that often depend on these hospitals as large employers in the communities they serve.[1] These financial challenges were compounded over the past several years during the COVID-19 pandemic, which placed an additional strain on the resources and capacities of rural hospital that were already operating on thin—often negative—margins and serving particularly vulnerable patient populations.

Recommendations for Committee Action

Congress has repeatedly reconfirmed its commitment to MDHs, SCHs and RRCs over the years by providing new protections to ensure their viability in rural communities. ARHA and its members share this goal of ensuring that federal hospital payment policies recognize the unique role and contributions these hospitals bring to the Medicare program and its beneficiaries.

Consistent with this mission, and in response to the committee's request for feedback on topics pertaining to addressing geographic payment differences, providing sustainable financing, improving the health care workforce, and aligning sites of service, the Alliance requests that the Committee on Ways and Means consider and advance legislation that would:

- Permanently extend the MDH program and low-volume hospital payment adjustment
- Update the base years for SCHs and MDHs paid on the basis of their hospital-specific rate
- Address rural health care workforce shortages by ensuring SCHs and MDHs paid using their hospital-specific rate receive IME adjustments, to encourage these hospitals to localize resident training in rural areas
- Reimburse rural hospitals fairly for uncompensated care by ensuring SCHs and MDHs paid on the basis of their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation
- Direct the Centers for Medicare and Medicaid Services (CMS) to extend rural SCH site-neutral exemptions to urban SCHs and MDHs
- Direct CMS to extend the rural SCH 7.1% payment adjustment to urban SCHs, and to study the appropriateness of making a similar payment adjustment for MDHs
- Ensure that any congressional efforts to enact additional site-neutral payment policies include appropriate exceptions that protect financially-vulnerable SCHs and MDHs, recognizing the unique role these facilities have in their communities.

[1] *Rural hospitals: The beating heart of a local economy*. June 2018. https://www.ruralhealth.us/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ

Permanently Extend the MDH Program and Low-Volume Adjustment

The MDH program and the low-volume hospital payment adjustment are support mechanisms that were created by Congress decades ago, and have traditionally been reauthorized together for limited periods. The current authorization runs through September 30, 2024, requiring Congress to enact another extension before the final quarter of the 118th Congress.

A permanent extension of these critical programs would bring more predictability and consistency to the rural hospitals that rely upon these payments to remain financially viable. This stability is often lacking with short-term extensions, given that hospitals cannot factor these payments into their budgets for the years in which they are due to expire.

The Alliance strongly supports the Rural Hospital Support Act (S. 1110), legislation reintroduced earlier this year by Senators Chuck Grassley (R-IA) and Bob Casey (D-PA) that would permanently extend the MDH program and low-volume adjustment. We look forward to the introduction of similar legislation in the House.

Enacting the provisions of S. 1110 well in advance of the September 30, 2024, deadline would provide vulnerable hospitals with more predictable Medicare reimbursements and greater financial stability, and we urge the committee to take up these provisions at its earliest convenience. This effort addresses the committee's request for comment on policies that support the long-term health of medical facilities to ensure access to care for patients in rural and underserved areas.

Update the Base Years for SCHs and MDHs

S. 1110 contains additional provisions that would better enable SCHs and MDHs to continue to provide high quality, cost-efficient care to the rural populations they serve.

Under Medicare's Inpatient Prospective Payment System (IPPS), SCHs and MDHs are paid the greater of the federal rate (i.e., the payment that the hospital would otherwise receive under the IPPS) 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 (in the case of MDHs, the hospital receives 75% of that difference).

Hospital-specific rates are tied to a hospital's costs in a specified year. For SCHs, the years are 1982, 1987, 1996 or 2006, and for MDHs, the years are 1982, 1987 or 2002. These years are overdue to be updated, and S. 1110 would provide for a more recent base year for both SCHs and MDHs. Updating and modernizing these base years would also address the committee's request for comment on policies that support the long-term health of medical facilities to ensure access to care for patients in rural and underserved areas.

Advance Workforce Legislation that Provides Fair IME Adjustments to SCHs and MDHs

Rural health care workforce shortages are well-documented, and Alliance hospitals can help alleviate physician shortages if they have adequate resources. Specifically, SCHs and MDHs are

well-situated to host residency programs, but SCHs and MDHs paid on the basis of their hospital-specific rate (as detailed above) are financially disincentivized to establish such programs.

If a hospital paid on the basis of the federal (or IPPS) rate initiates a teaching program, it receives both Direct Medical Education (DME) and Indirect Medical Education (IME) payments. While SCHs and MDHs paid on the basis of their hospital-specific rate *do* qualify to receive DME payments, they do *not* receive IME payments.

SCHs and MDHs—which comprise nearly 80% of hospitals eligible to establish training programs in rural communities—should receive the same incentives and financial buffer as hospitals paid under the federal rate. Based on CMS cost report data, 58% of SCHs and 46% of MDHs are paid on the basis of their hospital-specific rate. This formula for SCHs and MDHs should not disqualify the hospital from receiving full IME payments as they would under the federal rate formula. This full federal funding of DME and IME payments is necessary to establish and operate rural-based residency training programs.

The Alliance encourages the committee to include such a provision in any workforce package it considers this Congress. This proposal would address the committee's request for comment on policies to revitalize the health care workforce in order to improve patient access to care in rural and underserved areas.

Advance Legislation to Equitably Reimburse SCHs and MDHs for Uncompensated Care

Similarly, if a hospital paid on the basis of the federal rate serves a disproportionate number of low-income patients, it receives an increased payment under the Medicare disproportionate share hospital (DSH) payment adjustment, along with an uncompensated care pool allocation. However, DSH-eligible SCHs and MDHs that are paid under the hospital-specific rate do not receive hospital-specific payment adjustments to compensate them for uncompensated care.

This highlights another inequity that exists between the two payment mechanisms, and this discrepancy continues to undermine the viability of rural safety net hospitals. SCHs and MDHs that are paid under the hospital-specific rate should receive the *same* financial protections if they have high rates of uncompensated care, through the receipt of a DSH payment adjustment and an uncompensated care pool allocation.

Providing SCHs and MDHs with equitable and appropriate compensation will allow for greater financial stability for these important safety net hospitals, so they can continue sustaining their communities. The Alliance urges the committee to consider this inequity when crafting legislation to protect and sustain access to care in rural America, and notes that this proposal would also address the committee's request for comment on policies that support the long-term health of medical facilities to ensure access to care for patients in rural areas.

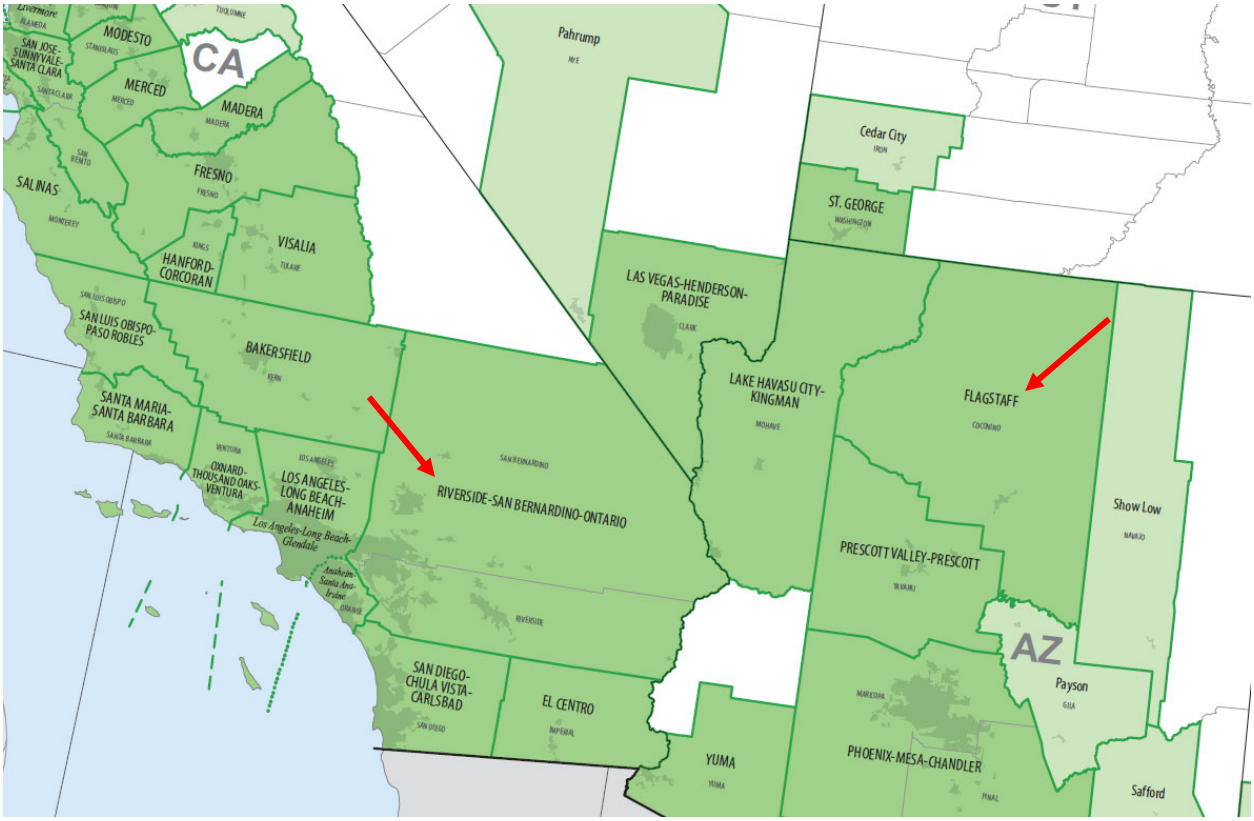
Direct CMS to Extend Rural SCH Site-Neutral Exemptions to Urban SCHs and MDHs

Under the Medicare outpatient prospective payment system (OPPS), CMS pays a "PFS-equivalent" rate of 40 percent of the OPPS payment rate for hospital outpatient clinic visits

coded under HCPCS G0463 when delivered by a previously excepted off-campus provider-based department. Beginning in CY 2023, CMS now exempts from this payment reduction services furnished by excepted off-campus provider-based departments of *rural* SCHs.

For years, the Alliance has been urging CMS to reconsider the site neutral policy, and to exempt SCHs and MDHs from it. While we were pleased that CMS determined to exempt *rural* SCHs, we were dismayed that the agency did not extend the same relief to *urban* SCHs and MDHs. These hospitals are similarly disadvantaged by the site neutral policy; Congress should direct CMS to provide a similar exemption.

CMS uses Metropolitan Statistical Areas (MSAs) to delineate between urban and rural areas. While the Alliance appreciates the need to distinguish urban and rural for a number of payment and policy mechanisms, MSAs are an imprecise tool for differentiating urban and rural areas. Given that MSAs use counties as building blocks, many areas are designated as "urban" because they have a single urbanized area. But if the county is unusually large, significant portions of that county may be as rural as the most isolated frontier area. Using MSAs to identify urban and rural areas is particularly problematic in the western United States where there are many very large counties that comprise MSAs (see, for example, San Bernardino County in California and Flagstaff and Pima Counties in Arizona).



There are instances where an SCH is designated urban by CMS, but the hospital is actually a considerable distance from the nearest urbanized area. Verde Valley Medical Center (Provider Number 03-0007), for example, is located in Prescott, AZ and is considered an urban SCH.

However, the closest urbanized area with more than 40,000 people is Flagstaff, AZ, which is nearly 100 miles away.[2] Verde Valley has undergone an urban-to-rural reclassification, so it is eligible for these protections. Hospitals like Methodist Hospital South (45-0165) in Jourdanton, Texas have not undergone urban-to-rural reclassification, and so are not eligible for these protections. These are not urban areas by most reasonable standards, except the MSA standard.

For these reasons, CMS should extend this exemption to urban SCHs because using MSAs to determine urban and rural areas is imprecise, and distinguishing between urban and rural SCHs when applying payment policy unfairly disadvantages urban SCHs that are the sole source of hospital services in their communities, like their rural counterparts. Urban SCHs are serving communities that are truly rural in character. In fact, as CMS knows, to be an *urban* SCH, a hospital has to be even further (35 miles) from another hospital to qualify than if it were a *rural* hospital. CMS also can reduce incentives to undergo urban-to-rural reclassification to take advantage of these protections.

Regarding MDHs, GAO data shows that Medicare profit margins and total hospital profit margins declined for MDHs from fiscal year 2011 through 2017, from -6.9 percent to -12.9 percent and 1.6 percent to -0.2 percent, respectively. [3] The degree to which Medicare margins declined for MDHs during this time period (6 percentage points) was greater than the degree to which they declined for rural hospitals (3.8 percentage points) and all hospitals (2.5 percentage points). The number of MDHs declined 28 percent from 193 hospitals in fiscal year 2011 to 128 hospitals in 2017 as hospitals became ineligible for MDH status, and 16 closed between 2013 and 2017, or experienced other changes.[4]

Taken together, supporting SCHs and MDHs by ensuring they receive the site neutral exemption would help secure access to care in rural and underserved communities. Rural SCHs, urban SCHs and MDHs are often the sole health care providers in isolated areas where health care access is lacking. Our analysis shows that 56 percent of rural SCHs, 73 percent of urban SCHs, and 60 percent of MDHs are located in at least one type of medically underserved area as defined by Health Resources and Services Administration (HRSA) Medically Underserved Area designations.

Hospital Type	Hospital Count	Hospitals in MUA	Percent
Rural Sole Community Hospital	448	251	56%
Urban Sole Community Hospitals redesignated as rural under § 412.103	77	33	43%
Urban Sole Community Hospitals *(not redesignated as rural)*	15	11	73%
Medicare Dependent Hospital	169	102	60%

M+ Analysis of Medically Underserved Area (MUA)[5] designations from HRSA.

[2] Metropolitan and Micropolitan Statistical Areas of the United States and Puerto Rico, US Census Bureau. July 2015. https://www2.census.gov/geo/maps/metroarea/us_wall/Jul2015/cbsa_us_0715.pdf
[3] GAO, Information on Medicare-Dependent Hospitals, GAO-20-300 (Washington, D.C.: February, 2020). https://www.gao.gov/assets/gao-20-300.pdf
[4] GAO, Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors, GAO-18-634 (Washington, D.C.: Aug. 29, 2018). https://www.gao.gov/products/gao-18-634
[5] A hospital is determined to be in a Medically Underserved Area (MUA) if the hospital's main address meets the requirement of at least one MUA designation type based on either geographic area, specific

The Alliance shared this analysis and recommendations with CMS in the 2023 rulemaking cycle. CMS declined to make the recommended changes, relying on a 2005 study of resource costs that found higher resource costs in *rural* SCHs, and noting that the 2003 legislation that required that 2005 study demonstrated that "Congress did not determine that any of these hospital types required additional payments for outpatient services."

For these reasons, the Alliance encourages the committee to direct CMS to extend rural SCH site-neutral exemptions to urban SCHs and MDHs. This proposal would address the committee's request for comment on policies to improve existing payment methodologies to end the perpetuation of historical payment inequities.

Direct CMS to Extend the Rural SCH 7.1% Payment Adjustment to Urban SCHs, and Study the Appropriateness of Making a Similar Payment Adjustment for MDHs

Under current CMS policy, Medicare payments to rural SCHs for outpatient services are increased by 7.1 percent. CMS makes this adjustment because it found that, pursuant to a study required by Congress,[6] compared to urban hospitals, rural SCHs have substantially higher costs, and need a payment adjustment to be comparably treated under the OPPS.

For the reasons set forth in the previous section, the Alliance has continually urged CMS to extend the rural SCH 7.1% payment adjustment to urban SCHs as well, and to study the appropriateness of making a similar payment adjustment for MDHs. CMS has not made these changes, and has stated that it does not have the authority to do so because Congress specified that the policy apply to rural hospitals.

As noted above, CMS uses MSAs to delineate between urban and rural areas, though MSAs are not the most precise tool for actually characterizing urban and rural areas. As a result, there are instances where an SCH is designated urban by CMS, but the hospital is actually a considerable distance from the nearest urbanized area.

By specifying that the 7.1% adjustment applies to *all* SCHs, as well as MDHs, Congress can provide another mechanism to contribute to increased financial stability for rural hospitals. As such, we urge the committee to clarify its intent with respect to these adjustments. This proposal would address the committee's request for comment on policies to improve existing payment methodologies to end the perpetuation of historical payment inequities.

Protect MDHs and SCHs from Site-Neutral Payment Reductions

As noted throughout these comments, MDHs and SCHs are in dire financial straits. More cuts will force further closures. The Alliance concurs that payment policies could be refined to better align payment incentives and protect beneficiaries, but we also encourage Congress to balance

population characteristics of that geographic area (i.e., homeless population), or a governor's designation. For detail, please refer to the Health Resources and Services Administration website: https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation

[6] § 411(b), Pub. L. No. 108-173.

beneficiary financial protection with beneficiary access to care. Payment policy changes that cause beneficiaries to lose access to hospital services will not serve beneficiary or taxpayer interests. As the Ways and Means Committee considers equalized payment policies that lower costs while preserving access to care, it can and should exempt certain rural hospitals from cuts, create stop loss provisions, or at the very least delay or phase in changes for select rural providers.

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Thank you for your consideration of these comments. The Alliance appreciates your commitment to improving rural health care, and we look forward to continuing to serve as a resource to your committee staff on these efforts. Please contact me at 202.204.1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman