March 14, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: Preventing Rural Hospital Closures

Dear Administrator Brooks-LaSure—

The Alliance for Rural Hospital Access (ARHA, or the Alliance) appreciates your efforts to improve rural healthcare. We read with interest your comments to the American Medical Association on February 13, 2024, during which you noted that the Centers for Medicare and Medicaid Services (CMS) is considering ways to slow the rate of rural hospital closures, including both regulatory actions and legislative steps that Congress could take.

The Alliance is grateful for this commitment and we're reaching out today to share with you a number of proposals—both regulatory and legislative, summarized here and set forth in greater detail below—that would improve rural hospitals' financial stability and viability, in order to ensure continued access to care in rural communities:

- **Outpatient Prospective Payment System (OPPS)**
  - CMS should extend rural Sole Community Hospital (SCH) site-neutral exemptions to urban SCHs and Medicare Dependent Hospitals (MDHs).
  - CMS should extend the rural SCH 7.1% payment adjustment to urban SCHs, and study the appropriateness of making a similar payment adjustment for MDHs.
- **Inpatient Prospective Payment System (IPPS)**
  - CMS should use its authority to ensure SCHs and MDHs paid using their hospital-specific rate receive Indirect Medical Education (IME) adjustments, to encourage these hospitals to localize resident training in rural areas.
  - CMS should use its authority to reimburse rural hospitals fairly for uncompensated care by ensuring SCHs and MDHs paid using their hospital-specific receive a disproportionate share hospital (DSH) payment adjustment and an uncompensated care pool allocation.
- **Congressional Action**
  - CMS should urge Congress to permanently extend the MDH program and low-volume hospital payment adjustment.
  - CMS should urge Congress to update the base years for SCHs and MDHs paid on the basis of their hospital-specific rate.

- CMS should encourage Congress to 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 have in their communities.

Background on the Alliance and Rural Hospital Designations

The Alliance is comprised of hospitals designated as MDHs, 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 communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close.

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, patients 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

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 Regulatory and Legislative Action

Congress and CMS have reconfirmed their commitment to these hospitals repeatedly over the years by providing new protections to ensure their viability and to ensure patient access to hospital services in rural communities. ARHA and its members share this goal of ensuring that federal hospital payment policies recognize the unique role and important contributions these hospitals bring to the Medicare program and its beneficiaries. Consistent with this mission, the Alliance encourages CMS to take the following steps to protect rural hospitals and the communities they serve.

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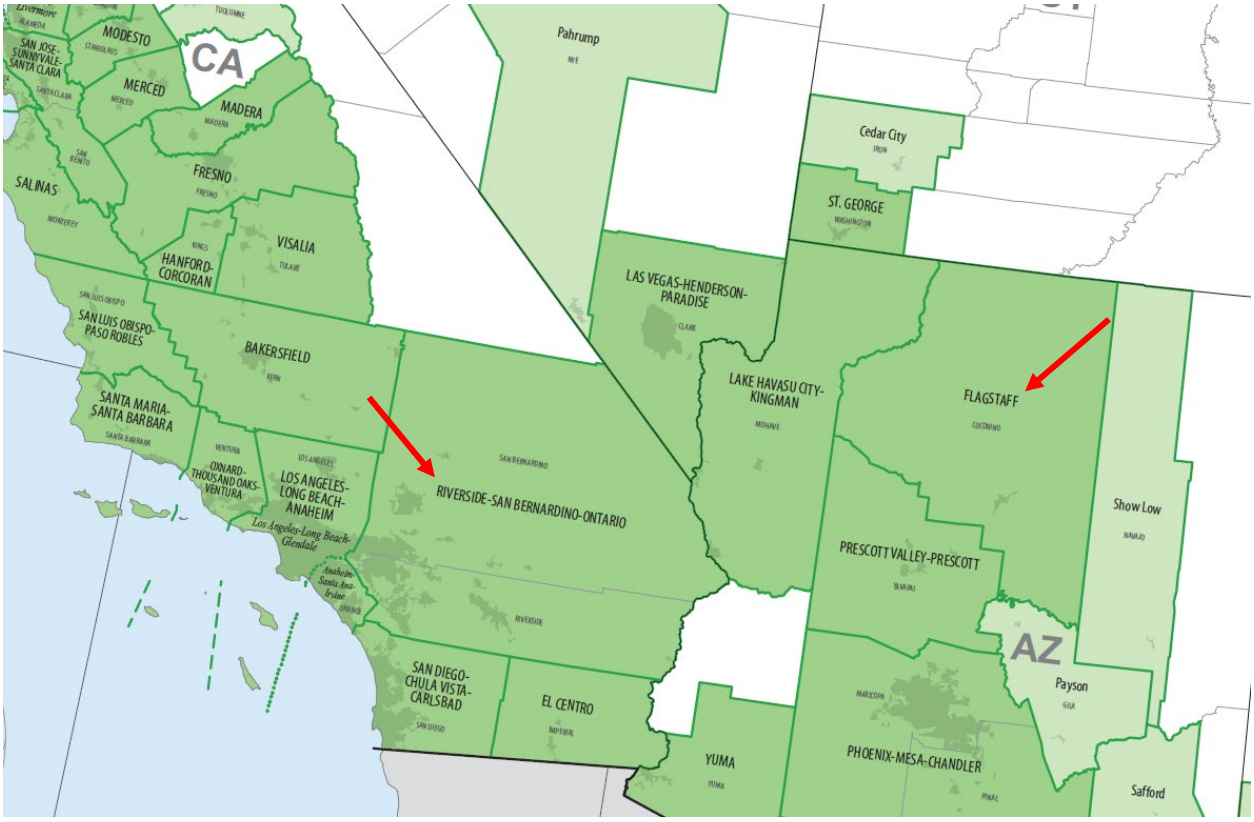
[1] *Rural hospitals: The beating heart of a local economy*. June 2018. https://www.ruralhealth.us/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ

<u>OPPS</u> – Extend Rural SCH Site-Neutral Exemptions to Urban SCHs and MDHs

Under the Medicare 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 began exempting from this payment reduction services furnished by excepted off-campus provider-based departments of *rural* SCHs.

In our previous OPPS comment letters, the Alliance urged 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 remain dismayed that CMS has not extended the same relief to *urban* SCHs and MDHs. These hospitals are similarly disadvantaged by the site neutral policy and CMS should 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]

Ensuring that SCHs and MDHs receive the site neutral exemption would help protect 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.

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[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

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.

When we shared this analysis with CMS in the 2023 rulemaking cycle, the agency 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."

We respectfully urge CMS to reconsider this position. Doing so would be a concrete, data-driven way to bolster the financial stability of rural hospitals.

OPPS – 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 also urged CMS in previous OPPS comment letters 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. The Alliance is disappointed that CMS has not made these changes.

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.

If CMS believes it does not have the authority to make these changes because Congress specified that the policy apply to rural hospitals, then the Alliance encourages CMS to urge Congress to legislatively specify that the 7.1% adjustment applies to *all* SCHs, as well as MDHs. This would be another step by which CMS could provide increased financial stability for rural hospitals.

[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 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.

<u>IPPS</u> – Ensure SCHs and MDHs Paid Using Their Hospital-Specific Rate Receive IME Adjustments

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 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 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 urges CMS to use its authority to ensure SCHs and MDHs paid using their hospital-specific rate receive IME adjustments, to encourage these hospitals to localize resident training in rural areas.

<u>IPPS</u> – Ensure SCHs and MDHs Paid Using Their Hospital-Specific Rate Receive a DSH Payment Adjustment and an Uncompensated Care Pool Allocation

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 DSH payment adjustment, along with an uncompensated care pool allocation. However, DSH-eligible SCHs and MDHs that are paid using their 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. As such, the Alliance urges CMS to use its authority to reimburse rural hospitals fairly for uncompensated care by ensuring SCHs and MDHs paid using their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation.

<u>Legislation</u> – Urge Congress to 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 December 31, 2024, requiring lawmakers to enact another extension before the end 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.

Enacting the provisions of S. 1110 well in advance of the December 31, 2024, deadline would provide vulnerable hospitals with more predictable Medicare reimbursements and greater financial stability, and we encourage CMS to urge Congress to take up these provisions at its earliest convenience.

<u>Legislation</u> – Urge Congress to 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 the 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 support the long-term health of medical facilities to ensure access to care for patients in rural and underserved areas. As such, we encourage CMS to urge Congress to enact these provisions of S. 1110 as well.

<u>Legislation</u> – Urge Congress to 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 also believes that Congress must balance

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 Congress considers equalized payment policies that lower costs while preserving access to care, we encourage CMS to encourage lawmakers to exempt SCHs and MDHs from such cuts.

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The Alliance appreciates your commitment to protecting rural hospitals and improving rural healthcare. We would be pleased to discuss any of these initiatives in greater detail with you or a member of your team. Please contact me at 202.204.1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman