May 20, 2024

Submitted via email: Statementsfortherecord@finance.senate.gov

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Statement for the Record – Rural Health Care: Supporting Lives and Improving Communities

Dear Chairman Wyden—

The Alliance for Rural Hospital Access (ARHA, or the Alliance) thanks you for your commitment to improving rural health care and is pleased to submit this statement for the record following the committee's May 16, 2024 hearing titled *Rural Health Care: Supporting Lives and Improving Communities*.

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.

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.

As part of your efforts to support and improve rural health, the Alliance requests that the Committee on Finance 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 indirect medical education (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 Medicare disproportionate share hospital (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.

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 Congress 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. This concern was raised by Senator Chuck Grassley (R-IA) during the hearing, and Dr. Keith Mueller agreed, stressing that rural hospitals should not have to expend limited time and resources working

through the budgetary implications of the potential expiration of these programs and worrying about what will happen if the funding runs out.

The Alliance strongly supports the Rural Hospital Support Act (S. 1110), legislation reintroduced earlier this year by Senators Bob Casey (D-PA) and Grassley 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 urge the committee to take up these provisions at its earliest convenience.

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. We encourage the committee to advance these provisions as well.

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 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.

During the hearing, Senator Catherine Cortez Masto (D-NV) raised the issue of ensuring that SCHs and MDHs paid on the basis of their hospital-specific rate receive IME adjustments, and Dr. Mueller agreed that SCHs and MDHs that train residents should receive fair incentives, and that addressing this gap in Medicare payment is one policy lever that would help address rural workforce shortages.

The Alliance has repeatedly asked CMS to use its authority to make this adjustment, but CMS has declined to take action. As such, in order for this policy to be advanced, the Alliance encourages the committee to include it in any rural health/workforce package it considers this Congress.

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 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.

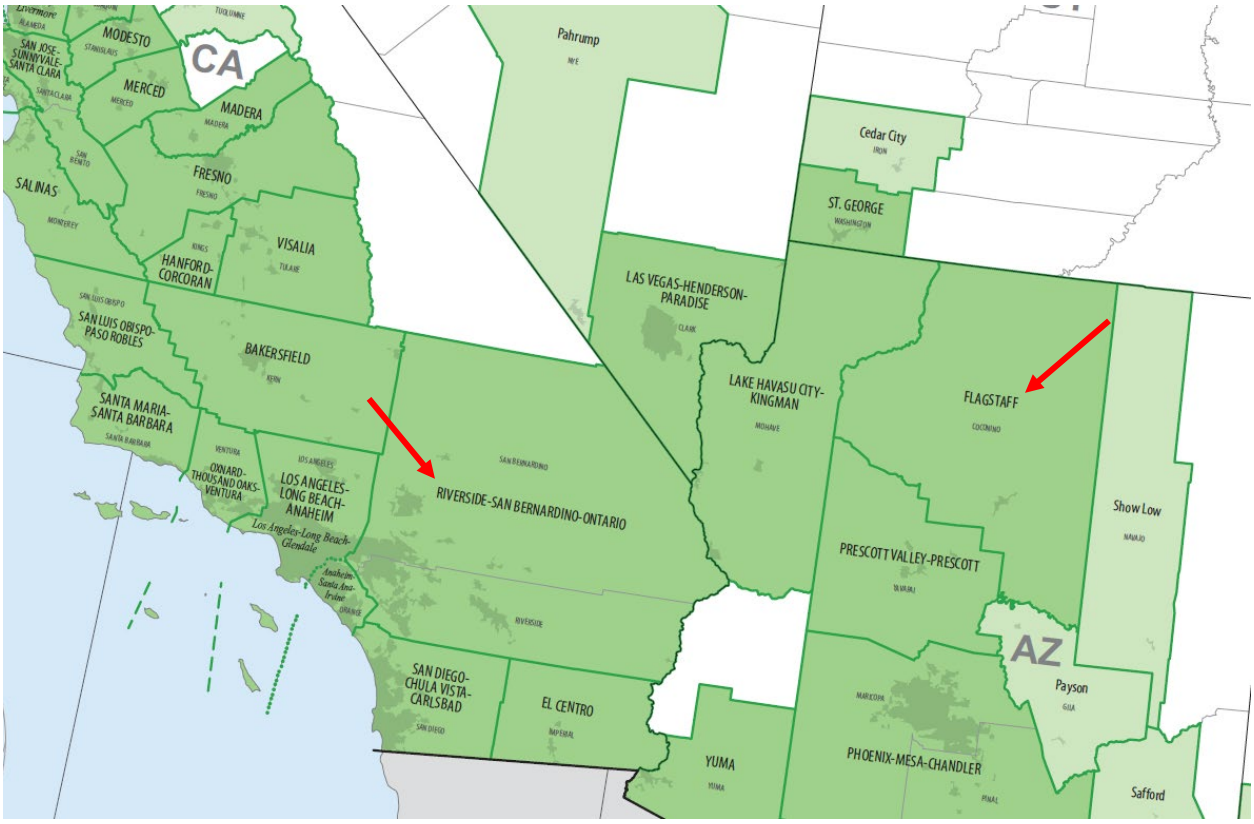
Providing SCHs and MDHs with equitable and appropriate compensation will allow for greater financial stability for these important safety net hospitals, so they can continue sustaining their communities. Again, the Alliance has repeatedly asked CMS to use its authority to fix this inequity, but CMS has declined to act. The Alliance therefore urges the committee to consider this inequity when crafting legislation to protect and sustain access to rural health care.

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.[1] 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.

[1] 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

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. [2] 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.[3]

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)[4] designations from HRSA.

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

[2] GAO, Information on Medicare-Dependent Hospitals, GAO-20-300 (Washington, D.C.: February, 2020). https://www.gao.gov/assets/gao-20-300.pdf

[3] 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

[4] 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

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.

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,[5] 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 Congress' intent with respect to these adjustments.

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 beneficiary financial protection with beneficiary access to care.

Site neutral payment reforms would be in part intended to motivate provider behavioral changes—i.e., services previously provided in hospital outpatient departments (HOPDs) that can be safely performed in ambulatory surgical centers (ASCs) or physician offices would migrate to those settings when payments are aligned. However, lawmakers should not expect providers in rural areas to be able to respond as intended, as 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. The Medicare Payment Advisory Commission (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

[5] § 411(b), Pub. L. No. 108-173.

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.

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.

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 SCHs and MDHs from proposed site neutral policy changes.

* * * * * * * * * * *

Thank you for your consideration of the proposals set forth in this statement. 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