October 15, 2023

Chairman Jodey Arrington
House Budget Committee
1107 Longworth House Office Building
Washington, DC 20515

Chairman Michael Burgess
House Budget Committee Health Care Task Force
204 Cannon House Office Building
Washington, DC 20515

Dear Chairman Arrington, Chairman Burgess, and Members of the Budget Committee and Health Care Task Force,

The National Rural Health Association (NRHA) thanks the Chairmen and members of the Task Force for putting forth this request for information regarding the actions Congress may take to improve health outcomes while lowering healthcare spending. We appreciate the chance to provide information and policy solutions on important issues facing rural health care and look forward to working together to increase access to quality care for rural residents while reducing spending.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. NRHA works to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA recognizes the importance of prioritizing and modernizing the healthcare system to empower medical professionals to effectively serve patients in rural communities. Within this response, we examine some of the financial challenges facing rural health, address current inefficiencies that hinder health outcomes, and propose solutions to maximize the value of the healthcare provided to rural Americans.

Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending.

Rural hospitals.

NRHA asks that Congress permanently end the 96-hour average length of stay rule for CAHs. Relatedly, NRHA urges Congress to remove the condition of payment that requires physicians to certify upon admission that a patient can reasonably expect to be discharged within 96 hours. Annual average lengths of stay and certification requirements are too prohibitive as rural hospitals need flexibility to treat patients as clinically appropriate in a local setting, while adjusting to larger system fluctuations like infectious disease surges and delays in post-acute placement as described above. We ask that the Committee advance H.R. 1565, the Critical Access Hospital Relief Act, out of Committee. For the average length of stay, the Committee should introduce legislation immediately to remove this outdated rule.

NRHA views the requirement for beneficiaries to have a 72-hour qualifying hospital stay before admission to a SNF as an outdated barrier to placing beneficiaries in the appropriate care setting. This requirement should be removed. Due to advances in treatment for many conditions, like joint replacements, hospital stays and recovery are more short-term. In the past, a procedure would have a longer length of stay in acute care before transfer, but oftentimes that is not the case now and hospitals should be able to appropriately move beneficiaries to rehabilitative care. Congress should

also allow for direct admission to hospital swing beds for patients who do not require acute care and otherwise meet SNF admission criteria for many of the same reasons. This would help rural beneficiaries receive care when showing signs of declining health without waiting to deteriorate further or get sicker. Preventively allowing patients in swing beds would ultimately achieve cost savings for providers, the government, and beneficiaries while supporting patient safety and access.

Modernizing Rural Health Clinic Administration and Payment Methodologies.
Rural Health Clinics (RHCs) are a bedrock of the rural health safety net. Over 5,300 RHCs across 45 states provide vital access to primary care services to rural residents. RHCs serve 37.7 million patients per year which is more than 11% of the entire population and over 60% of the 60.8 million Americans that live in rural areas. The RHC statute has not been updated since Congress passed it in 1977 but health care practice and delivery have changed. H.R. 3730/S. 198, the RHC Burden Reduction Act, includes several important updates to help RHCs operate with less administrative burden and better serve patients. This legislation comes at little or no cost to taxpayers but would have significant impacts on RHCs.

NRHA urges Congress to address harmful modifications to the provider-based RHC payment methodology that occurred in the CAA, 2021, which caused unintended consequences for provider-based RHCs and jeopardizes access to care. NRHA recommends that Congress implement a quality measure reporting program in exchange for enhanced reimbursement to offset the payment methodology change. On average, RHCs have been less involved in quality measure reporting and value-based care initiatives than other Medicare designations. Through this policy, Congress will receive data on the RHC program that has been historically unavailable. Additionally, this will keep the provider-based RHC program stable for the creation of additional RHCs affiliated with small rural hospitals to meet future needs. House legislation from the 117th Congress, H.R. 5883, the Rural Health Fairness in Competition Act, provides a framework for addressing this issue in the current Congress. For more information, please see our letter to House and Senate leadership from the 117th Congress.

Price transparency.
NRHA is concerned by recent legislative efforts to increase and expand hospital price transparency. Complying with the price transparency requirements is costly and burdensome for rural facilities. Rural hospitals that cannot afford to comply may be subject to expensive and automatic civil monetary penalties. NRHA supports amending the hospital price transparency statute to exempt rural hospitals. In the meantime, we also support CMS offering one on one technical assistance to rural hospitals and granting a grace period for review and compliance with requirements.

Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes.

Innovative models.
Fee-for-service (FFS) reimbursement does not align with the reality of operating rural hospitals and providers, mainly due to low patient volumes. Value-based care, or population-based payment models, have the potential to solve for rural low-volume challenges that come along with FFS payment. However, CMS' Innovation Center (CMMI) has struggled to properly include rural providers in its models, in some circumstances due to statutory barriers. Congress charged CMMI with developing and testing new payment and service delivery models that must achieve cost savings. The decades of underinvestment in rural health care delivery makes achieving cost savings virtually impossible. Alternative payment methodologies for rural providers and higher acuity patient mix can create additional barriers to model integration. In some cases, CMMI has explicitly excluded some rural providers from taking part in their models. Most recently Rural Health Clinics (RHCs) were cut

out of the new Making Care Primary model and NRHA expressed its deep disappointment in this choice. Another barrier is the requirement on the number of attributed beneficiaries for providers which cuts out rural because of sparsely populated patient populations and lower volumes.

Congress should direct investments to building out and supporting rural providers in value-based care. The Committee should grant greater authority to the HHS Secretary, through CMMI, to develop and implement voluntary alternative rural payment models. Such models should include a global budget or enhanced cost-based reimbursement. In addition, NRHA believes that exempting rural providers from CMMI's cost-savings mandate would alleviate some barriers to entry in innovative demonstration projects. Congress must equip CMMI with the authority to waive the cost savings requirement in order to develop rural-centric models or to allow rural providers to engage in CMMI models broadly without achieving cost savings at the outset.

Additionally, many CAHs are the main or sole source of knowledge and expertise in their communities on operating programs like home health agencies, skilled nursing facilities, Meals on Wheels programs, assisted living, and many other services. Unfortunately, these are not a traditional part of the CAH reimbursement formula and thus CAHs rely on limited funding to operate these services.

Due to the current method of required overhead reporting on the Medicare cost report for CAHs, those that operate these programs are often required to allocate hospital overhead to these programs on methods that are similar to how overhead is allocated to general patient care departments of the hospital itself, when often it is limited hospital support services that provide the necessary infrastructure to support the operation of these programs in the communities they serve.

These methods and not being able to directly assign support services or overhead costs to these programs, so there is an over assignment in overhead costs to those programs as well as a loss of Medicare reimbursement in turn as hospital support and overhead costs are not truly reflected in patient care departments on the CAH cost reports when filed and reviewed by the Medicare program. This can often be a hinderance or deterrent for many hospitals from either operating or providing support through program operation and involvement to many of these necessary community services. Rural communities would greatly benefit from these programs, which can address social determinants of health, and in turn decrease health care costs in the long term. CAH cost reports and reimbursement methodology must be modernized to fix this oversight.

Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long term health costs.

The importance of investing in primary care.
Prioritizing patient use of preventive and primary care can result in lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. National health expenditures exceeded $12,914 per person in 2021, yet the proportion spent on preventive and primary care is much lower than in the U.S. than in comparable nations. A shift in appropriations to support greater access to comprehensive preventive and primary care is imperative to achieving a stronger, higher-performing healthcare system.

Primary care access is incredibly important for rural patients as the average rural resident is older, sicker, and poorer than their urban counterparts. Low Medicare and Medicaid reimbursement rates for rural generalist and outpatient primary care services, combined with lower-than-average volume and higher than average patient complexity, limits rural primary care providers. Fee-for-service payment is predominant in the rural primary care payment system resulting in episodic care that is

often too brief and incomplete. It is critical that HHS develop new value-based payment models that support coordinated and integrated primary care which creates high-quality patient outcomes at lower costs. Recently introduced legislation from the Senate Health, Education, Labor, and Pensions (HELP) committee, includes a number of measures to support primary care.

Recommendations to reduce improper payments in federal health care programs.

Site neutral payment exemption.
NRHA acknowledges that in certain cases the payment differential between physicians' offices and off-campus provider-based departments (PBDs) may be driving the increase in volume to the latter. However, we stress that, if Congress explores site neutral payment policies, rural hospitals must be exempted. While addressing the cost of care for rural residents is critical, it is essential that rural provider viability is not inadvertently impacted. Paying off-campus rural providers less than the full OPPS rate contributes to destabilizing rural health care delivery. Off-campus PBDs may be the only source of care in many rural communities and thus play a critical role in keeping care local and ensuring that rural patients can receive the services that they need. CMS made strides to exempt sole community hospitals (SCHs) from site neutral payments on the basis that access, not the payment differential, led to higher patient volumes. NRHA strongly believes that this is the case for all rural off-campus PBDs.

Any decline in payments threatens a rural provider's ability to keep their doors open. Higher costs of PBDs in rural hospitals may be attributed to the need to spread fixed costs across a lower volume of services. Additionally, hospitals often furnish more complex care and must meet more stringent regulatory requirements than physicians' offices. Hospitals are highly regulated and the burdens that are associated with compliance should be accounted for in payment. The site neutral rate does not account for the type of care furnished nor the resources needed at rural off-campus PBDs. Rural hospitals must be excluded from across-the-board site neutral policies.

In addition, if Congress pursues site neutral policies, NRHA believes that any savings generated should be reinvested to help rural, low-volume facilities stay financially viable. One option would be to reinvest savings into a fund to help rural providers address patients' social determinants of health, like transportation or food security. Many safety net providers offer services, like transportation, but absorb the cost because it is not reimbursable but is a huge benefit to their community. This would ultimately improve health outcomes and save money down the road as patients benefiting from these services have their basic needs met and can seek more preventive care. Another option is to address cost-shifting. Redirecting savings to cover fixed costs or overhead costs at low-volume facilities would take a financial burden off of rural hospitals and could eventually do away with the need to recover these costs through higher charges for patient encounters.

Low wage index policy.
Rural hospitals have significantly lower wage indices than urban hospitals. When controlling for number of beds, net patient revenue, Medicare payment classification, average daily census, and percent Medicare patients, the average rural wage index is 0.1261 points less than urban hospitals. Small rural hospitals have the lowest hospital wage indices in the nation. The median wage index is lowest for rural hospitals with 25 or fewer beds, less than $25 million in net patient revenue, and in more remote areas, and highest for urban hospitals in every Census region. The low wage index policy has closed disparities between high-wage, predominantly urban, and lower-wage, predominately rural hospitals. Congress should codify CMS' low wage index policy. Relatedly, H.R. 3635/S. 803, the Save Rural Hospitals Act, would equalize Medicare payments by establishing a national minimum wage index floor to ensure that rural hospitals receive fair payment for the care that they provide.

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Lugar status.
Lugar Status enables rural hospitals to redesignate to receive wage index adjustments that better reflect the labor costs in the area. For wage index purposes, hospitals in Lugar counties are considered urban because of commuting patterns from rural areas into neighboring urban counties. However, CMS has incorrectly tied together Lugar status, direct GME (DGME), and indirect medical education (IME) programs, subsequently harming rural medical education. IME payments are based on the ratio of resident physicians to the number of beds in a hospital, with a limit on how many residents are reimbursed. Traditionally, rural hospitals are granted an exemption from limitations and may start new residency training programs. CMS has put forth an interpretation of the Lugar statute that considers all Lugar hospital as urban for all purposes, including IME. NRHA strongly believes that CMS' interpretation is incorrect. NRHA voiced this concern in more detail in our FY 2024 Inpatient Prospective Payment System comment. Congress must adopt clarifying language in the statute to resolve this issue.

Thank you for the opportunity to weigh in on this important issue. Please contact Doson Nguyen (dnguyen@ruralhealth.us) with any questions or for more detail on any of the information above. NRHA would welcome a meeting with the Committee to discuss our response and put forth viable policy solutions to improve rural health care for patients and providers.

Sincerely,

Alan Morgan

Chief Executive Officer

National Rural Health Association