National Rural Health Association

March 27, 2025
Submitted via email: statementsfortherecord@finance.senate.gov

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. 219 Dirksen Senate Office Building
Washington, DC 20510

Re: Statement for the Record – *the Nomination of Mehmet Oz, of Pennsylvania, to be Administrator of the Centers for Medicare and Medicaid Services.*

Dear Chairman Crapo and Ranking Member Wyden:

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record on the hearing to consider the nomination of Dr. Mehmet Oz to be Administrator of the Centers for Medicare and Medicaid Services (CMS) held by the full Committee on March 14, 2025.

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. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA appreciates the recognition of the challenges rural hospitals and communities face, as recognized in remarks by Ranking Member Wyden and Senators Grassley, Bennet, Lankford, Hassan, Daines, Cortez Masto, Blackburn, Smith, and Lujan. With new leadership coming into D.C., Congress must continue to implement transformative policies that can help support and improve rural healthcare. Since 2010, over 190 rural hospitals have closed or discontinued inpatient services.[1] Further, nearly 50% of rural hospitals operate on negative margins.[2] Rural populations are older, tend to rely more on public coverage, and are more likely to be low-income, unemployed, and under- or uninsured.[3] This means that on average, over 70% of rural hospital revenue comes from Medicare and Medicaid, making these public payers paramount to rural hospital viability.[4]

When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin exits, affecting the larger rural area. Following a rural hospital closure, patients must travel farther to reach emergency care and residents experience diminished access to specialists and hospital services.[5] Rural hospitals not only furnish quality health services to the community, but serve to attract residents, businesses, and industry to the area; employ residents; and stimulate the local economy. Rural hospital closures are linked to decreased community economic growth and increased poverty among residents.[6] NRHA is prepared to continue to work

[1] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[2] https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf
[3] Vann Newkirk & Anthony Damico, *The Affordable Care Act and Insurance Coverage in Rural* Areas, KFF, May 29, 2014, https://www.kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-.
[4] Zachary Levinson, et al., *Key Facts About Hospitals: Rural Hospitals*, KFF, Feb. 19, 2025, https://www.kff.org/key-facts-about-hospitals/?entry=rural-hospitals-rural-discharges-by-payer.
[5] https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12810.
[6] *Id.*

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550

with its partners on Capitol Hill and at CMS to protect and strengthen the payment systems that support our rural providers.

NRHA would like to reiterate and highlight our top priorities for Congress and the Administration to consider in order to support and uplift the healthcare needs of more than 63 million rural Americans.

Make Medicare Advantage work for rural healthcare.

Medicare Advantage (MA) enrollment has grown exponentially in recent years and rural areas are not immune from this trend. Almost half of rural beneficiaries are enrolled in an MA plan instead of Traditional Medicare, leading to ripple effects for rural providers ranging from increased administrative burden to undue financial implications.[7] NRHA asks that CMS and Congress work together to ensure that MA plans serve the best interests of rural patients and providers.

MA plans must pay rural hospitals and rural health clinics (RHCs) at Traditional Medicare rates. Critical access hospitals (CAHs) are paid 101% of reasonable costs for most services. RHCs receive an all-inclusive rate from Medicare for each visit. These two rural provider types in particular are struggling with payment from MA plans as many do not pay rates that are on par with their Traditional Medicare rates. The CAH designation was created in 1997 to address a wave of rural hospital closures throughout the 1980s and 1990s and remains crucial in keeping rural hospitals afloat today. Cost-based reimbursement for CAHs is meant to reduce financial vulnerability and improve rural access to healthcare given the unique challenges of providing care in rural areas. The RHC program began in the 1970s to increase access to primary care for rural patients. Enhanced reimbursement is key to keeping these providers sustainable in rural communities.

Currently, regulations on MA payment state that services furnished by providers without a contract with an MA plan must accept as payment in full the amount that it could collect if the beneficiary were enrolled in Traditional Medicare. Sub-regulatory guidance on MA payment to out-of-network providers also states that MA plans are generally required to pay at least Traditional Medicare rates for Medicare covered services. NRHA urges CMS to use its existing authority to ensure MA plans are complying with this charge.

For rural providers that are contracted with an MA plan, NRHA asks that Congress pursue legislation to require plans to pay CAHs and RHCs at least Traditional Medicare rates. As rural MA enrollment increases, the importance of these rural designations erodes because providers are not receiving their cost-based or all-inclusive rates for a growing portion of their Medicare patients.

Other significant MA challenges include increased administrative burden and financial stress from denials and delays in payment. Even if a rural provider receives payment equivalent to their Traditional Medicare rate, plans often deny the claim after the beneficiary received the service. In other cases, MA plans delay payment or make the process of getting paid the correct amount so time consuming and burdensome that rural providers do not have adequate staff, time, or resources to address every payment issue. Similarly, rural providers struggle to keep pace with the increasing number of prior authorization requests required for beneficiaries to receive a service, as well as improper denials of requests.[8]

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[7] https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf.

[8] Please find more information on rural Medicare Advantage challenges here: https://www.ruralhealth.us/getmedia/93c6dec3-01c6-47e0-baff-9ff13b3fba48/NRHA-Medicare-Advantage-RFI-5-29-24.pdf.

Secure key rural health care programs.

Conditions in rural communities make providing health care challenging, including low patient volumes, complex patient populations, workforce shortages, and inadequate reimbursement rates. Several special rural payment designations and federal programs exist to meet the needs of and alleviate particular challenges for subsets of rural providers. The following actions are needed to protect critical safety net rural programs.

NRHA advocates for permanent, or a minimum 5-year extension, of programs that expire October 1, 2025, as part of *H.R. 1968 Full-Year Continuing Appropriations Act and Extensions Act*, including programs for **Medicare-Dependent Hospitals**, hospitals receiving a **Low Volume Hospital payment adjustment** *(S. 335, the Rural Hospital Support Act and H.R. 1805, the Assistance for Rural Community Hospitals Act)*, and **rural ground ambulance services** *(H.R. 2232 Protecting Access to Ground Ambulance Medical Servies Act)*. Rural providers need certainty around Medicare reimbursement for budgeting and planning purposes. A series of short-term extenders for these designations puts hospitals in an uncertain position that makes long-term financial planning more difficult.

Stop implementation of payment policies harmful to rural providers.

Provider payment reforms being discussed in Congress do not account for how rural providers on the ground would be disproportionately impacted due to their unique funding mechanisms and financial instability. Rural hospitals see a higher public payer mix, more uninsured patients, and cannot sustain changes to Medicare and Medicaid financing. As such, **NRHA strongly opposes attempts to expand site neutral payment policies.** Data from CMS indicates that rural hospitals' reliance on outpatient services has grown, with outpatient revenue rising from 66% in 2011 to nearly 75% in 2021. Medicare revenue represents a large share of this income, making full Medicare outpatient payments crucial for rural hospitals compared to their urban counterparts. In many rural communities, off-campus provider-based departments are the only point of access to care. Site neutral policies will burden rural hospitals that rely heavily upon off-campus outpatient departments to meet their communities' needs.

Sustain rural healthcare infrastructure.

Rural health care financing is made up of several funding sources, like 340B Drug Program savings, public and private payers, state and federal grant funds, and applicable rural payment designations. **Congress must take the following actions to bolster these funding streams and in turn support rural access to local care:**

- Make transformative changes to Medicare payment for rural hospitals, including eliminating sequestration, extending disproportionate share payments for sole community and Medicare-dependent hospitals paid under their hospital specific rate, codifying the low wage index policy promulgated by CMS from 2020 to 2024, and establishing an area wage index floor. *H.R. 833, Save America's Rural Hospitals Act*.
- Authorize and expand the Rural Hospital Technical Assistance program at the Department of Agriculture and continue to adequately fund the Rural Hospital Stabilization pilot program at FORHP. *H.R. 1417, Rural Healthcare Facilities Technical Assistance Program Act.*
- Make technical changes to the Rural Emergency Hospital (REHs) designation to make it a more accessible and sustainable option for rural hospitals considering conversion. *S. 4322, Rural Emergency Hospital Improvement Act (118th Congress) and H.R. 44, Rural 340B Access Act.*

- Protect the 340B Drug Pricing Program for rural covered entities, particularly the use of contract pharmacies which enhance access for rural patients that do not live near a hospital or clinic. *S. 5021/H.R. 340B Patients Act, H.R. 2534 PROTECT 340B Act.*
- Improve rural hospitals' ability to respond to obstetric emergencies. In the midst of an obstetric unit closure crisis in rural America, ensuring providers are well-equipped to manage obstetric emergencies without a dedicated labor and delivery unit is crucial. *S. 380/H.R. 1254, Rural Obstetrics Readiness Act.*

Reduce regulatory burden on small rural providers.

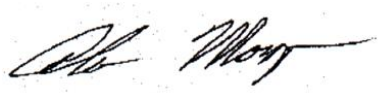
NRHA calls for CMS to rescind two major rules from CMS that burdens on already strained rural providers. These rules include the Minimum Staffing Standards for Long-Term Care Facilities rule which creates mandatory nursing staff levels for nursing facilities with no true exemptions for rural facilities. Additionally, the new conditions of participation (COPs) for hospitals that provide obstetric (OB) services, including rural hospitals and critical access hospitals from the CMS 2025 Medicare Outpatient Prospective Payment System rulemaking.

Protect Medicaid for rural communities.

NRHA urges Congress to not reduce funding for the Medicaid program and asks that CMS continue to responsibly administer the program. Medicaid is a lifeline for sustaining rural healthcare systems, including hospitals, clinics, community health centers, and long-term care facilities. Reductions in Medicaid funding would force many facilities to reduce or eliminate essential service lines, delay equipment upgrades, or close their doors entirely. Cuts to the Medicaid program will disproportionately affect rural communities, where almost 20% of non-elderly adults and 40% of children are enrolled.[9] Further, Medicaid cuts would force rural families to face higher out-of-pocket expenses, leading many to delay or forgo necessary treatments. This burden would worsen rural health outcomes, which already lag behind urban health outcomes, especially for those managing chronic conditions like diabetes, heart disease, and cancer.

These targeted policies would protect, sustain, and improve health care delivery for rural patients. NRHA calls on Congress and the Administration to prioritize rural health and ensure rural communities have the same accessible, quality health care as their urban counterparts. For additional information, please contact Carrie Cochran-McClain at ccochran@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[9] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.