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October 3, 2023

The Honorable Jason Smith, Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

RE: Request for Information on Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith:

Thank you for the opportunity to provide input on what Congress should do to preserve and strengthen healthcare services in rural areas. Over the past decade, more than 100 rural communities across the country have lost access to essential healthcare services, such as maternity care, inpatient care, and emergency care, and hundreds more are at risk of losing those services over the next several years because of the financial problems facing rural hospitals and clinics. Current federal programs fail to address the root causes of these problems, and in some cases they are making things worse.

We urge that Congress quickly enact legislation that includes the following provisions:

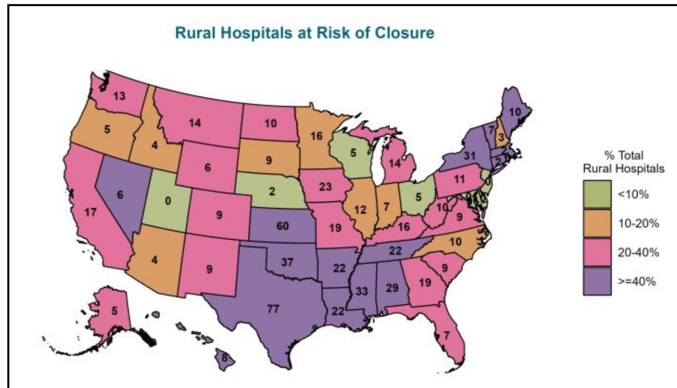
- Require that Medicare Advantage (MA) plans pay Critical Access Hospitals and other small rural hospitals at least as much as Original Medicare pays the hospitals for the same services, and require that the plans pay claims from small rural hospitals in a timely fashion.
- Require that MA plans contract for services with any rural hospital or clinic that is willing to provide services to Medicare beneficiaries enrolled in the MA plan for the same payment that the hospital or clinic would receive if the beneficiaries were enrolled in Original Medicare.
- Require that a Qualified Health Plan sold on a health insurance exchange must include a small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.
- Require that the Centers for Medicare and Medicaid Services (CMS) promptly approve a State Plan Amendment submitted by a state Medicaid agency that would require Medicaid Managed Care Organizations (MCOs) to pay small rural hospitals and clinics at least as much as those hospitals and clinics are paid by Medicare.

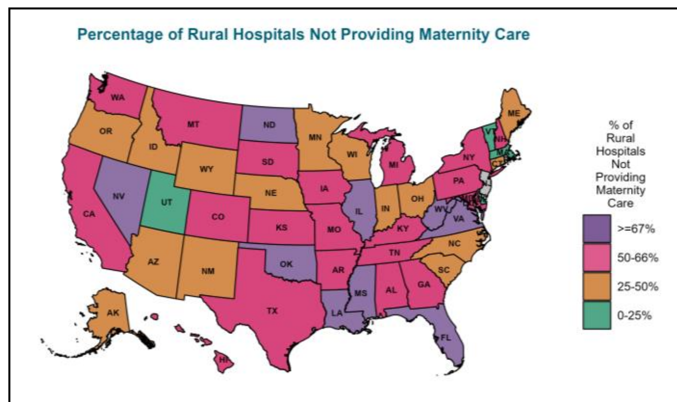
None of these requirements would require any increase in federal spending, yet they could help prevent many rural hospital closures. The requirements for Medicare Advantage plans would simply ensure that the large amounts of money CMS is already paying to these plans on behalf of rural Medicare beneficiaries are used to provide adequate payments to rural hospitals and clinics rather than to increase profits for the health insurance companies. Similarly, the requirements for commercial insurance policies would ensure that the premiums rural residents are paying for these policies and the federal subsidies for those premiums are used to pay adequately for the services those rural citizens need. These federal requirements could encourage state insurance departments and Medicaid agencies to take similar actions.

The rationale for these recommendations is explained in the remainder of this letter.

The Crisis Facing Rural Healthcare

More than 600 rural hospitals – nearly 30% of all rural hospitals in the country – are at risk of closing in the near future, and over 200 of these hospitals are at *immediate risk* of closing. Most of the at-risk hospitals are located in isolated communities where loss of the hospital could result in the loss of all or almost all local healthcare services, including emergency care and primary care. Millions of people could be directly harmed if these hospitals close, and people in all parts of the country could be affected through the negative impacts on workers in agriculture and other industries.





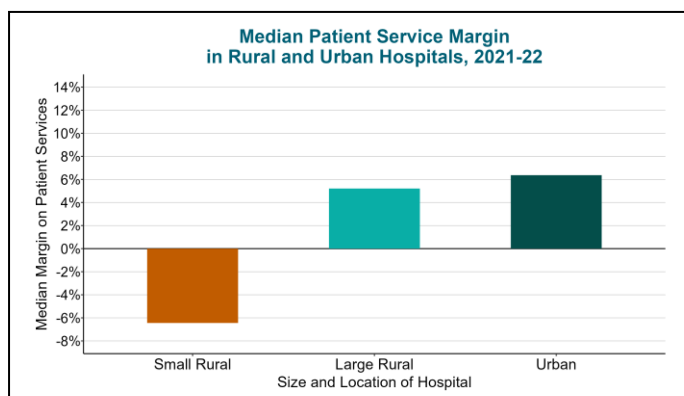
Many rural hospitals have only been able to remain open by eliminating essential services in their communities. For example, over the past decade, more than 200 rural hospitals have stopped delivering babies, and [fewer than half of the rural hospitals in the U.S. currently offer labor and delivery services]. Consequently, the number of rural *hospital closures* does not measure the full extent of the *loss of healthcare access* experienced by rural communities.

Small Rural Hospitals and Their Communities Need the Most Help

The reason that rural hospitals are being forced to eliminate services or shut down entirely is because health insurance plans pay them less than what it costs to deliver essential services. The hospitals' financial losses have been growing because the cost of delivering healthcare services has been increasing and payments from health plans haven't kept up.

Higher costs have had a negative impact on profit margins at every hospital in the country. But in most cases, urban hospitals and even large rural hospitals have continued to make profits on patient services. Their profit margins may be *lower* than in the past, but the margins are still *positive*.

In contrast, most *small* rural hospitals have been *losing* money on patient services for several years, including prior to the pandemic. For them, "lower margins" means even bigger losses, and the bigger the losses, the sooner the hospital will run out of money and be forced to close. **Most of the rural hospitals that are at risk of closing are small rural hospitals, not larger rural hospitals.** We define a rural hospital as "small" if its annual expenses are below the



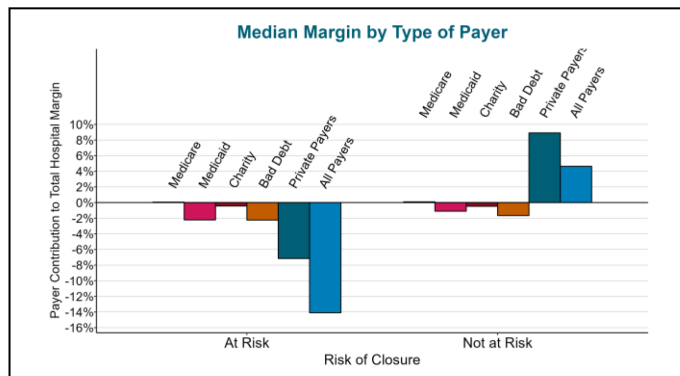
median for all rural hospitals (about $38 million in 2022).

There are over 1,000 small rural hospitals in the U.S., representing more than one-fourth of the short-term general hospitals in the country. Small rural hospitals deliver not only traditional hospital services such as emergency care, inpatient care, and laboratory testing, but most of them also deliver primary care and inpatient rehabilitation services. Most of the communities they serve are at least a half-hour drive from the nearest alternative hospital, and in many cases, there are no other sources of health care in their community.

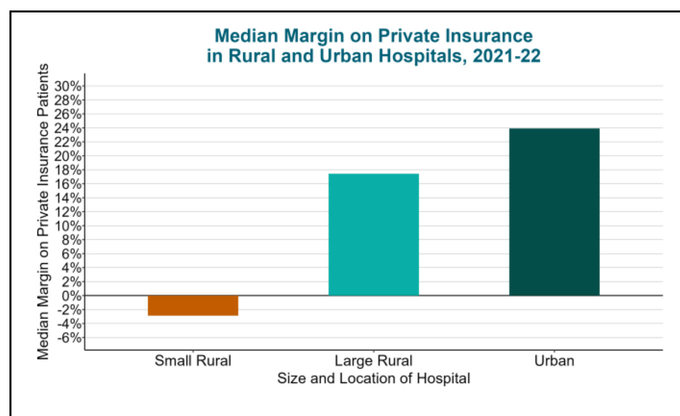
Most small rural hospitals were able to offset their financial losses and avoid closure over the last two years because of the significant amount of federal pandemic assistance grants they received. However, those grants have now ended, while costs have continued to increase, so small rural hospitals are facing bigger losses with no way to pay for them.

Low Payments from Private Insurance Plans Are Forcing Hospitals to Close

The primary reason hundreds of rural hospitals are at risk of closing is that private insurance plans are paying them less than what it costs to deliver services to patients. Although the at-risk hospitals are losing money on uninsured patients and Medicaid patients, losses on private insurance patients are the biggest cause of their overall losses.



Most large rural hospitals and urban hospitals make large profits on patients with private insurance. The exact opposite is true at most small rural hospitals. **Private insurance plans typically pay small rural hospitals less than what they pay large hospitals and much less than what it costs a rural hospital to deliver services in a small rural community**.



A common myth about small rural hospitals is that most of their patients are on Medicare and that low payments from Medicare are causing the hospitals to lose money. The fact is, on average, half of all of the services at small rural hospitals are delivered to patients with private insurance. As a result, even a small percentage loss on these patients has a big negative impact on the hospital's overall margin.

There are multiple ways in which private insurance companies underpay small rural hospitals for their services:

- The insurance company pays the rural hospital less than it pays larger hospitals for the same service;
- The insurance company fails to pay more when the cost of delivering a service is higher in the rural area than urban areas;

- The insurance company uses problematic prior authorization rules to deny payment for a service even though the patient needed treatment and it was covered by their insurance;
- The insurance company rejects the claim submitted by the hospital for minor technical reasons;
- The insurance company delays payments by many months, forcing the hospital to borrow money from other sources to pay its own bills.

Big hospitals can afford to hire staff and consulting firms to negotiate with insurance companies for higher payments, to challenge inappropriate prior authorization denials, and to resubmit rejected claims until they are paid. Small rural hospitals do not have the resources to do those things, so the small hospitals end up with large financial losses for a large portion of their patients.

Medicare Advantage Plans Are a Growing Part of the Problem

Although large hospitals routinely complain that Medicare underpays them for services, Medicare is often the *best* payer for small rural hospitals. Most small rural hospitals are classified as Critical Access Hospitals, and CMS pays them for services to Medicare beneficiaries based on what it actually costs the hospitals to deliver those services, rather than paying fees that were designed for larger hospitals.

However, **the requirement to pay Critical Access Hospitals based on the actual cost of services does not apply to Medicare beneficiaries enrolled in Medicare Advantage (MA) plans. Moreover, Medicare Advantage plans are operated by commercial insurance companies, and they are permitted to use all of the same problematic methods of delaying and denying payments as other commercial insurance plans.**

Almost half of Medicare beneficiaries nationally are now enrolled in Medicare Advantage plans rather than Original Medicare. Although the enrollment rate has been lower in rural areas than urban areas, it has been increasing rapidly as a result of aggressive marketing efforts by Medicare Advantage plans. As a result, **many small rural hospitals are experiencing greater financial losses each year as more seniors in their community enroll in Medicare Advantage plans**.

(It is important to note that Critical Access Hospitals are supposed to be paid 101% of the actual cost of services by Medicare, but due to Congressional sequestration requirements, they currently only receive 99% of the cost. As a result, they are being forced to lose money even on Original Medicare patients. However, the payments from Medicare Advantage plans are typically even less than this.)

Current Federal Programs Fail to Address the Problems

Unfortunately, none of the recent programs created by Congress or by CMS have addressed the root causes of the problems facing rural hospitals and clinics, and in some cases, they have made the problems worse.

The Rural Emergency Hospital Program

Beginning in 2023, rural hospitals with fewer than 50 beds are allowed to convert to "Rural Emergency Hospital" status if they eliminate their inpatient services. Eliminating inpatient care means senior citizens and other residents of the rural community have to be transferred to a distant city if they need a short hospital stay for treatment of a chronic disease exacerbation or a common condition like pneumonia. Because of staff shortages in larger hospitals, there may not be a hospital bed readily available in any nearby city, which could result in seniors and other community residents failing to receive the care they need in a timely fashion. Also, because the rural hospital is also required to eliminate its swing beds if it converts to a Rural Emergency Hospital, local residents who currently receive inpatient rehabilitation and/or long-term nursing care in those beds can no longer receive those services close to home.

It is a myth that rural hospitals are losing money solely or primarily because they provide inpatient care to small numbers of patients. In fact, in most cases, it is just the opposite – the revenues generated by inpatient care at a small rural hospital exceed the direct costs of delivering that care. As a result, in most cases, requiring a rural hospital to eliminate inpatient care would reduce the hospital's revenues more than the reduction in costs, making the hospital worse off financially as well as reducing access to care for local residents.

The biggest causes of financial losses at most small rural hospitals are inadequate payments from insurance companies for emergency department visits and for primary care clinic visits. **Converting to a Rural Emergency Hospital would do nothing to ensure that Medicare Advantage plans, commercial health plans, or Medicaid managed care organizations pay the hospital adequately for emergency services, primary care services, and other outpatient services.** These are the payers that are causing the hospital to lose money today.

Moreover, a Critical Access Hospital can only participate in the Rural Emergency Hospital program if it gives up cost-based payment from Medicare for outpatient services. This would reduce the hospital's *Medicare revenues* on outpatient services rather than reduce the hospital's *losses from private insurance plans*. Although the Rural Emergency Hospital would receive a supplemental annual payment of about $3 million from Medicare, that may or may not be sufficient to offset all of the higher losses the hospital would experience due to the change in Medicare payments. As a result, the Rural Emergency Hospital would likely continue to experience losses in the future.

Value-Based Payments

CMS has created a variety of "value-based payment" programs that claim to reward high-quality, efficient care. However, most of these programs do not pay more or differently for the services that patients need. They either provide shared savings bonuses if a provider manages to reduce the total amount Medicare spends on its patients, or, increasingly, the programs require providers to take financial risk for Medicare spending.

Most small rural hospitals cannot benefit from CMS "shared savings" programs. Most small rural hospitals do not have enough patients to meet the minimum requirements for participation in the Medicare Shared Savings Program, and even if they band together to do so, it is difficult for them to qualify for shared savings bonuses because the minimum savings threshold is so high and because rural residents are less likely to be receiving the kinds of unnecessary services that could be eliminated in order to save money. If a rural hospital hires additional staff or consultants to help it succeed in the shared savings program, it will increase its costs with no guarantee of receiving any additional payments to offset the higher expenses. If the hospital reduces the number of services it delivers to patients, it will create savings for Medicare but it will also reduce its own revenues by more than any shared savings bonus it would receive.

Both rural hospitals and residents of rural communities would be harmed by forcing rural hospitals to take on financial risk for total healthcare spending. "Downside risk" is especially problematic for small rural hospitals, because they do not deliver and cannot control many of the most expensive services their residents may need, and a requirement that the rural hospital pay penalties when community residents need expensive services at urban hospitals would worsen the rural hospitals' financial problems. The primary goal of so-called "population-based payment" programs is to reduce Medicare spending, not to preserve access to care or to improve the quality of services for patients. The bonuses and penalties in these programs create a financial incentive for providers to withhold services that patients need, to discourage patients from receiving high-cost services, and to avoid providing care to patients who have serious health problems. This can harm rural residents rather than help them.

Global Budgets

Another program that has been proposed to help rural hospitals is a "global hospital budget." In a global budget system, a government agency would determine the total amount of revenue a hospital should receive. The hospital would not be permitted to receive more or less than that amount, regardless of the number or types of services it delivers or how much it costs to deliver those services.

Large rural hospitals located in communities that are experiencing population losses, and rural hospitals that want to eliminate specific types of services, could benefit from a global budget, at least in the short run, because it would prevent those hospitals' revenues from decreasing when the volume of services decreases. However, small rural hospitals that are currently losing money, and small hospitals that need to deliver *more* services to meet the needs of their community, would likely be harmed, since their revenues could not increase to cover the costs of necessary services. During the initial months of the pandemic, a fixed global budget would have prevented hospitals from losing revenue when patients were not receiving elective services, but later, when COVID cases surged, a fixed budget would have prevented hospitals from delivering all of the services needed in their communities.

If the global budget established by government regulators is not large enough to enable the hospital to deliver an adequate number of services, access to care for patients will suffer. Maryland, the only state in the country that has implemented global budgets, had the longest emergency department wait times of any state in the country after implementing global budgets, and the smallest rural hospital in Maryland closed in 2020 despite operating under a global budget. In other countries where hospitals receive global budgets, many patients have to wait months to obtain the services they need.

The Center for Medicare and Medicaid Innovation (CMMI) developed a global budget demonstration program for rural hospitals called the "CHART Model." Under this program, a rural hospital would have been required to accept a budget that was smaller than the revenue it received in the past, even if its past revenues were insufficient to cover the costs of its services. Moreover, CMMI would have reduced the hospital's budget every year in order to achieve savings for Medicare every year.

Not surprisingly, no rural hospitals were willing to participate in the CHART model since it would have made them even more likely to close or cut back essential services, and CMMI was forced to abandon the program earlier this year. Unfortunately, rather than trying to develop a program that could actually help small rural hospitals, CMMI recently announced a new program called "AHEAD" that appears to be even worse for rural hospitals than the CHART model.

How to Prevent Rural Hospital Closures

Significant changes must be made in both the amounts and method of payment for rural hospital services in order to prevent more rural hospitals from closing in the future. Rural hospital closures threaten the nation's food supply and energy production, because farms, ranches, mines, drilling sites, wind farms, and solar energy facilities are located primarily in rural areas, and they will not be able to attract and retain workers if the workers cannot get adequate healthcare services.

Require That Health Insurance Payments Cover the Cost of Services in Rural Communities

Health insurance plans must pay amounts that are adequate to support the cost of services in rural areas. Payments that are sufficient to cover the cost of services at large hospitals will not be adequate at small rural hospitals because it costs more to deliver healthcare services in rural communities. This is not because rural hospitals are inefficient, but because of the smaller number of patients served relative to the fixed costs of the services. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the

minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher.

As discussed above, the primary reason small rural hospitals and clinics are losing money is not low payments from Medicare, but low payments and payment denials by Medicare Advantage plans, commercial insurance plans, and Medicaid managed care organizations. While an increase in Medicare payments to small rural hospitals and clinics could help reduce their losses, there is no reason why the Medicare program should subsidize inadequate payments from private insurance plans.

Congress can and should take action to force private insurance plans to pay rural hospitals adequately. The specific steps it could take to do so include:

- **Require that Medicare Advantage (MA) plans pay Critical Access Hospitals and other small rural hospitals at least as much as Original Medicare pays the hospitals for the same services, and require that the plans pay claims from small rural hospitals in a timely fashion.**
- **Require that MA plans contract for services with any rural hospital or clinic that is willing to provide services to Medicare beneficiaries enrolled in the MA plan for the same payment that the hospital or clinic would receive if the beneficiaries were enrolled in Original Medicare.**
- **Require that a Qualified Health Plan sold on a health insurance exchange must include a small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.**
- **Require that the Centers for Medicare and Medicaid Services (CMS) promptly approve a State Plan Amendment submitted by a state Medicaid agency that would require Medicaid Managed Care Organizations (MCOs) to pay small rural hospitals and clinics at least as much as those hospitals and clinics are paid by Medicare for the same services.**

None of these requirements would require any increase in federal spending, yet they could help prevent many rural hospital closures. The requirements on Medicare Advantage plans would simply ensure that the large amounts of money CMS is already paying to these plans on behalf of rural Medicare beneficiaries are used to provide adequate payments to rural hospitals and clinics rather than to increase profits for the health insurance companies. Similarly, the requirements for commercial insurance policies would ensure that the premiums rural residents are paying for these policies and the federal subsidies for those premiums are used to pay adequately for the services those rural citizens need.

Moreover, **these federal requirements could encourage state insurance departments and Medicaid agencies to take similar actions.** For example, state insurance departments could also require that insurance plans operating in the state contract with small rural hospitals that are willing to accept payments similar to what they receive from Medicare and to require that the plans pay small rural hospitals in a timely manner.

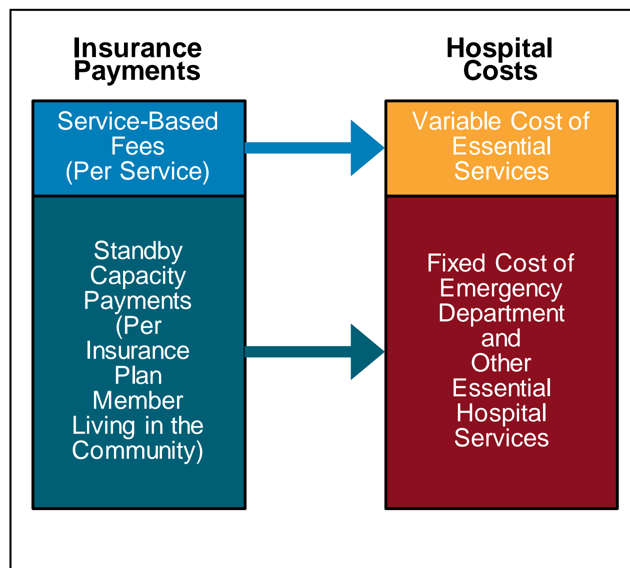
It is important to understand that because the at-risk hospitals are so small, increasing payments to levels sufficient to prevent closures would only cost about $4 billion per year, i.e., only 1/10 of 1% of total national healthcare spending. Most of the higher payments would support primary care and emergency care, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Spending would likely increase as much or more than this if hospitals close, because reduced access to preventive care and failure to receive prompt treatment will cause residents of the communities to be sicker and need more services in the future.

Create Standby Capacity Payments to Support the Fixed Costs of Essential Rural Services

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers, including Medicare, use to pay for services. Small rural hospitals are paid nothing for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and other staff to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

Moreover, if a small rural hospital or clinic provides primary care and other services designed to help patients in the community stay healthy, the number of ED visits and treatment services at the hospital will decrease, causing greater financial losses for the hospital.

A hospital's ability to deliver a service on short notice is often referred to as "standby capacity," because a minimum level of personnel and equipment must be standing by in case a patient needs the service, even if it turns out that no patient actually does need it. The coronavirus pandemic made many people aware for the first time that current payment systems do not ensure that hospitals have enough standby capacity to handle unexpectedly large increases in the number of patients who need hospital care. While large hospitals can pay for the costs of standby capacity using the profits they make on delivering services, small rural hospitals do not have that ability.



Community fire departments aren't supported by charging high fees for fighting fires, and small rural hospitals shouldn't be supported through high fees paid by people who are ill or injured. In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive ***Standby Capacity Payments*** from both private and public payers in addition to being paid ***Service-Based Fees*** when individual services are delivered. The Standby Capacity Payments would support the fixed costs of essential services at the hospital, and the Service-Based Fees would cover the variable costs of those services. The Service-Based Fees for essential services would be much lower than current fees because most of the cost of these services would be covered by the Standby Capacity Payments. This would also make these services more affordable for patients with high deductible insurance plans and for patients without insurance. More details on this approach are available in CHQPR's report *A Better Way to Pay Rural Hospitals*.

Medicare can and should be a leader in implementing Standby Capacity Payments for rural hospitals. To achieve that, Congress could require that CMS create a program to pay Standby Capacity Payments and Service-Based Fees for Medicare beneficiaries, and allow any small rural hospital to voluntarily enroll. This would be the same approach Congress used when it created the Critical Access Hospital program, i.e., creating a better payment model in Medicare for small rural hospitals, and giving rural hospitals the option of whether to participate.

The Need for Immediate Action

Action is needed immediately to prevent more rural hospital closures. Once a hospital announces it is closing, it is likely too late to save it. Moreover, long before it shuts down entirely, the hospital will probably be forced to eliminate important healthcare services in an effort to stay afloat. This will not only harm patients' health, it could also cause employers to leave the community.

Failure to provide payments that will sustain small rural hospitals would be penny-wise and pound-foolish. Spending by health insurance plans would likely increase by a greater amount if the hospitals close. This is because the reduced access to preventive care and delays in treatment resulting from a rural hospital closure will cause residents of the community to have more serious health problems that require expensive services in urban hospitals. Paying more now to preserve rural healthcare services is a better way to invest resources and to improve the health of all citizens.

I commend you and the other members of the Committee for taking the initiative to address these important issues and to seek input from stakeholders on the best ways to do so. I hope these recommendations will be helpful to you in formulating your approach.

I would be happy to answer any questions you may have and to provide additional information or assistance. You can contact me by email at Miller.Harold@CHQPR.org or by telephone at (412) 803-3650.

Sincerely,

Harold D. Miller
President and CEO