RURAL HOSPITAL COALITION

November 27, 2019

**Via Rural_Urban@mail.house.gov**

Re: Rural and Underserved Communities Health Task Force Request for Information

To Whom It May Concern:

On behalf of the Rural Hospital Coalition ("RHC") that includes hospitals in 33 states, we appreciate the opportunity to respond to your request for feedback in regard to health care issues facing Americans in rural communities. We appreciate your willingness to ask for these comments and discuss important solutions to improve the health status and outcomes for those who live in rural communities.

The RHC represents nearly one-fifth of all rural hospitals in America. Our hospitals are major economic drivers in our communities, providing jobs, economic development and the health care needed to keep rural Americans thriving. Rural hospitals are community anchors that ensure access to high-quality health care services for approximately 60 million Americans living in rural communities.

We ask that you consider changing policies in the following areas to improve health care outcomes within underserved communities, as outlined in the RFI: care quality improvements, workforce shortages, telehealth, broadband access, and payment.

**Medicaid and Medicare DSH**

In serving rural communities, rural hospitals are often paid less for our services than the actual cost to provide care. This puts significant financial pressure on our hospitals, with many being forced to cut vital services or close their doors altogether – leaving patients without access to care.

Medicaid and Medicare DSH payments were intended to offset hospitals' uncompensated care costs and to improve access to Medicaid. In the Medicare program, there is inequity, and rural hospitals do not receive an equitable percentage of payment to urban hospitals. Regarding Medicaid, we have a lot of hospitals in states that have not expanded Medicaid, so we are hopeful that the DSH cuts be delayed or rescinded, as they will have a greater impact on rural providers.

We ask you to consider two policy changes: first, eliminate the reduction to Medicaid DSH permanently; and second, create equality in the Medicare DSH payment for all hospitals, regardless of whether they are rural or urban.

The implementation of Medicaid DSH payment cuts has been temporarily delayed through December 21, 2019; however, we request a permanent extension of this delay, as it will have a greater impact on rural hospitals. Unless Congress acts, Medicaid DSH reductions of $4 billion will go into effect for this fiscal year and $8 billion a year thereafter until fiscal year 2025. These cuts will cost our hospitals approximately $33.1 million the first year and approximately $66.2 million the second year and beyond. Due to the significant financial impact that these cuts will have on our hospitals, we request that the delay be extended or that the cut be rescinded so that our hospitals will be able to continue to provide access to care and high-quality services.

Under Medicare, there are many classifications of rural hospitals, which include Medicare Dependent Hospitals, Sole Community Hospitals, Rural Referral Centers. While there is variation in the percentage of DSH paid based on type of hospital, there is not parity with the urban hospitals. We ask that all rural hospitals that are paid similarly to an urban hospital, receive the same percentage of DSH payment as the urban hospitals receive. Further, rural hospitals cannot qualify for a capital DSH adjustment, and we believe that our hospitals should be afforded the opportunity to receive the same level of funding as urban hospitals do.

**Rural Health Quality Improvements, Improving Health Care Provider Shortages and Avoiding Closures**

The RHC strongly supports legislation that increases access to quality care and prevents hospital closures and/or eliminates vital inpatient service lines in rural communities. We support the *Rural Health Agenda* that includes three bills, discussed below.

These bills are aimed at important efforts that all rural hospitals are experiencing: keeping physicians and nurses in rural areas; providing awards to those hospitals and providers that find new innovations to improve care; and providing access to telemedicine. We applaud the sponsors of these bills in the House and encourage the Committee to include them for expedited passage this Congress.

(1) Rural Health America Corps Act

We support H.R. 4899, the bipartisan *Rural America Health Corps Act*, that would encourage academic medical centers and health care professionals to spend time in rural and underserved areas. In offering loan repayment to physicians who do residencies in rural areas and potentially attracting physicians to stay in these areas, it would show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas.

We also support the Nurse Loan Repayment Program, S. 1399 and H.R. 728, *Title VIII Nursing Workforce Reauthorization Act of 2019*, that would allow nurses to receive loan repayment at our hospitals. This legislation would more effectively combat the current nursing shortage and help meet the high demand for qualified nurses in underserved and remote areas.

(2) Rural Health Innovation Act

We support the bipartisan *Rural Health Innovation Act*, H.R. 4898, that would create a pilot program expanding rural health departments' urgent care services. It would also direct the Centers for Medicare & Medicaid Services' ("CMS's") Innovation Center to test out a new telehealth payment mode. In offering innovation awards to encourage and expand the best ideas for improving health care access in rural areas, it is an initiative that would address the use of telehealth.

(3) Telehealth Across States Lines Act

We also support H.R. 4900, the bipartisan *Telehealth Across State Lines Act of 2019*, that will expand telehealth to improve accessibility and access to qualified providers. Specifically, it would direct the HHS Secretary to come up with guidelines for virtual care across state lines, part of a larger rural health care plan in the Senate. It would also establish a new grant program helping telemedicine projects expand into rural areas and would have a positive impact on health outcomes within rural communities by means of telehealth.

Further, we believe that telehealth technology is a key component to assist us in a rural community to provide care and to manage the 24/7 services to fill the behavioral health and OPIOID addiction population demand. We believe most rural hospitals have the capacity to convert unutilized beds in our rural or non-urban hospitals to behavioral health beds and other inpatient services. There is an urgent need to address opioid addiction and its repercussions. HHS has already declined to make it easier to share patient's substance abuse treatment records among providers working in Accountable Care Organizations. Without swift and large-scale efforts, the crisis will continue to grow, leaving a huge burden on community providers.

**Hospital Ownership Parity**

In order to ensure access to programs, services, and technology for individuals in rural communities, all rural hospitals, regardless of their ownership type, must have access or be eligible to compete for grants and services. Thus, we request modification of the Public Health Services Act ("PHS") and Federal Communications Commission ("FCC") authority restrictions that limit rural hospitals from eligibility to obtain resources. Significant to this RFI, eligibility for funding should be given to tax-paying hospitals and systems for broadband and telecommunications services under the FCC Rural Health Care Program.

**Permanent Extension of Rural Payment Policies**

The rural payment policies created by Congress have been critical to the preservation of health care services to rural Americans. RHC applauds Congress for extending the improved payment for low-volume hospitals and the Medicare Dependent Hospitals ("MDH") programs. Going

forward, we urge Congress to strengthen these policies and make them permanent. Our hospitals need the certainty that comes with permanent Medicare payment supports.

(1) LVH Program

The Low Volume Hospital ("LVH") program recognizes that certain hospitals are more isolated and do not have the volume for economies of scale in ensuring adequate payment. The sliding-scale payment adjustment created by the LVH program helps compensate for such a competitive disadvantage where patients are likely to be poorer and have an overall worse health status. Thus, we request that the LVH program be made permanent.

(2) MDH Designation

We also request that the MDH designation be permanently extended. The MDH program was designed to provide an additional measure of protection for smaller, rural hospitals serving a disproportionate Medicare caseload of greater than 60%. A greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payment under PPS.

(3) Wage Index

In the FY 2020 Inpatient Hospital PPS final rule, CMS reduced the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values (those with wage index values below the 25th percentile wage index value across all hospitals) in an effort to mitigate wage index disparities, including those resulting from the inclusion of hospitals with rural reclassifications. However, this change is only in effect for four years. We request that this change be permanently implemented.

**Conclusion**

As explained above, these topics have a significant impact on our hospitals and the ability to ensure continued access to health care services in our communities. Again, we appreciate the opportunity to discuss these issues aimed at improving the health status and outcomes for those who live in rural and underserved communities.

If you have any questions, please do not hesitate to contact me at taylorn@gtlaw.com or (202) 331-3133.

Sincerely,

Nancy E. Taylor
Shareholder
Greenberg Traurig, LLP