National Rural Health Association

May 4, 2022

The Honorable Ron Wyden
Chairman
U.S. Senate Committee on Finance
211 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Richard Neal
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
1139 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Ron Wyden, Ranking Member Mike Crapo, Chairman Richard Neal, Ranking Member Kevin Brady, Members of the Senate Finance Committee, and Members of the House Ways and Means Committee:

The Critical Access Hospital (CAH) Medicare designation is a fixture for rural communities across the United States. As such, the National Rural Health Association (NRHA) urges Congress to take necessary actions to support this essential rural health safety net provider as the country moves beyond the COVID-19 pandemic. To do so, Congress should take the following steps to ensure stability for CAHs across the country.

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

Since 2010, 138 rural hospitals have closed, 64 of which were CAHs.[i] Long-term financial viability of CAHs is difficult due of low patient volumes, reimbursement levels lower than cost, the health and socio-economic status of rural residents, higher rates of uncompensated care, challenging payer mixes, and many other factors beyond hospital control.[ii] [iii] [iv] [v] CAH closures are of great concern because they are often located further away from other access points for care. Median distances between a CAH and the next closest hospital of like size is 18.6 miles and the next closest hospital with 100 or more acute care beds is 36.5 miles.[vi] In addition, CAHs in very rural and geographically isolated areas often provide primary care as well as emergency, diagnostic, and outpatient services.[vii] With millions of Americans dependent on CAHs, it is imperative that policy be put in place to prevent their closures.

Understanding the role CAHs play in rural health care, NRHA recommends the House Ways and Means, and Senate Finance Committees take the following actions to uphold the designation.

National Rural Health Association

Increase Medicare payments to CAHs to ensure financial stability

1. Eliminate Medicare sequestration for CAHs, and other rural hospital designations.

In 2011, Congress passed legislation instituting a two percent sequestration reduction to all Medicare fee-for-service payments through 2030. In 2021, through passage of the Bipartisan Infrastructure Law, Congress extended this sequestration through 2031. Reductions in Medicare reimbursement due to sequestration impact the financial profitability of rural hospitals, and in particular CAHs who are paid below their actual costs due to sequestration. In statute, CAHs receive 101 percent cost-based reimbursement for both inpatient and outpatient services. However, Medicare sequestration policy results in CAHs receiving just 99 percent of allowable costs. According to Chartis Center for Rural Health, current Medicare sequestration policy could have a $139 million impact from July-September of 2022 and potential result in nearly 2,800 jobs lost for CAHs nationwide.

At the beginning of the COVID-19 pandemic, Congress took decisive action to support health care providers by suspending Medicare sequestration. With sequestration going back into effect on April 1, 2022, NRHA fears Chartis' prediction of hospital closures and job loss could come to light. To address this issue, NRHA urges support for **Section 101 of H.R. 6400, the Save America's Rural Hospitals Act**. Section 101 would permanently eliminate Medicare sequestration for rural hospitals. Knowing that sequestration policies disproportionately impact rural providers, this provision would enhance the safety net of rural communities and provide increased financial sustainability.

2. Increase or eliminate bad debt reimbursement.

Rural hospitals have Medicare bad debt percentages that are 60 percent higher on average than urban hospitals. As such, NRHA believes the bad debt a rural hospital is liable for should be reduced from 30 percent to 15 percent or less. According to Chartis Center for Rural Health, current Medicare bad debt policy could have a $109 million impact on an annual basis and result in nearly 2,300 community jobs lost for CAHs nationwide. NRHA urges support for **Section 102 of H.R. 6400**. Section 102 would reduce the bad debt CAHs are liable for from 30 percent to 15 percent. This provision would enhance the safety net of rural communities and improve the financial stability of CAHs.

3. Provide funding for CAHs and other rural hospitals to improve their health care infrastructure.

Rural providers have had their limits tested throughout the COVID-19 pandemic. One constant NRHA members have expressed is the need for improved and updated facilities to accommodate safety requirements. NRHA urges Congress to include a section for hospital infrastructure so that rural providers can improve and expand their facilities. NRHA asks this to be modeled after **Section 40003 of H.R. 1848, the LIFT America Act**, which appropriates $10 billion to improve hospital infrastructure. NRHA requests such provision be accompanied by a 20 percent rural carve-out to reflect the national rural population needing services.

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Remove unnecessary regulatory burdens

1. **Permanently remove condition of payment requirements that CAHs length of stay be limited to 96 hours.**

During the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) suspended this condition of payment (CoP) requirement for the duration of the COVID-19 public health emergency (PHE). The CAH 96-hour rule requires a physician to certify that a patient can reasonably be expected to be discharged or transferred within 96 hours. CAHs already must meet a separate condition of participation, which requires that acute inpatient care provided to patients not exceed 96 hours per patient *on an average* annual basis. In its 2018 Inpatient Prospective Payment System (IPPS) final rule, CMS made the 96-hour rule a low priority for medical review records, but the regulation still causes confusion and interferes with the best judgement of physicians and other health care providers.

Because the rule has been suspended for more than two years now, NRHA believes it is timely to permanently wipe this unnecessary regulation from the CoP requirements at CMS. While the suspension has been in place, average length of stay at CAHs has not risen above the four-day threshold, showing the unnecessary nature of this burdensome regulation. Both the Trump Administration and Biden Administration have said Congressional action is needed to permanently remove this provision. NRHA urges swift Congress action to support **Section 301 of H.R. 6400** which would permanently remove the 96-hour physician certification requirement with respect to inpatient CAH services.

2. **Ensure providers ability to transition to, and maintain, CAH status.**

The CAH designation is an important opportunity for struggling, rural prospective payment system (PPS) hospitals. NRHA believes that allowing vulnerable rural PPS hospitals to transition to the CAH designation will provide increased support for these providers. Unfortunately, accessibility to the program is hamstringed by current statute. As such, NRHA recommends the following actions:

A. **Reinstate CAH necessary provider status.**

NRHA believes that by reinstating CAH necessary provider status, which removes the 35-mile limit for CAH designation, about 200 of the nation's most vulnerable rural PPS hospitals would be able to transition to the CAH payment model. This relief could provide the necessary support needed for many rural providers to remain serving their communities. NRHA supports **H.R. 1639** / **S. 644** **the Rural Hospital Closure Relief Act** to allow additional hospitals to qualify as CAHs.

B. **Ensure rural CAHs are able to maintain their CAH certification.**

In 2015, CMS narrowed the eligibility criteria for hospitals to certify or recertify as CAHs. By inserting a more restrictive standard for what qualifies as a "secondary road," currently designated CAHs may no longer meet the distance requirements to retain and maintain their CAH certification. NRHA believes this is ill-advised and urges Congress to act to ensure CAHs can maintain their certifications. NRHA supports **H.R. 489, the Protecting Rural Access to Care Act**, which limits the scope of guidance used by CMS regarding the secondary road criteria for CAHs. As rural hospitals continue to close across the country, ensuring CAHs are able to maintain their payment status could not be more critical, especially as rural communities recover from the COVID-19 pandemic.

3. **Adjust coinsurance requirements for outpatient CAH services under Medicare.**

Under current law, when a patient goes to a CAH they are billed 20 percent of the charges submitted to CMS. In other hospital settings reimbursed through a fee schedule, patients are billed 20 percent of the reasonable costs determined by CMS for that procedure. Unfortunately, what this looks like on the ground is rural beneficiaries being charged more for coinsurance because of where they obtain care geographically. NRHA supports **H.R. 5660, the Fairness for Rural Medicare Beneficiaries Act of 2021** to eliminate what is an unfair burden on patients seeking care in rural communities.

Ensure access to behavioral health services via telehealth remain viable at CAHs

During the COVID-19 public health emergency, hospitals, including CAHs, have been temporarily allowed to expand telehealth services, allowing patients to access vital care from their homes. In the Consolidated Appropriations Act of 2022, telehealth flexibilities found in the Coronavirus Aid, Relief, and Economic Security (CARES) Act were continued beyond the duration of the PHE for 151 days. Unfortunately, flexibilities administered to CAHs via the 1135 waiver process were not. NRHA is concerned that PHE patients receiving care via telehealth at CAHs will lose access to these critical services should Congress not address this issue, particularly those receiving behavioral telehealth services. Mental health needs have spiked in rural communities since the beginning of the pandemic. NRHA supports **H.R. 2228, the Rural Behavioral Health Access Act of 2021,** which will ensure that Medicare continues payment of outpatient critical access hospital (CAH) services consisting of telehealth behavioral therapy, including audio-only services.

Provide essential technical assistance support for small rural hospitals

1. **Reauthorize the Medicare Rural Hospital Flexibility Program (FLEX)**

The FLEX program is designed to improve and sustain access to quality health care services in rural communities. In particular, it supports the conversion and designation of small rural hospitals to CAH status and provides support for rural hospital stability. In need of reauthorization, NRHA urges Congress to show support of this valuable program by including a new item for rural health transformation grants to help eligible providers transition to new models and evolve to meet community needs and the changing health care environment. To do so, NRHA asks for support of **Section 401 of H.R. 6400**.

2. **Provide continued funding for the United States Department of Agriculture (USDA) Rural Hospital Technical Assistance (TA) program.**

The USDA Rural Hospital TA program was developed as a pilot program for rural hospitals to assist rural residents, businesses, and professionals in the health sector by providing affordable, effective, and educated support to help rural hospitals better manage their financial and business strategies. In Fiscal Year (FY) 2022, the USDA Rural Hospital TA program was funded at $2 million. **NRHA requests this critical program receives increased funding to $5 million.** As the rural hospital closure crisis continues, and more hospitals are operating on negative margins, effective TA strategies are needed to support these vulnerable facilities.

Thank you for your consideration of these requests. NRHA looks forward to working with Members of the Committee to ensure that CAHs remain viable financially for their communities. If you have questions on the needs of CAHs, please contact Josh Jorgensen (**jjorgensen@ruralhealth.us**).
Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

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