WISCONSIN HOSPITAL ASSOCIATION

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October 5, 2023

The Honorable Jason Smith
U.S. Congressman
1139 Longworth Office Building
Washington, DC 20515-0001

RE: House Ways and Means Committee Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith:

Thank you for taking an interest in the challenges our health care system faces in providing adequate access to health care in rural and underserved areas. The Wisconsin Hospital Association represents more than 150 member hospitals and integrated health systems, including small Critical Access Hospitals (CAHs), mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Given our broad membership, we feel we bring a valuable perspective to the discussion of how Congress might improve access to health care in rural and underserved areas.

Geographic Payment Disparity in the Medicare Wage Index

The Medicare Hospital Area Wage Index began in 1983, as Medicare moved away from cost-based payment toward a prospective payment system. It ties a portion of Medicare hospital payments to the labor market a hospital is located in. Like most policies that come out of Congress, the Area Wage Index started with good intentions and a rational premise – that federal hospital payments should reflect the labor market a hospital is located in. However, as is also true with some government policies, the wage index has been heavily gamed by different Members of Congress over the years to benefit specific constituencies.

Two relatively recent examples of this include the "Bay State Boondoggle" and Rural Imputed Floor for Urban-only states. Congress created a "rural floor" in 1997 that requires a wage index for an urban area in a state to be higher than the highest rural area's wage index. While this has no basis in economic theory, it has functioned to shift Medicare dollars from rural areas to urban areas.

Prior to passage of the Affordable Care Act, this rural floor policy was budget neutral within a state – shifting dollars within the state. However, the ACA made this budget-neutral on a national basis, shifting dollars from rural areas across the country to urban areas. At the same time, a rural CAH in Nantucket Massachusetts became a prospective payment system (PPS) hospital. Since Nantucket is a wealthy area, it created a very high rural floor, which raised the wage index of all hospitals within the state, and now at the expense of rural hospitals across the country. The result of this was to artificially reallocate dollars primarily to certain states like Massachusetts at the expense of other states, a phenomenon that was known as the "Bay State Boondoggle."

Another example of gamesmanship is the imputed rural floor. Because three urban states (Delaware, New Jersey, and Rhode Island) have no rural hospitals, CMS created an "imputed" or made up rural floor for them that artificially raised the wage index for hospitals in those states. This policy expired in 2018 and CMS rightly ended it in the 2019 inpatient rule. However, certain members of Congress slipped a provision into the American Rescue Plan Act of 2021 that restored this imputed rural floor policy. Though this was thankfully no longer on a budget neutral basis, it still serves to unfairly steer scarce federal Medicare dollars to these states.

With these two examples, we believe it is time for Congress to re-valuate the wage index. While the Centers for Medicare and Medicaid Services has been undertaking policies to attempt even out artificial disparities in the wage index, these policies, applied on a budget-neutral basis, have their own pitfalls in redistributing dollars. We urge Congress to re-evaluate ways to restore the wage index to its original intent and remove the ability for states or members of Congress to manipulate it in a way that artificially benefits certain urban areas at the expense of rural areas.

Improving Medicare Behavioral Health Reimbursement for Distinct Part Units attached to Critical Access Hospitals

Critical Access Hospitals (CAHs) are required to have no more than 25 beds. However, they may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. In an effort to tamp down on the number of rural hospitals that had been closing, Congress created the CAH program with special cost-based reimbursement that pays CAHs a Medicare rate of 101% of their allowable costs. The idea is that CAHs need to break even on Medicare patients because they do not have the volume of commercial patients to offset losses a typical PPS hospital sees on Medicare. (For instance, in Wisconsin, hospitals receive, on average, only 73% of what it costs them to provide Medicare services. The national average, is 84% of cost under Medicare).

Unfortunately, due to sequestration, CAHs now receive only 99% of Medicare's allowable costs. And when one considers that there are certain legitimate expenses that are not even considered allowable costs, CAHs get paid even less than the rates that are supposedly designed to allow them to break even on Medicare patients.

While we support fixing those aforementioned issues with CAH payments as a separate matter, an even more egregious issue is that Medicare pays distinct part units (DPU) even less, at the normal PPS rate. Wisconsin has a handful of CAHs that operate distinct part psychiatric units that lose significant dollars for the hospital, but operate as part of the mission of serving their community. One example is a hospital in Stoughton, WI just outside of Madison that operates a DPU that specializes in geriatric psychiatric patients. This hospital serves patients from 16 surrounding counties, providing care for patients with significant challenges related to dementia, bipolar disorder, schizophrenia, and psychosis.

Unfortunately, due to the payment structure of DPUs, not only does this CAH lose 35 cents on the dollar for every Medicare patient served at the geri-psych DPU, they also cannot include some of the shared staffing costs on their CAH's overall cost report. The result is a loss of about $1.3 million annually, or nearly 20% of their overall bottom line. ***If Congress wants to truly incentivize more behavioral health care, instead of significantly underpaying these hospitals for providing these services, it should be rewarding them with better reimbursement, or at least the same Medicare reimbursement they get for their other CAH patients.***

Making the Medicare Low Volume Adjustment and Medicare Dependent Hospital Program Permanent and Reopening Necessary Provider Status for CAHs

In December of 2022, Congress passed omnibus legislation that provided another short-term extension for the Medicare-Dependent Hospital (MDH) and Low Volume Hospital adjustment (LVH) designations through October of 2024. These programs serve hospitals with low volumes by giving them slightly enhanced payments above the PPS rate, but below the cost-based rate CAHs receive. These programs help sustain "tweener" hospitals – those that are both too large to be eligible for critical access hospital status but too small to have

the volumes that would otherwise help them offset the losses they experience treating Medicare and Medicaid patients.

Unfortunately, the short-term extensions Congress provides when it reauthorizes these programs leads to significant stress for these hospitals that depend on these higher Medicare payments to maintain financial viability. ***To provide more financial certainty, Congress should permanently reauthorize these programs.***

Furthermore, we recommend Congress bring back, on a limited basis, the necessary provider designation that would allow some of these hospitals to convert to CAHs and receive cost-based reimbursement. CAHs designated by their state as a necessary provider prior to January 1, 2006, are exempt from the requirement to be no more than a 35-mile drive from another hospital or a 15-mile drive from another hospital with mountainous terrain or only secondary roads. When some hospitals had to decide – nearly twenty years ago – whether to apply for this status, they had much higher inpatient volumes, and did not want to limit themselves to a bed cap of 25 patients. Fast forward to today, and some of these same hospitals have an average daily census below 25 patients. Reopening the necessary provider designation for these hospitals would provide another tool to maintain rural hospital financial viability.

Bringing Back COVID Waiver flexibility for the CAH 96 – Hour Rule and Nursing home 3-day Stay Rule

The COVID-19 public health emergency provided hospitals with unprecedented regulatory flexibility and served as a pilot program or proof of concept for the benefits of these reforms. We greatly appreciated Congress recognizing the value of extending flexibilities for telehealth and the Acute Care Hospital at Home program. ***Unfortunately, with the expiration of the public health emergency on May 11, 2023, Congress missed a significant opportunity to continue valuable flexibilities in enforcement of the CAH 96-hour rule and nursing home 3-day stay rule.***

The CAH 96-hour rule requires (via CMS rule) physicians admitting patients into a CAH to certify the patient is expected to be discharged within 96 hours. The CAH *statute* also requires the annual average length-of-stay (ALOS) for CAHs be under 96 hours. When this rule was waived during COVID, CAHs found a way to improve their care and treat patients that they previously would have sent away to a tertiary hospital. This was a benefit to those patients, who were able to receive care in their local community. It also benefited the higher-level tertiary hospitals by increasing their capacity to serve patients that had higher acuity care needs. All of this was by necessity, as those tertiary hospitals were at capacity and could not accept as many patients from CAHs as they had previously.

Likewise, the waiver of the nursing home 3-day stay rule benefited hospitals by making it easier to transfer patients to a nursing home without having to worry about whether Medicare would pay for the nursing home stay. The waiver of this rule helped hospitals free up space for patients who needed hospital care by transitioning patients to a more appropriate care setting sooner. ***We also heard specifically from CAHs with nursing home swing beds that it allowed them to take on more swing bed patients.***

Unfortunately, the expiration of the PHE put these hospitals between a rock and a hard place. If a patient now comes to their emergency department and the hospital does not see a need to admit them, but also is worried they are unsafe to be discharged to their home, they now have to take into consideration whether the patient can pay out-of-pocket for a nursing home stay. The removal of this waiver has had a disproportionate impact on rural hospitals, because they are less likely to be part of an Accountable Care Organization which continue to benefit from the waiver of this policy.

While WHA has been told there are concerns from Congress about the fiscal impact of continuing this waiver, we have seen no concrete budget estimates. Furthermore, when we compared data of Wisconsin hospitals, we did not see a significant spike in patients being transferred to nursing homes in fewer than 3 days compared to those transferred after more than three days – likely due to sustained challenges in finding adequate nursing

home patients. We believe this could mean that expected impact to the federal budget is not as significant as policymakers fear, and CMS should have the data from the waiver period to provide an accurate national estimate.

Adequately Funding and Providing Flexibility for Rural Health Clinics

The 2021 Consolidated Appropriations Act changed the way rural health clinics (RHCs) are paid by creating a new cap on payments for existing provider-based RHCs. These provider-based RHCs are typically an extension of a small rural, critical access hospital. Additionally, the act also created a lower cap on payments for any newly established provider-based RHC, bringing them in line with either independent RHCs or those established by hospitals with more than 50 beds. While the goal of this policy change was to narrow the payment disparity between how RHCs are reimbursed, it has created unintended consequences for access to care in rural areas.

Unfortunately, the new law did not take into consideration organizations already planning to establish new RHCs, a process that can often take multiple years. Organizations that were planning on opening new RHCs with the prior revenue model have now been forced into the new, lower capped rate. Losing break-even Medicare rates can be the difference between small health care organizations being able to afford preserving services in local communities versus patients having to drive a significant distance to the nearest urban center. We have also heard that the new rates are simply not high enough to sustain the level of services one would expect to be provided. This creates disparities in the type of care available to rural citizens compared to those in urban areas.

WHA supported legislation introduced last session (the Rural Health Fairness in Competition Act, H.R. 5883) to restore the previous higher payment rate to provider-based RHCs in exchange for them reporting quality measures. We urge Congress to reintroduce that legislation this session. Furthermore, Congress should explore more regulatory flexibility for RHCs. For instance, RHCs must abide by regulations that require 51% of their services to be primary care, and yet behavioral health and oral health are not considered primary care. This is a significant disincentive to providing these services and, paradoxically, comes at a time when a growing number of policymakers are trying to increase access to such services.

Protecting HPSA Designations for States that Report Data to HRSA

The workforce shortage continues to have a significant impact on healthcare, like many other sectors. Hospitals that are located in a health professional shortage area (HPSA) are able to receive certain benefits that help them grow their workforce, including:

1. CONRAD-30 J1 Visa waivers that allow hospitals to host foreign-born medical students after they complete their residency, without them having to return home for 2 years before applying for immigrant status to the U.S.
2. Loan Repayment programs through either the National Health Service Corp or Wisconsin Office of Rural Health.
3. Bonus points on applications for graduate medical education slots and state and federal grants.
4. Enhanced payment for certain Medicare and Medicaid primary care services that help them provide higher pay to their practitioners.

Unfortunately, Wisconsin is at risk of losing its designated health professional services areas covering around 25 hospital locations due to the way the Health Resources Services Administration has updated its HPSA renewal process. Ironically, this is coming at a time when hospitals report growing – not shrinking – health care workforce staffing challenges.

WHA and its members appreciated that HRSA listened to concerns from hospitals in 2022 and paused their plans to withdraw HPSAs based on their new process. Yet, HRSA has said it will go ahead and withdraw those that no longer meet its criteria by the start of 2024. Wisconsin appears to have a significantly higher number of locations at risk of being withdrawn, and we are concerned that this may be due to Wisconsin being more proactive in reporting its workforce data to HRSA than other states. If this is the case, HRSAs policies are punishing states for taking the effort to provide updated data and rewarding states that do not even attempt to update their data, by allowing those states to maintain HPSAs without reporting new data.

We believe HRSA needs to again press pause on plans to withdraw any HPSAs until this can be sorted out, or especially if a state has a disproportionately high number of HPSAs proposed for withdrawal like Wisconsin.

Site-Neutral Payment Policies

WHA was disappointed to see certain members of Congress attempt to institute site-neutral payment policies for drug administration at off-campus hospital outpatient departments. This policy is estimated to have a $114 million negative impact to Wisconsin hospitals over 10 years. While we understand the desire from some in Congress to have Medicare payments more accurately reflect the cost of the particular service provided, site-neutral payment policies will not meaningfully move the needle toward that objective; they will simply amount to a cut to hospitals if policy makers do not attempt to backfill such cuts elsewhere.

As Ways & Means Committee member Gwen Moore of Milwaukee, WI noted during the committee markup of this proposal, hospitals are already underpaid by Medicare. Congresswoman More also noted that hospitals and their outpatient departments provide higher acuity care – or safety-net services – that independent clinics are not required to and do not provide. This includes 24/7 inpatient and emergency care, as well as EMTALA obligations that require them to provide life-saving care to anyone who walks into their emergency department.

If hospitals are required to provide these services, why would it make sense to think that they should be paid the same lower rates as settings that are not required to provide such services? Additionally, we found that when CMS instituted site-neutral cuts for E&M codes in its 2019 OPPS rule, these cuts had a disproportionate impact on rural "tweener" hospitals. We are concerned that such cuts may further threaten the viability of such hospitals.

Finally, it is worth considering how hospitals might react to such a policy on a long-term basis. Hospitals were able to use the higher provider-based payments to increase access to care at sites beyond the 4 walls of a hospital, given Medicare's better payment structure for these settings. However, if that payment structure goes away, it very well may decrease access to care, as some hospitals may choose to bring these services back to their main campus to lessen the impact of such cuts. This could create more patient care bottlenecks that have disproportionate impact in rural areas.

In closing, WHA greatly appreciates the Ways & Means committee taking an interest in these important issues. We would like to extend an invitation for Ways & Means committee members to get out of the "swamp" of DC and come visit our Wisconsin hospitals where you can hear from our hospital leaders first-hand about the challenges they are facing and what options policymakers might pursue to remove geographic disparities and incentivize better care for rural communities.

Sincerely,

Eric Borgerding
President & CEO