United States Senate
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February 17, 2021

The Honorable Richard Hilderbrand
Chair
Committee on Public Health and Welfare
Kansas Senate
Statehouse, Room 118-M
Topeka, KS 66612

Senator Hilderbrand:

Thank you for your continued efforts on combating the COVID-19 pandemic and addressing the financial struggles physicians and other health care providers are currently facing. The COVID-19 pandemic revealed existing vulnerabilities in our health care system, and none were more exposed than health care facilities serving rural communities. To ensure access to health care in rural communities in the long term, we must think outside the box and provide options for alternative financing and organizational structures that eliminate inefficient overhead costs while maintaining necessary health services in rural communities. To this end, I write in support of SB 175/HB 2261, legislation that would establish the Rural Emergency Hospital (REH) designation in Kansas statute.

Most rural hospitals in Kansas are Critical Access Hospitals (CAH), a designation that requires them to maintain acute care beds. Since 2010, seven hospitals in Kansas have either closed or converted, and many more may follow the same path.[1] It is estimated that 31 Kansas hospitals are financially vulnerable, 12 are most vulnerable, and 19 are at risk of closing.[2] Federal agencies and Congress have been working to address this problem by identifying trends the precede hospital closures. Last year, the Medicare Payment Advisory Commission (MedPAC) examined claims data from 40 rural hospitals that closed and found declines in inpatient care.[3] Specifically, there was a 53 percent decline from all payers and a 61 percent decline under Medicare, and most of the Medicare declines were due to beneficiaries bypassing the local hospital or a shrinking market for inpatient services. However, emergency services were relatively stable and outpatient services decreased only slightly. MedPAC also found in an earlier study that higher reimbursement rates for inpatient care did not improve financial stability of CAHs because the extra payments were absorbed by high inpatient

[1] The University of North Carolina at Chapel Hill Cecil G. Sheps Center for Health Services Research, 179 Rural Hospital Closures: January 2005 – Present (135 since 2010), accessed February 10, 2020, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[2] The Chartis Group, *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability*, February 2020, https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf.
[3] Medicare Payment Advisory Commission, *Congressional Request: Medicare Beneficiaries' Access to Care in Rural Areas*, November 9, 2020, http://medpac.gov/docs/default-source/meeting-materials/rural-access-medpac-nov-2020.pdf?sfvrsn=0. *See also* Adam Gadzinski, Justin Dimick, Zaojun Ye, and David C. Miller, "Utilization and outcomes of inpatient surgical care at critical access hospitals in the United States," JAMA surgery 148, no. 7 (2013): 589-596.

costs per day of care.[4] Overall, data suggests that specializing in emergency and outpatient services may be a more viable option in cases where providing inpatient care is too costly to maintain with insufficient demand.

I have sought to mitigate these financial difficulties at the federal level by working with the U.S. Centers for Medicare and Medicaid Services (CMS) and my colleagues in Congress on bipartisan initiatives that would help rural hospitals improve financial sustainability and access to quality care. More recently, I supported creating the Rural Emergency Hospital designation under the Consolidated Appropriations Act, 2021.[5] This designation creates a new option for rural communities that cannot support a CAH with mandatory acute care beds.

The new law includes guardrails to ensure quality care, and stakeholders will have an opportunity to help shape implementing regulations through notice-and-comment rulemaking and guidance. To enroll in this new category, CAHs will not provide inpatient care nor exceed an annual per-patient length of stay more than 24 hours. To maintain quality care for emergency services, REHs must maintain a transfer agreement with a Level I or II trauma center and have an around-the-clock staffed emergency department including a physician, nurse practitioner, clinical nurse specialist, or physician assistant – pursuant to state scope of practice laws. They must also maintain Medicare Conditions of Participation from their previous designation to ensure patient health and safety in the hospital setting. Finally, they must meet applicable state licensing requirements.

The voluntary REH designation may offer a sustainable payment system. Similar to MedPAC's recommendations, REH payments will be made under the Medicare Hospital Outpatient Prospective Payment System with a 5 percent add-on payment for covered services. Hospitals will also receive a fixed monthly payment based on a modified reimbursement formula for CAHs, and it will be subject to the hospital market basket percentage increase. This designation will go into effect on January 1, 2023.

As a fellow Kansan and physician from Great Bend, I supported this section of the legislation as it presents an option for health care providers with a passion for rural health to continue serving their community. This new payment model offers a new option that mitigates the binary choice of running a full inpatient hospital and shutting doors completely in rural communities. I want to give CAH administrators and their patients the opportunity to evaluate all available options and select a model that best meets their local needs. As you consider this legislation, please know that I will prioritize our rural hospitals and will advise CMS to develop practical and feasible regulations. Also, in ensuring access to quality care, I will continue to advance legislation that improves access to telehealth. Thank you for your leadership and consideration.

Sincerely,

Roger W. Marshall

Roger Marshall, M.D.
U.S. Senator

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[4] Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System, June 2016, pp 214-216, http://www.medpac.gov/docs/default-source/reports/chapter-7-improving-efficiency-and-preserving-access-to-emergency-care-in-rural-areas-june-2016-repo.pdf?sfvrsn=0.

[5] Consolidated Appropriations Act, 2021, Pub. L. No. 116-68, Division CC, Health Extenders, Sec. 125, pp 2187-2206.