Documents for the Record

HE Hearing on "Fiscal Year 2024 Department of Health and Human Services Budget"

03/29/2023

Majority:

- February 17, 2023, CMS informational bulletin
- Academy of Physicians in Clinical Research statement
- July 2021, Senate Bill 1264 2021 midyear report, submitted by Rep. Michael Burgess, M.D.

Minority:

- March 29, 2023, statement from Rep. Cherfilus-McCormick
- March 28, 2023, article from Star Tribune entitled, "A Minnesota family 's desperate search for care reveals state's mental health crisis"
- August 2018 GAO Report entitled, "Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factor"

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: February 17, 2023

FROM: Daniel Tsai, Deputy Administrator and Director

SUBJECT: Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs) under 42 C.F.R. § 438.6(c). Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax would comply with the statutory and regulatory prohibition on "hold harmless" arrangements—that is, arrangements in which the "State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax"—as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations. In response to these questions, this informational bulletin reiterates our longstanding position on the existing federal requirements that pertain to health-care related taxes and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

CMS recognizes that health care-related taxes are a critical source of funding for many states' Medicaid programs, including for payments to safety net providers. CMS supports states' adoption of health care-related taxes when they are consistent with federal requirements. CMS approves many state payment proposals annually that are supported by health care-related taxes that appear to meet federal requirements. CMS recognizes the challenges faced by states and health care providers in identifying sources of non-federal share financing and implementing Medicaid payment methodologies that assure payments are consistent with federal requirements.

Medicaid statute and regulations afford states flexibility to tailor health care-related taxes within certain parameters to meet their provider community needs and align with broader state tax policies and priorities for their Medicaid programs. CMS remains committed to providing states with technical assistance aiming to ensure that health care-related taxes used to finance the non-federal share of Medicaid expenditures meet the states' policy goals and comply with federal requirements. For example, CMS is authorized to waive the requirements that health care-related

taxes be broad-based and/or uniform, when applicable conditions are met. [1] CMS regularly works with states to approve such waivers in furtherance of state goals while complying with federal requirements.

Although the applicable statutory and regulatory provisions afford states considerable flexibility in establishing health care-related taxes, such taxes must be imposed in a manner consistent with applicable federal statutes and regulations, including that they may not involve hold harmless arrangements, to avoid a reduction in the state's Medicaid expenditures eligible for federal financial participation. Occasionally, CMS encounters health care-related tax programs that appear to contain hold harmless arrangements, which contravene section 1903(w)(1)(A)(iii) and (w)(4) of the Act and 42 C.F.R. § 433.68(b)(3) and (f). Such arrangements are inconsistent with statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax programs that appear to contain a hold harmless arrangement that involves the taxpaying providers redistributing Medicaid payments after receipt to ensure that all taxpaying providers receive all or a portion of their tax costs back (typically ensuring that each taxpaying provider receives at least its total tax amount back).

In this informational bulletin, CMS is reiterating the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, states and providers should be transparent regarding any explicit or implicit agreements in place or under development to ensure that all health care-related taxes meet federal requirements to avoid a statutorily required reduction in the state's Medicaid expenditures otherwise eligible for federal financial participation. CMS recommends that states that have questions or concerns about the permissibility of a health care-related tax raise these concerns to CMS early in the process of developing the state's tax program to avoid issues surrounding the permissibility of the non-federal share of Medicaid expenditures. CMS also intends to work with states that may have existing questionable arrangements to ensure compliance with federal statutory and regulatory requirements.

Health Care-Related Taxes and Hold Harmless Arrangements

During standard oversight activities and the review of state payment proposals, particularly managed care SDPs and fee-for-service payment state plan amendments (SPAs), CMS is increasingly encountering health care-related tax programs that appear to contain hold harmless arrangements involving the redistribution of Medicaid payments. In these arrangements, a state or other unit of government imposes a health-care related tax, then uses the tax revenue to support the non-federal share of Medicaid payments back to the class of providers subject to the

[1] For non-broad based and/or non-uniform health care related taxes, these conditions are: that the tax be imposed on a permissible class or class, that the tax be generally redistributive, that the tax be not directly correlated with Medicaid payments, and that the tax lack a hold harmless arrangement. See section 1903 (w)(3)(E)(ii) for the requirement that the tax demonstrate that it is 'generally redistributive" and "not directly correlated with Medicaid payments." For the statistical test demonstrating that the tax is "generally redistributive" see 42 CFR § 433.68 (e)(1) for waivers of the broad based requirement only and 42 C.F.R. § 433.68 (e)(2) for waivers of the uniformity requirement whether or not the tax is broad-based. See section 1903 (w)(4) and implementing regulations at 42 C.F.R. § 433.68 (f) for the hold harmless requirements. See section 1903 (w)(7) and 42 C.F.R. § 433.56 for a list of permissible classes upon which states may impose health care-related taxes.

tax. The taxpayers appear to have entered into oral or written agreements (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments to ensure that all taxpayers receive all or a portion of their tax back, when considering each provider's retained portion of any original Medicaid payment (either directly from the state or from the state through a managed care plan[2]) and any redistribution payment received by the provider from another taxpayer or taxpayers. These redistribution payments may be made directly from one taxpaying provider to another, or the funds may be contributed first to an intermediary redistribution pool.

In these hold harmless arrangements, there appear to be agreements among providers (explicit or implicit in nature) such that providers that furnish a relatively high percentage of Medicaid-covered services redistribute a portion of their Medicaid payments to providers with relatively low (or no) Medicaid service percentage. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These tax programs appear to contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3) that require a reduction in medical assistance expenditures prior to the calculation of federal financial participation as required under section 1903(w)(1)(A) and (w)(1)(A)(iii) of the Act. Here is a detailed example of a hold harmless arrangement involving Medicaid payment redistribution:

- A state imposes a hospital tax based on the volume of inpatient hospital services provided. The tax is broad-based, uniform, and is imposed on 10 hospitals.
- Six of the hospitals serve a high percentage of Medicaid beneficiaries, three serve a low percentage of Medicaid beneficiaries, and one hospital does not participate in Medicaid.
- The state uses the tax revenue as the source of non-federal share of Medicaid payments, which are made back to nine of the hospitals through SDPs. The tenth hospital, which does not participate in Medicaid, does not receive any SDPs directly from state-contracted managed care plans.
- Nine hospitals enter into oral or written agreements (meaning an explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments that the eight of the nine Medicaid-participating hospitals receive. Under this arrangement, five of the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from the managed care plans, then redistribute a portion of their Medicaid payments to the remaining four hospitals with lower Medicaid service percentages (including to the one hospital that does not participate in Medicaid). The redistribution amounts are calculated to guarantee that the nine participating hospitals, including those redistributing their own payments and those receiving the redistribution amounts, receive most, all, or more than all of their total tax cost back.
- The agreement among the taxpaying hospitals results in a reasonable expectation that the taxpaying hospitals, whether directly through their Medicaid payments or due to the

[2] The term managed care plan is used here and throughout this guidance to include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) as defined in 42 C.F.R. § 438.2.

availability of the redistributed payments received from five of the six high Medicaid service volume hospitals (regardless of whether the funds were first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.

- The high-percentage Medicaid hospitals are willing to participate because they still financially benefit from the tax program (even net of the redistribution payments they make to the lower Medicaid service volume hospitals), and the redistribution enables broad support for the tax program from all hospitals, ensuring constituent support for the state law authorizing the tax program.

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Implementing regulations at 42 C.F.R. § 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount" (emphasis added). In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments)."[3]

The word "indirect" in the regulation, highlighted in the excerpt above, makes clear that the state or other unit of government imposing the tax itself need not be involved in the actual redistribution of Medicaid payments for the purpose of making taxpayers whole for the arrangement to qualify as a hold harmless. It is possible for a state to indirectly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that guarantees to hold taxpayers harmless for any portion of the costs of the tax, if some or all of the taxpayers receive those payments at issue through an intermediary (for example, a hospital association or similar provider affiliated organization) rather than directly from the state or its contracted managed care plan. As CMS further explained in preamble to the 2008 final rule, we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[4] In the preamble, we also gave an example of state laws providing grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes; even though no state law typically required residents to use the grant funds to pay the increased nursing home fees, these direct state payments to nursing home residents indirectly held the nursing facilities harmless for their health care-related tax costs because of the reasonable expectation that their residents would use the state payments to repay the nursing facilities for all or a portion of their tax costs.[5] It remains true that hold harmless arrangements typically are not overtly established through state law but can be based instead on reasonable expectations that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related tax costs.

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[3] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[4] 73 Federal Register 9694
[5] *Id.*

Accordingly, an arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 C.F.R. § 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.

Some states have cited challenges with identifying and providing details on redistribution arrangements because they may not be parties to the redistribution agreements. A lack of transparency involving health care-related taxes and Medicaid payments may prevent both CMS and states from having information necessary to ensure sources of non-federal share meet statutory requirements. States have an obligation to ensure that the sources of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, states should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist.

As part of the agency's normal oversight activities and review of state payment proposals, CMS intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of health care-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements. As part of their obligation to ensure state sources of non-federal share meet federal requirements, we expect states to have detailed information available regarding their health care-related taxes. Consistent with federal requirements, CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments. States should work with their providers to ensure necessary information is available. Where appropriate, states should examine their provider participation agreements and managed care plan contracts to ensure that providers, as a condition of participation in Medicaid and/or of network participation for a Medicaid managed care plan, agree to provide necessary information to the state. States may consult section 1902(a)(6) of the Act, 45 C.F.R. § 75.364, 42 C.F.R. § 433.74, and 42 C.F.R. part 438 for any requirements related to CMS' authority to request records and documentation related to the Medicaid program. In particular, 42 C.F.R. § 433.74(a) requires that states, "must also provide any additional information requested by the Secretary related to any . . . taxes imposed on . . . health care providers," and the "States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures." 42 C.F.R. § 433.74(d) specifies that a failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation. If CMS or an outside oversight agency, such as the state auditing agency or the HHS Office of Inspector General discovers the existence of impermissible financing practices related to health care-related taxes CMS will take enforcement action as necessary. CMS is available to provide technical assistance and work with states to ensure the permissibility of all of the sources of the non-federal share of Medicaid expenditures, including any health care-related taxes the state may impose.

Conclusion

CMS recognizes that health care-related taxes can be a permissible source of funding for the non-federal share of Medicaid expenditures. CMS is available to provide technical assistance to states, including by reviewing proposals or existing arrangements and providing feedback to develop or modify health care-related taxes to align with state policy goals and federal requirements. One key federal requirement is that a health care-related tax cannot have a hold harmless provision that guarantees to return all or a portion of the tax back to the taxpayer. Health care-related tax programs in which taxpayers enter into agreements (explicit or implicit in nature) to redistribute Medicaid payments so that taxpayers have a reasonable expectation that they will receive all or a portion of their tax cost back generally involve a hold harmless arrangement that does not comply with federal statute and regulations.

CMS will continue to approve permissible health care-related tax programs that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS intends to work collaboratively with states by providing technical assistance as necessary to ensure the programmatic and fiscal integrity of the Medicaid program. For questions or to request technical assistance, please contact Rory Howe at rory.howe@cms.hhs.gov.

Washington, DC — The Academy of Physicians in Clinical Research (APCR) issued the following statement ahead of Congressional hearings on the President's 2024 proposed budget:

The administration's proposal to expand use of untested drug price setting provisions from the 2022 Inflation Reduction Act (IRA) is shortsighted. Many have already warned of the impact price controls will have on future drug development and post-approval research, particularly for cancer and rare diseases. This is of concern to our members, physicians who design and carry out clinical trials.

As clinical researchers, APCR member lead trials that produce new medications as well as new or expanded indications for therapies previously approved by FDA. Medicare's new authority is already having an impact on research and development decision making, particularly for small molecules.

We urge the Congress to look critically at the proposal to expand CMS' price setting authority included in the President's budget.

Senate Bill 1264 2021 midyear report

July 2021

TDI

Texas Department of Insurance
www.tdi.texas.gov

Contents

Publication date: July 2021
Publication ID: SB1264UP | 0721
This document is available online at www.tdi.texas.gov/reports

Overview

Senate Bill 1264 from the 2019 Texas Legislature protects consumers with state-regulated health plans from surprise medical bills in emergencies and situations where the consumer didn't select the provider. The program continues to grow, with dispute resolution requests received in the first six months of 2021 already exceeding the number of requests for all of 2020.

SB 1264 creates a mechanism for providers to resolve billing disputes directly with health plans and prohibits balance billing consumers for these services. In the first 18 months of implementation, the Texas Department of Insurance (TDI) has received 98,586 eligible requests to resolve medical billing disputes totaling $450 million. SB 1264 protects consumers from receiving balance bills for the disputed amounts.

TDI must issue a report on the impacts of the legislation each biennium. In addition to the required biennial report, TDI also produced a six-month report in 2020 and is doing so again this year to help monitor implementation of the new law.

Background

SB 1264 protects consumers in emergencies and situations where the consumer did not select the provider, such as a radiologist who reviewed an X-ray. In these circumstances, out-of-network providers and facilities are prohibited from billing the consumer more than the consumer's cost sharing. SB 1264 applies to services received on or after January 1, 2020.

SB 1264 applies to health plans regulated by TDI and people with coverage through the state employee or teacher retirement systems – or about 20% of Texans. It creates two distinct billing dispute resolution processes – arbitration for physicians and other similar providers and mediation for facilities and labs.

Federal legislation – the No Surprises Act – will provide balance billing protections for consumers with other types of health coverage starting January 1, 2022. TDI is requesting information from the U.S. Centers for Medicare & Medicaid Services to determine if the federal process will affect the state's arbitration and mediation processes.

Information on the Texas arbitration and mediation processes and timelines is available on the TDI website.

Key data points

Continued growth

The number of dispute resolution requests continues to increase each month. Requests received in the first half of 2021 exceed 2020 totals.

Arbitration and mediation requests

Year	Arbitration requests	Mediation requests
2020	44,910	3,855
Jan-June 2021	50,230	13,582

Complaints down

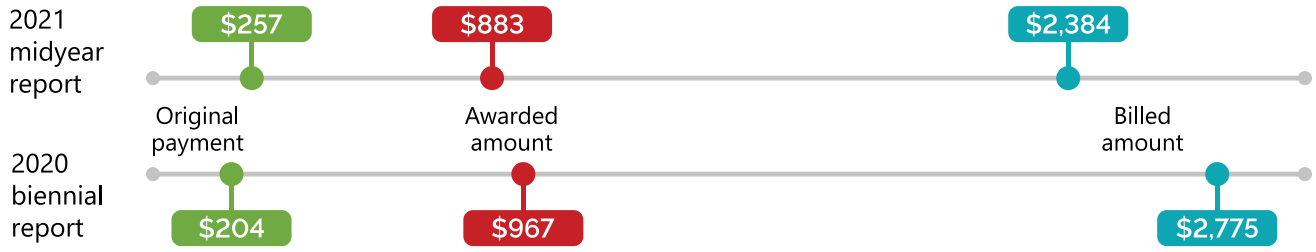
SB 1264's balance billing protections have resulted in sharp declines in consumer complaints. In 2019, TDI received 1,031 complaints about balance billing. In 2020, TDI received 40, and there have been 28 complaints in the first half of 2021. Most of the recent complaints involve confusion about coinsurance amounts or plans not regulated by TDI.

Shifts in outcomes

We continue to see changes in the average original billed amounts, payment amounts, and settlement/award amounts. It's unclear if these changes are related to the implementation of the new dispute resolution process, the pandemic's effect on elective services in 2020, other causes, or a combination of factors. The graphics below compare the first half of 2021 to the data published in the required biennial report, which covered January to October 2020.

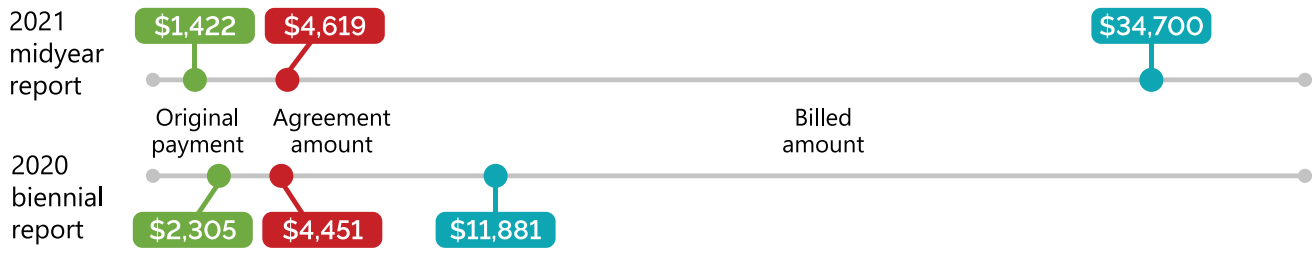
Arbitration requests settled in informal teleconference

Decided by an arbitrator



Mediation requests settled in informal teleconference

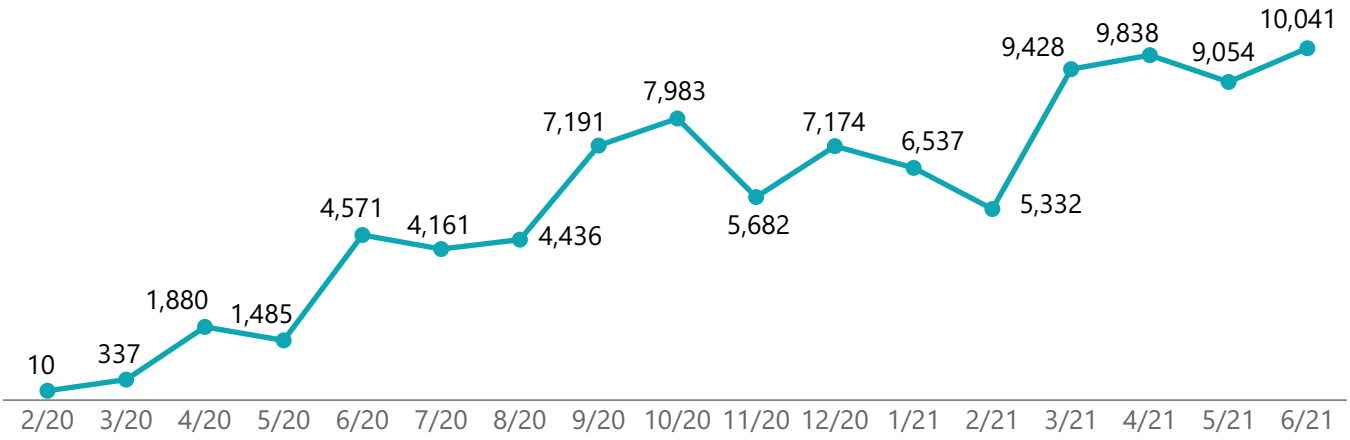
Settled with a mediator



Arbitration

SB 1264 outlines an arbitration process for billing disputes between out-of-network health care providers (not facilities) and health plans. In 2020, TDI received 44,910 requests for arbitration. In the first half of 2021, TDI received 50,230 requests.

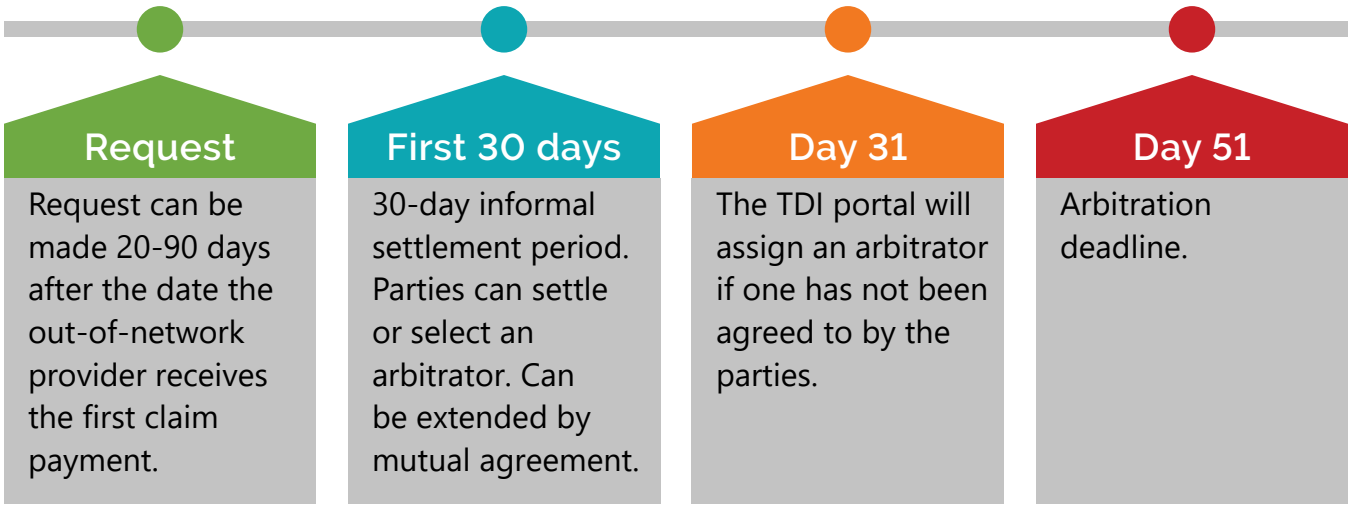
Arbitration requests by month



Arbitration requests by provider type

Provider type	Jan-June 2021
Emergency department physician	35,172
Anesthesiologist	8,238
Certified registered nurse anesthetist	1,993
Radiologist	1,749
Surgical assistant	759
Physician assistant	741
Assistant surgeon	686
Neuromonitor	321
Surgeon	169
Hospitalist	117
Nurse practitioner	96
Pathologist	72
Neonatologist	29
Neurologist	10
Other	78
Total	**50,230**

Arbitration timeline



How cases are resolved

Some requests received through June 30, 2021, are still in the dispute resolution process or were not eligible for dispute resolution under SB 1264.

Arbitration request resolution

- 19,194 requests settled in the first 30 days
- 13,648 requests settled by an arbitrator
- 5,997 ineligible or withdrawn

The resolution data below reflect requests involving a single claim for services. Requests involving multiple claims were excluded to avoid skewing the data.

Settled in informal teleconference

Decided by an arbitrator

Bundled requests

SB 1264 allows providers to include multiple claims on a single arbitration request, as long as the total amount in dispute is $5,000 or less and involves a single provider. In the first half of 2021, 17.4% of arbitration requests have involved multiple claims – down from 31% in 2020.

Arbitrator fees

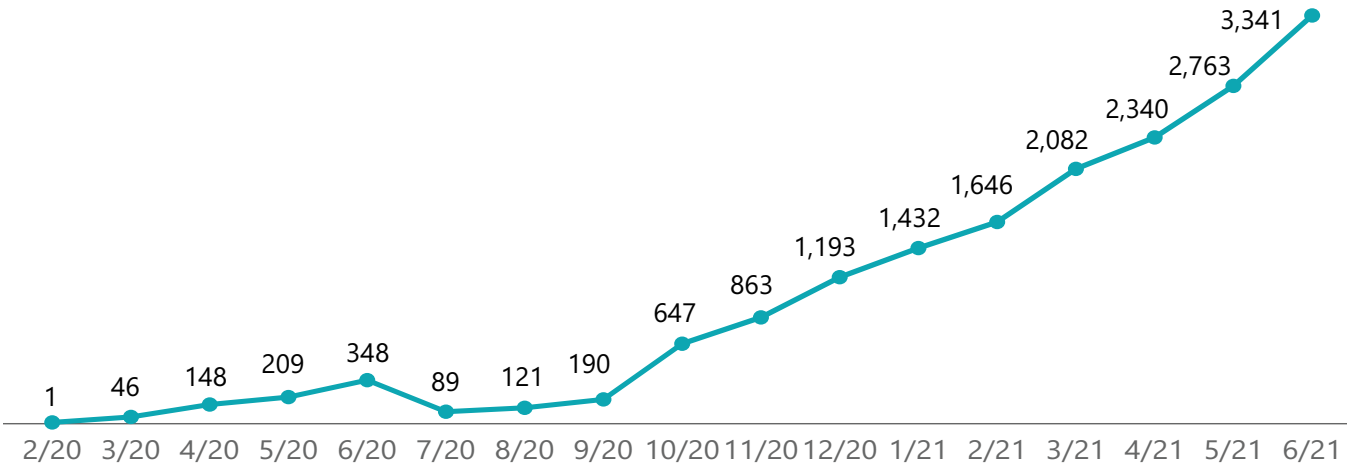
SB 1264 does not limit arbitrator fees. Instead, arbitrators set their own fixed fees per case. There is no fee to submit a request for dispute resolution or take part in informal settlement discussions. Each party pays half the fee once TDI assigns the case to an arbitrator.

Median fee:	$1,000
Lowest fee:	$350
Highest fee:	$5,000
Total fees paid:	$30,000,800

Mediation

SB 1264 outlines a mediation process for billing disputes between out-of-network facilities and health plans. In the first half of 2021, TDI has received 13,582 requests for mediation – more than three times the total for all of 2020.

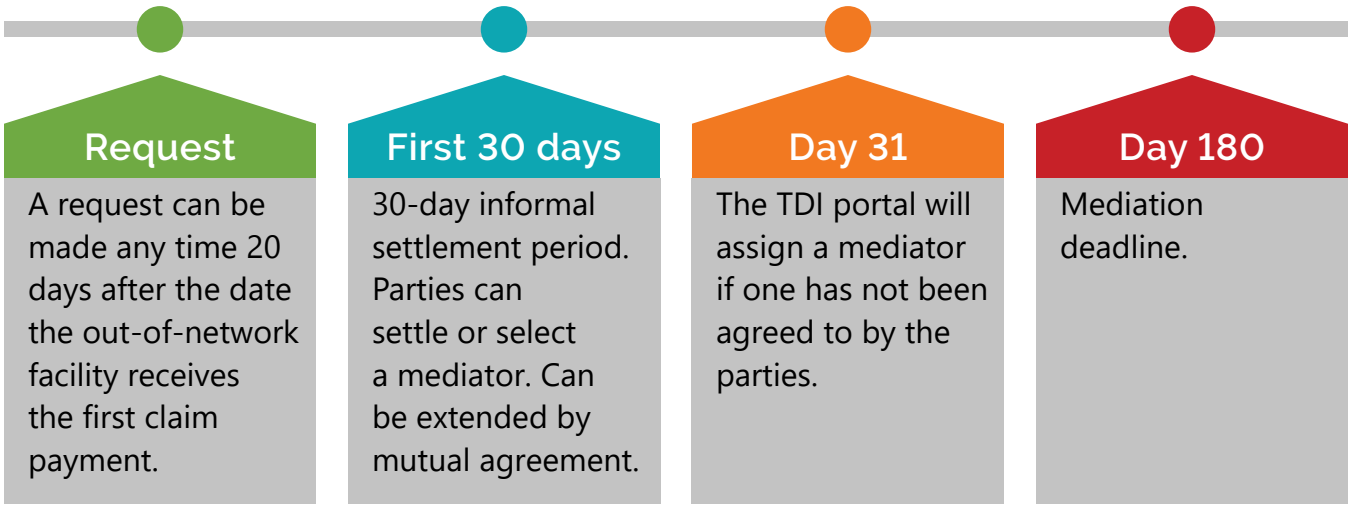
Mediation requests by month



Mediation requests by facility type

Facility type	Requests
Freestanding emergency room	10,322
Hospital	3,208
Ambulatory surgical center	23
Lab	19
Birthing center	10
Total	**13,582**

Mediation timeline



Resolution of mediation requests

Some requests received through June 30, 2021, are still in the dispute resolution process or were not eligible for dispute resolution under SB 1264.

Mediation request resolution

- 9,157 requests settled in the first 30 days
- 80 requests settled by a mediator
- 1,877 ineligible or withdrawn

The resolution data below reflect requests involving a single claim for services. Requests involving multiple claims were excluded to avoid skewing the data.

Settled in informal teleconference

Settled with a mediator

Bundled requests

TDI rules allow parties to a mediation to combine claims by mutual agreement for a single facility into one request. In the first half of 2021, 1.2% of mediation requests involved multiple claims – down from 3% in 2020.

Mediator fees

SB 1264 does not limit the fees charged by mediators. Instead, mediators set their own fixed fees per case. There is no fee to submit a request for dispute resolution or take part in informal settlement discussions. Each party pays half the fee once TDI assigns the case to a mediator.

Median fee:	$750
Lowest fee:	$80
Highest fee:	$3,000
Total fees paid:	$841,166

Texas Department of Insurance
Senate Bill 1264 2021 midyear update
SB1264UP | 0721

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Statement for the Record
Congresswoman Sheila Cherfilus-McCormick (FL-20)
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Hearing on President Biden's Fiscal Year 2024 Budget Request for Health and Human Services
Wednesday, March 29, 2023

Thank you to Chair McMorris Rodgers, Ranking Member Pallone, Subcommittee on Health Chairman Guthrie and Subcommittee on Health Ranking Member Eshoo for allowing me to submit this statement for the record for today's critical hearing.

On February 9, 2023, I introduced H.R. 901, the *Disposable ENDS Product Enforcement Act of 2023*. My legislation, which currently has over a dozen cosponsors, would require the Secretary of the Department of Health and Human Services to update the Food and Drug Administration's (FDA) guidance entitled "Enforcement Priorities for Electronic Nicotine Delivery System (ENDS) and Other Deemed Products on the Market Without Premarket Authorization" issued in April 2020, to include a description of how the Secretary will also prioritize enforcement against disposable ENDS products, including such nicotine products not derived from tobacco.

As the mother of two children and a former healthcare executive, the issue of our children's health is paramount to me. Unfortunately, too many of our youth are forming nicotine addictions and increasing their risk of future addiction to other drugs. I am deeply troubled by Chinese manufacturers and suppliers flooding the U.S. market with unregulated, harmful substances that alter our children's brain development and lives. I urge the Biden Administration and Secretary Becerra to close the harmful loophole that allows flavored disposable ENDS products to be on our store shelves and within reach of our children.

In 2020, the Trump Administration took a half step and made getting cartridge-based flavored ENDS products (other than tobacco and menthol) a priority for FDA. However, the actions of the Trump Administration created an opening for companies to swoop in and sell disposable versions of e-cigarettes with flavors such as fruity pebbles and bubble gum. These were the same flavors targeted for enforcement when sold with cartridge-based ENDS products.

In November 2022, FDA released data from the 2022 National Youth Tobacco Survey showing that flavored disposable e-cigarettes are minors' most common device type. That was not the case just a couple of years ago when flavored *cartridge-based* products like Juul drove youth usage. In 2020, FDA issued a guidance document explaining that it would prioritize enforcement against this product category. That was understandable and much appreciated. Retailers noticed and largely cleared their shelves of flavored cartridge-based vapes. Unfortunately, since FDA specifically noted in footnote 21 of the guidance that *disposable* products were not within this

prioritized category, the market became flooded with flavored disposable vapes. Other than sending a few warning letters, FDA has done absolutely nothing since to address this youth health crisis.

I urge Secretary Becerra to review H.R. 901 and consider using his existing authority to instruct FDA to prioritize enforcement of disposable vapes unlawfully on the market and report back to this esteemed Committee on the number of compliance and enforcement actions taken against their manufacturers. I understand enforcement actions may take some time, but this inaction is unacceptable. Currently, flavored disposable vapes can be purchased at most convenience stores within a one-mile radius of this hearing room and certainly throughout my district. At a minimum, I respectfully request Secretary Becerra's commitment to urge FDA to communicate to retailers that flavored disposable vapes are *unlawful* and that the agency will prioritize enforcement against their manufacturers.

I again thank the Committee for their courtesy and look forward to hearing from the Secretary on how HHS plans to get Chinese-manufactured flavored disposable vapes off the store shelves and out of the hands of our children.

Respectfully,

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Sheila Cherfilus-McCormick
Member of Congress

A Minnesota family's desperate search for care reveals state's mental health crisis

Insurance reimbursement rates — coupled with constraints on staffing and hospital beds — limit options for psychiatric patients, including children.

Harrison Bolchen, center, had to wait eight days for an inpatient psychiatric bed after being aggressive toward his brother and threatening to harm himself.

First in a series by Christopher Snowbeck, photos by Richard Tsong-Taatarii

Star Tribune • March 23, 2023

When he was about 18 months old, Harrison Bolchen loved matching words to letters. He would call out "A" and his mom would say "ant" and Harrison would reply "aardvark." They'd gleefully volley words, back and forth, before moving on to "B."

He explored parks with his family and laughed with the other kids at child care.

But at age 4, his behavior shifted. He had bouts of aggression. And he began running away from his parents.

His outbursts hit a new level last year — forcing the family to seek help at an ER.

Harrison, 13, who is autistic and has a mood disorder, was at such high risk for harming himself and others that emergency department caregivers scrambled to admit him to an inpatient psychiatric bed, but they couldn't find one.

MARK VANC

Video (03:35): Northwood Children's Services in Duluth is one of a handful of psychiatric residential treatment facilities

Not in Minnesota. Not in the Dakotas. Not in Wisconsin, Iowa or even Illinois.

He spent eight days waiting.

Such desperate — and often futile — searches for a psychiatric hospital bed are a symptom of decades of underfunding for mental health services in Minnesota and a system that's never been fully built for what patients need.

Patients struggle to find and use outpatient mental health care that could help prevent hospitalizations. Those who are admitted sometimes languish in hospital beds because there isn't room at step-down facilities. And non-hospital facilities that might be good alternatives aren't available, pushing patients into crowded emergency departments.

It is all complicated by the financial incentives in health care. Newly available data analyzed by the Star Tribune (https://www.startribune.com/minnesotas-mental-health-crisis-our-methodology-price-transparency-data-hospital-payment-rates/600261445) reveals how both medical insurers and the state-federal Medicaid program pay hospitals for psychoses treatment at a much lower per-day rate than other common physical conditions, such as pneumonia and heart failure.

The starkest example shows commercial health insurers pay about $14,000 per day for patients needing hip or knee replacement vs. less than $2,000 per day for mental health treatment. Medicaid health plans reveal a similar gap with a repayment rate of nearly $8,000 per day for hip and knee replacement vs. about $1,300 per day for psychoses.

"The numbers absolutely highlight the problem — and the problem is profound," said Dan Fromm, the chief financial officer at Robbinsdale-based North Memorial Health Hospital.

"The payment models don't make it possible to invest in inpatient mental health and get any kind of meaningful return, which means you can't recruit and attract the [mental health] providers and professionals you need to staff the units," said Fromm, who previously served as CFO at Fairview Health Services, the state's largest inpatient mental health provider.

'Young people are struggling'

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Harrison, 13, hung out with his dad, Chris ... tailored to students with sensory needs.

In hospitals across Minnesota, pediatric and adult mental health patients are boarding in emergency departments for "extraordinarily long periods of time," said Dr. Casey Clements, an emergency physician at Mayo Clinic.

It's all the consequence of a 50-year history where generations of patients have been forced to scramble without a comprehensive system to care for mental illness, said Dr. Paul Goering, a psychiatrist who was the longtime leader for inpatient mental health care at Allina Health System.

"Beds are the bottleneck right now," Goering said. "The work and the financial rewards aren't aligned. ... The squeeze in hospitals has always been that mental health is not going to make as much money as other kinds of things."

Without a comprehensive system, he said, hospital services – like emergency rooms – will be the default safety net.

In recent years, an average of 559 adult psychoses patients in and around the Twin Cities had to wait more than a day to be admitted to inpatient facilities annually, a Minnesota Department of Health report (https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/fvwacadappendixc.pdf) found. The number of adult patients leaving the ER against medical advice is up, according to the 2022 report, growing from 34 in 2016 to 56 in 2020.

At a game store in South St. Paul, Harrison showed one of his cards at a Pokémon gathering. His experience demonstrates th families are in when they seek mental healt services.

The mental health crisis spans all age groups but increasingly is hitting young people, a group that was suffering more problems even before the COVID-19 pandemic, said Dr. Katarzyna Litak, a child and adolescent psychiatrist at the University of Minnesota.

The federal government's biennial Youth Risk Behavior Survey (https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf) , released in February, found a record 57% of female high school students in 2021 reporting persistent feelings of sadness or hopelessness during the previous year. A decade earlier, the rate was 36%. While the rates were lower for male high school students, they are also increasing over time.

Thirty percent of females said they had seriously considered attempting suicide, up from 19% in 2011. Feelings of hopelessness and serious consideration of suicide were even higher among high school students who identified as lesbian, gay, bisexual or questioning.

Litak said access to psychiatric beds and other types of care continues to fall short of the need.

"Young people are struggling," she said.

While the crisis grows, bed capacity hasn't kept up. The number of pediatric mental health beds in Minnesota's general inpatient hospitals remained steady between 2015 and 2021, while adult capacity declined 4%.

State figures show the number of behavioral/mental health patients transferred from hospitals in the Twin Cities area to out-of-state facilities more than doubled from 66 in 2017 to 154 in 2021. Last year, these transfers, for children and adults alike, were on pace to set a new record, according to the Emergency Medical Services Regulatory Board.

"There's no easy answer — it's not just one thing," said Sue Abderholden, executive director of NAMI Minnesota.

"Hospitals should be trying to do more. Payers should pay more. All of that needs to happen," said Abderholden, whose group is the local affiliate of the National Alliance on Mental Illness. "And we need to address the workforce shortages as well. ... We have a crisis on our hands."

Hospital mental health workers are in short supply, the state says, with 80% of Minnesota counties designated as areas with a mental health shortage.

An issue of rates

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Behavior analyst Randal Westergard, left, discussed Harrison's progress with his pare

In 2019 and 2020, the federal government established new price transparency rules requiring hospitals and insurers to publicly disclose payments for individual services. The Star Tribune's analysis focused on payment rates for the 20 most common categories of hospital care, excluding pregnancy-related codes, as shown in data provided by Turquoise Health, a San Diego-based firm that collects the information.

Median payments to Minnesota hospitals were adjusted by the average length of stay for patients. The results show the median per-day payment for psychoses — the only mental health category in the study and the one where patients have the longest hospital stays — was lower than for all

other 19 types of care such as sepsis and chronic obstructive pulmonary disease.

While hospitals get paid in many ways beyond the billing codes analyzed by the Star Tribune, the newspaper's numbers reflect how reimbursement for mental health generally is lower than for other diagnoses, said Beth Heinz, the executive for mental health and addiction services at M Health Fairview.

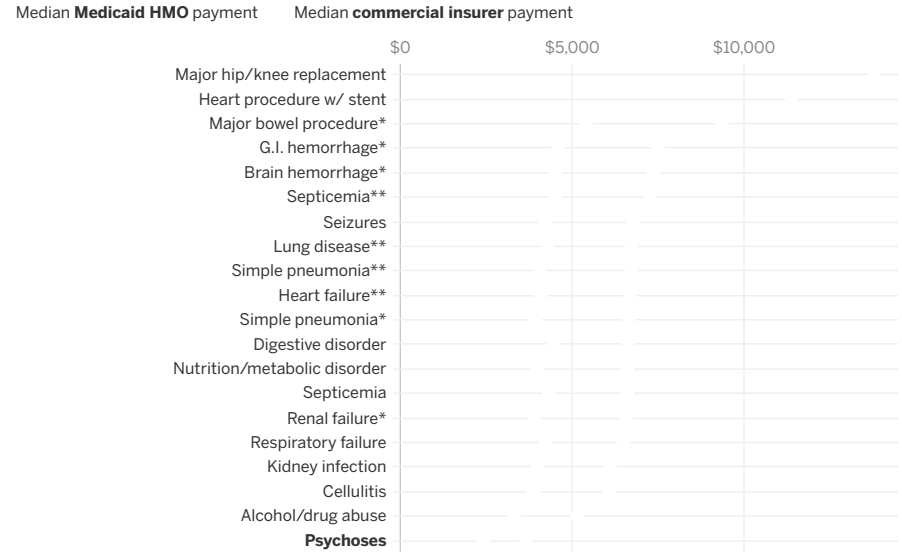
The reimbursement gaps across conditions were similar for both commercial and government-sponsored coverage. Health plans for people in Medicaid — the program for lower income people and some with disabilities — paid significantly less than commercial health insurers.

at their home in West St. Paul. At-home car helped him thrive.

Less revenue for mental health, addiction care

Public and private health insurers pay Minnesota hospitals significantly less per day for certain patients admitted with psychoses and alcohol/drug abuse problems than for certain common physical health ailments. *Hover/tap for detail*

MEDIAN RANGE OF COST FOR HOSPITALIZATIONS PER DAY



** With comorbidities or complications. ** With major comorbidities or complications.*

Median payment rates are calculated by Star Tribune from 2023 data provided by Turquoise Health across 83 Minnesota hospitals — just over half the statewide total — with rates from about two dozen payers. Median payments are divided by average length of stay to calculate per-day rates for the 20 most common MS-DRGs in Minnesota hospitals in 2017 excluding pregnancy-related codes.

Mark Boswell, Star Tribune

For decades, low Medicaid pay has been acutely felt in psychiatric care as the program covers a disproportionate share of mental health patients.

"In order to break even, you have to charge the commercial health insurers more," said Rick Gundling, a senior vice president of the Healthcare Financial Management Association.

Hospital officials say a lot of the pay difference across the 20 services makes sense, given the resources required for different services. Joint replacement surgery and heart procedures with stents, for example, use more expensive technologies than inpatient psychiatric care does.

But, Gundling said, the payment system that accounts for these resource differences isn't perfect. He and other experts say higher payments explain why hospitals typically spend more on marketing and construction for higher-tech services.

"These large differences in payments can contribute to hospitals prioritizing access to other, higher-paying services at the expense of mental health/behavioral health services," said Christopher Whaley, a health economist at Rand Corp.

The Star Tribune's comparison of per-day payments is important because hospitals are limited in the number of beds they can operate at any one time, said Matt Anderson, a former health policy expert at the Minnesota Hospital Association who also served as Medicaid Director for the Minnesota Department of Human Services.

There's pressure, he said, to maximize profitability from each available bed.

Nonprofit hospitals invest in services that aren't moneymakers as part of their charitable mission, said Anderson, now a senior lecturer at the University of Minnesota School of Public Health. Yet it's also true that reimbursement rates generally drive which health care services are built, as higher payments can bring better profit margins, he said.

"There are much greater financial incentives to deliver physical and acute care than to deliver mental health and behavioral care," Anderson said. "There are even greater financial incentives to deliver specialized or sub-specialized physical care and surgical/procedural care."

Boarding and bottlenecks

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Friend Leif Jugovich talked trading cards wi
Harrison at Dreamers Vault Games in Soutl
Paul.

Harrison shares comic strips to make people laugh and loves describing his Pokémon cards.

He does well at school in an environment tailored for students with sensory needs. And he's happy to tell visitors about his Lego sets scattered around his bedroom.

"He's very bright. He's charming. I really enjoy Harrison," said Amy Esler, a psychologist at the University of Minnesota who's treated Harrison over the past decade. "If we could just fix this behavior response for him, he would just be so successful."

In September, Harrison was aggressive toward his younger brother in the lead-up to a weekend when he threatened to harm himself. The family had to call law enforcement for help. It all culminated with dangerous behavior at school and then a trip to the emergency department at Children's Minnesota in St. Paul.

"I wasn't allowed out of this room," Harrison said of the ER. "For some reason, I was essentially being watched like 24 hours a day."

His mother, Tara Dobbelaere, said doctors and therapists have not yet identified what's driving the aggressive behaviors.

After eight days, his behavior stabilized enough that he could be discharged from the ER. At the time, Children's didn't have inpatient mental health beds.

While grateful for the emergency care, Dobbelaere couldn't believe the contrast from a few years ago when Harrison waited less than half a day to be admitted for inpatient treatment. Doctors say it's getting harder to find a bed for children with a history of aggression because they require specialized staff.

"That's the bind hospitals are in," Esler said. "If they want to provide these services, they know they're going to lose money. And also, these kids can be tough. They might throw something at you, and if you're not adequately staffed with people trained in de-escalation and positive behavior supports, there's a higher risk for injuries."

Worried about taking Harrison back home with their other children there, but with nowhere else to go, Dobbelaere and her husband booked short-term rental apartments via Airbnb. They alternated staying with their son for four weeks until they felt things were safer.

Even for children with mental illness who don't have aggression, it still could be a couple days' wait to find a bed, said Clements, the Mayo emergency physician.

A new option — for some

At Allina, Joe Clubb, the vice president of operations for mental health and addiction services, recalled two young patients who each spent more than 200 days in the hospital because there wasn't a step-down facility that could take them.

The patients might have been good candidates for a new type of pediatric residential facility (https://www.startribune.com/new-children-s-psychiatric-treatment-center-opens-in-duluth/488768311/) in Minnesota, he said, but there just aren't enough of them.

Called psychiatric residential treatment facilities, or PRTFs, the centers were launched in 2018 to help fill the care gap. Northwood Children's Services in Duluth was the first to open.

More than 200 students have attended since then and the average length of stay last year was just more than seven months. The duration fits with the amount of trauma students have experienced and the level of aggression and suicidal ideation they display, said Larry Pajari, the chief executive.

Despite the growing need, Northwood is one of only three facilities of its kind operating in Minnesota.

Hospitals regularly inquire about sending patients, but the waitlist at Northwood is long. "It's hard for me to prioritize certain kids over other kids that might have been waiting three to six months," Pajari said.

Medicaid HMOs will pay for children to stay at Northwood, he said, but only one commercial health insurer has done so.

Patient advocates say the lack of commercial coverage has stunted the growth of PRTFs. Most mental health providers, they point out, rely on higher payments from commercial insurers to offset lower Medicaid payments.

"It has been a bumpy ride," said Kirsten Anderson, executive director of AspireMN, a statewide association of child and family service providers. Commercial coverage would signal to providers that profitability is possible, she said.

Minnesota's nonprofit insurers say they are working to expand access and maintain that many patients can't get in because of a lack of facilities and staff — not because of a lack of coverage. Even so, advocates are pushing legislation to mandate coverage of PRTF care.

The bill would apply to "fully insured" health plans — a subset of the health insurance market that's regulated by the state. But that part of the market has been shrinking, used by just 18% of Minnesotans in 2020. It's much smaller than the 40% of Minnesotans enrolled in "self-insured" employer plans. A recent state Commerce Department report noted (https://mn.gov/commerce-stat/pdfs/Comm-AIR-HFXXXX-EvalRprt-2-508.pdf) one stakeholder's concern: the mandate could "drive more employer groups to switch to self-insured coverage to avoid potential costs."

Mandated coverage for PRTFs is just one of many reforms (https://www.startribune.com/minnesota-legislators-tackle-sinkholes-in-

mental-health-system/600257571/) being pushed this spring at the State Capitol. In his budget, Gov. Tim Walz proposes funding to help launch up to four new pediatric facilities.

Technology vs. labor

In November, Children's Minnesota opened (https://www.startribune.com/childrens-minnesota-unveils-new-inpatient-mental-health-unit-for-children/600227061/) mental health beds for the first time in the hospital's nearly 100-year history.

Creating the 22-bed unit was a difficult decision, said Dr. Gigi Chawla, chief of general pediatrics, in part because it required a significant investment in safety features.

Door handles are designed differently, to minimize the risk of patient harm. Rooms have special seating rather than chairs that could be picked up and thrown. Beds are part of a platform, so they can't be moved. Bathrooms are designed to minimize suicide.

Beyond construction costs, Chawla said, financial challenges with staffing and reimbursement force hospitals to honestly assess whether they can afford an inpatient psychiatry unit. Hospitals say shifting costs is key.

"There are things in health care that help sustain the business and many things in health care that are underwater," she said. "It doesn't mean you can't do them — it means the path to figuring out how to do them is partly dependent on the things that are above the water that can buoy the whole system."

Profits, losses and patients

Researchers say that while the public now has access to hospital revenue data for different types of services, that doesn't account for the costs, making it difficult to determine whether a payment rate covers expenses to turn a profit or result in a loss.

Rate differences are driven, first and foremost, by weighting systems that adjust base payments for the complexity and the technology used. The base payments are negotiated between insurers and hospitals.

Some health plans use a weighting system adopted by Minnesota's Medicaid program while others use a system from the federal Centers for Medicare and Medicaid Services (CMS). Use of those standards, insurers say, ensures parity in coverage.

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Jessica Brisbois, manager of acute mental health services at Children's in St. Paul, sho the safety and comfort features in the hosp new psychiatric care beds.

To better analyze hospital revenues, we looked some of the **most common inpatient hospital services.**

Mouse over and scroll to read more

But there have long been concerns that payment differences overstate the underlying cost differences between technology-intense services and those that are more labor-intensive, like mental health, said Dr. Michael Trangle, a psychiatrist and senior fellow at the HealthPartners Institute.

"Do we see our various diagnoses as comparable or do we have a bias against things that don't have catheters attached to them?" asked Lewis Zeidner, a vice president for mental health services at Fairview.

Inpatient psychiatry has a disproportionately large number of patients who stay a long time in the hospital due in part to discharge challenges, said Trangle, who for years had administrative responsibility for inpatient mental health at Regions Hospital in St. Paul.

Beyond contributing to ER backups, he said, these cases add to the financial challenge since many insurers pay rates that don't increase, or increase enough, as patients stay longer.

Members of Congress and the Medicare Payment Advisory Commission (MedPAC) are now questioning whether the CMS weighting system needs to be changed to better reflect the true cost of inpatient psychiatry.

A September report to the commission suggested the current system allows free-standing for-profit psychiatric hospitals to post large profit margins (https://www.medpac.gov/wp-content/uploads/2021/10/Inpatient-Psych-MedPAC-29-Sept-2022.pdf) on Medicare patients while mental health units in nonprofit hospitals lose significant sums.

Critics say free-standing hospitals can screen which patients they want to treat, since they don't operate emergency rooms, and select patients who will cost less.

"I hear it all the time: 'We can't find beds,'" Commissioner Lynn Barr said at a MedPAC meeting. "We're shocked by the profitability of the for-profit [facilities]. We should be equally shocked at the negative 20% margin of the nonprofit hospitals."

For now, more inpatient capacity is probably needed in Minnesota, since there aren't yet alternative safety net providers, said Goering, the psychiatrist and former Allina physician executive. But the long-term solution, he said, would reduce beds as part of a system with much more prevention, outpatient care and non-hospital urgent care.

"It's just been a failure of imagination and financing," Goering said.

Since Harrison's hospital stay in September, Tara Dobbelaere and her husband, Chris Bolchen, have worked with Dakota County human services to arrange for intensive in-home behavioral therapy.

Starting in early January, therapists met with Harrison and his parents to create a safety plan for the house. They tracked how often he stayed on task during sessions vs. running away or becoming aggressive. Harrison, along with his parents, extended the data collection throughout the day, chronicling compliance with rules on chores and screen time.

About a month later, care providers met with the family. Harrison had made so much progress they would begin reducing the number of sessions.

"When I saw you guys in November, there was just an energy of panic," Liz Hooks, a psychologist with Behavioral Dimensions in St. Louis Park, said during a February visit. "Now, there's already just a hugely different vibe in the house."

When Dobbelaere asked whether her son felt the difference, Harrison said: "I feel like I'm less likely to lash out."

His dad said there were still some conflicts, but power struggles with his son had almost completely disappeared.

"I feel like this fall was probably the darkest place we've gone to," Dobbelaere said. "We learned there is not a system to support kids like Harrison and that's so depressing. ... But for our family, at least we're not in that dark place anymore."

Data Editor MaryJo Webster contributed to this report. Staff writer Christopher Snowbeck reported this story while participating in the USC Annenberg Center for Health Journalism's 2022 Data Fellowship.

Christopher Snowbeck covers health insurers, including Minnetonka-based UnitedHealth Group, and the business of running hospitals and clinics.

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Minnesota's mental health crisis: Our methodology

How the Star Tribune selected and calculated payment rates using newly available data.

(https://www.startribune.com/minnesotas-mental-health-crisis-our-methodology-price-transparency-data-hospital-payment-rates/600261445/)

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United States Government Accountability Office

Report to Congressional Requesters

August 2018

RURAL HOSPITAL CLOSURES

Number and Characteristics of Affected Hospitals and Contributing Factors

GAO-18-634

August 2018

RURAL HOSPITAL CLOSURES

Number and Characteristics of Affected Hospitals and Contributing Factors

GAO Highlights

Highlights of GAO-18-634, a report to congressional requesters

Why GAO Did This Study

Research has shown that hospital closures can affect rural residents' access to health care services and that certain rural residents—particularly those who are elderly and low income—may be especially affected by rural hospital closures.

This report describes (1) how HHS supports and monitors rural hospitals' financial viability and rural residents' access to hospital services and (2) the number and characteristics of rural hospitals that have closed in recent years and what is known about the factors that have contributed to those closures.

GAO reviewed documents and interviewed officials from HHS and HHS-funded research centers; analyzed data compiled by HHS and an HHS-funded research center, with a focus on 2013 through 2017—the most recent year with complete data; reviewed relevant literature; and interviewed experts and stakeholders. GAO identified hospitals as rural if they met the Federal Office of Rural Health Policy's definition of rural.

GAO provided a draft of this report to HHS for comment. The Department provided technical comments, which GAO incorporated as appropriate.

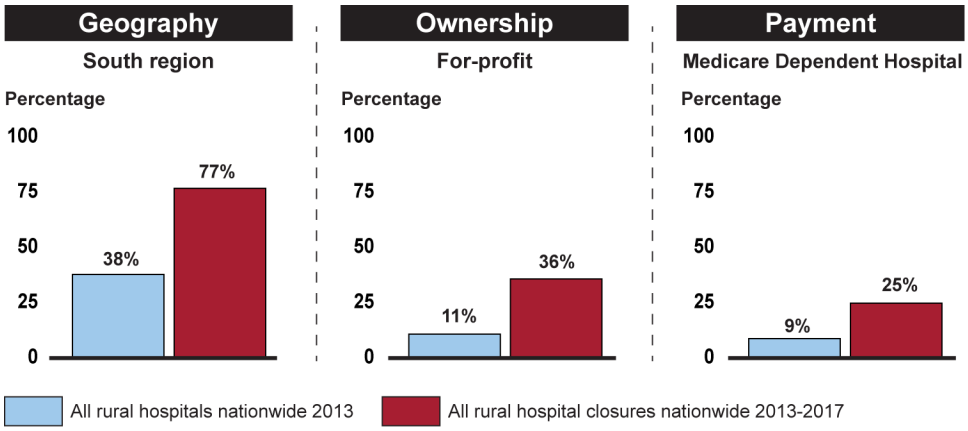
View GAO-18-634. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

The Department of Health and Human Services (HHS) administers multiple payment policies and programs that provide financial support for rural hospitals and funds research centers to monitor closures and study access. Among the payment policies administered by HHS are special payment designations for rural hospitals in which rural hospitals that meet certain criteria receive higher reimbursements for hospital services than they otherwise would receive under Medicare's standard payment methodology. HHS-funded research centers monitor rural hospitals' profitability and other financial indicators, and study access to facilities and specific services. HHS uses the results of monitoring activities to inform future areas of research and disseminate information.

GAO's analysis of data from HHS and an HHS-funded research center shows that 64 rural hospitals closed from 2013 through 2017. This represents approximately 3 percent of all the rural hospitals in 2013 and more than twice the number of closures of the prior 5-year period. GAO's analysis further shows that rural hospital closures disproportionately occurred in the South, among for-profit hospitals, and among hospitals that received the Medicare Dependent Hospital payment designation, one of the special Medicare payment designations for rural hospitals.

Percentage of Rural Hospitals in 2013 Relative to Percentage of Rural Hospital Closures from 2013 through 2017, by Selected Characteristics



Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

According to literature GAO reviewed and stakeholders GAO interviewed, rural hospital closures were generally preceded and caused by financial distress. In particular, rural hospitals that closed typically had negative margins that made it difficult to cover their fixed costs. According to these sources, financial distress has been exacerbated in recent years by multiple factors, including the decrease in patients seeking inpatient care and across-the-board Medicare payment reductions. In contrast, according to the literature GAO reviewed and stakeholders GAO interviewed, rural hospitals located in states that increased Medicaid eligibility and enrollment experienced fewer closures.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FORHP	Federal Office of Rural Health Policy
HHS	Department of Health and Human Services

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 29, 2018

The Honorable Claire McCaskill
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Timothy Walz
House of Representatives

Research has shown that hospital closures can affect rural residents' access to services. For example, a 2018 study found that, of the rural hospitals that closed from 2005 through 2017, 43 percent were more than 15 miles away from the next closest hospital.[1] In addition, a 2016 study found that rural residents—particularly those who are elderly and low-income—were more likely to delay or forgo care after a rural hospital closed if they had to travel longer distances to access hospital services.[2]

In 1987, the Federal Office of Rural Health Policy (FORHP)—an office overseen by the Department of Health and Human Services (HHS)—was established to advise HHS on the effects that federal health care policies and regulations have on the financial viability of small rural hospitals and access to health care in rural areas, among other things.[3] Both FORHP and another agency within HHS, the Centers for Medicare & Medicaid Services (CMS), administer payment policies and programs that support rural hospitals.

To better understand and respond to challenges facing rural hospitals, you asked us to describe HHS payment policies and programs focused on ensuring rural residents have access to necessary hospital services and what is known about recent rural hospital closures. This report describes

[1]See M. Clawar et al., *Range Matters: Rural Averages Can Conceal Important Information* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2018), 2.

[2]See J. Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* (Menlo Park, Calif.: Kaiser Family Foundation, 2016), 8.

[3]See 42 U.S.C § 912. FORHP is located in the Health Resources and Services Administration, an agency within HHS.

1. How HHS supports and monitors rural hospitals' financial viability and rural residents' access to hospital services; and
2. The number and characteristics of rural hospitals that have closed in recent years and what is known about the factors that contributed to those closures.

To identify how HHS supports and monitors rural hospitals' financial viability and rural residents' access to hospital services, we reviewed documents and interviewed officials from HHS and HHS-funded research centers, including the University of North Carolina's and the University of Iowa's rural health research centers.[4] HHS officials identified HHS payment policies and programs that provide key support to rural hospitals, and we reviewed laws, regulations, and HHS documents related to those policies and programs.

To identify the number and characteristics of rural hospitals that closed in recent years, we analyzed data on rural hospital closures compiled by the North Carolina rural health research center, and hospital-level data from CMS.[5] We also used these data to analyze and compare the characteristics of all rural hospitals, as of 2013, and rural hospitals that closed during the 5-year period from calendar years 2013 through 2017—the most recent years with complete data.[6] To assess the reliability of these data, we reviewed relevant documentation, interviewed

[4]In fiscal year 2017, HHS funded 9 rural health research centers, which are dedicated to producing policy-relevant research on health care and population health in rural areas.

[5]Specifically, we used CMS's Provider of Service files and Inpatient Prospective Payment Impact files.

[6]We limited our analysis to general acute care hospitals in the U.S. (i.e., we excluded federal hospitals, such as Indian Health Service hospitals; specialty and cancer hospitals; and hospitals in U.S. territories). We defined rural using FORHP's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3). The Rural-Urban Commuting Area codes are used by the United States Department of Agriculture to classify U.S. census tracts as urban or rural based on measures of population density, urbanization, and daily commuting. We defined a hospital closure as cessation of inpatient services. For context, we also analyzed the North Carolina rural health research center's data from the prior 5-year period (from 2008 through 2012); calculated the share of urban hospitals that closed from 2013 through 2017 using data from the North Carolina rural health research center, CMS, and Medicare Payment Advisory Commission publications describing annual hospital closures nationwide; and determined the number of rural hospitals that opened from 2014 through 2016 using Medicare Payment Advisory Commission publications (which defined rural as non-urban counties).

knowledgeable officials from FORHP and the North Carolina rural health research center, and performed electronic data tests to check for missing data and consistency with other published data. We determined the data were reliable for the purposes of our report. To identify additional information on the characteristics of the rural hospitals that closed and what is known about the factors that have contributed to those closures, we conducted a literature review. We identified literature through searching several bibliographic databases, including EconLit, MEDLINE, Scopus, and Social SciSearch. We identified additional literature through, for example, citations included in the literature we reviewed. We focused our review on literature published between 2013 and 2018, but also included some earlier literature for additional contextual information. Additionally, our literature review included research based on analysis of primary data sources, systematically summarized interviews, and case studies. In total, we identified and reviewed 17 relevant publications that met our standard for methodological rigor. We reviewed the degree of rigor across these studies and interpreted their findings based on this review. We also identified 17 additional publications that discussed contextual information related to rural hospitals that closed. For additional viewpoints on the characteristics of the rural hospitals that closed and the factors that contributed to those closures, we interviewed several stakeholders and experts: officials from FORHP and CMS and representatives from the American Hospital Association, the National Advisory Committee on Rural Health & Human Services, the National Rural Health Association, and the University of North Carolina's and University of Iowa's rural health research centers.

We conducted this performance audit from December 2017 to August 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Rural Hospitals and Areas

In 2017, about 2,250 general acute care hospitals in the United States were located in areas that met FORHP's definition of rural; these rural hospitals represented approximately 48 percent of hospitals nationwide and 16 percent of inpatient beds. These hospitals were spread across the

84 percent of the United States land area that FORHP classified as rural, and served the 18 percent of the United States population that lived in these areas.[7]

While there are significant differences across rural areas and populations, as a whole they differ from their urban counterparts in several ways. For example, rural areas have the following characteristics:

- **Higher percentage of elderly residents.** In 2014, 18 percent of the population was aged 65 or older in rural counties, compared with 14 percent in urban counties.[8]
- **Higher percentage of residents with limitations in activities caused by chronic conditions.** In 2010-2011, 18 percent of adults in rural counties had limitations in activities caused by chronic health conditions, compared with 13 percent in large, central urban counties.[9]
- **Lower median household income.** In 2014, the median household income in rural counties was approximately $44,000, compared to $58,000 in urban counties.[10]

Rural areas have also experienced several changes in recent years that have exacerbated these differences. For example, according to research by the United States Department of Agriculture, rural areas have experienced the following changes:

- **Decreasing population.** From 2010 through 2015, the population in rural areas declined, on average, by 0.07 percent per year, while the population in urban areas increased, on average, by 0.9 percent per year.

[7]These estimates are of the 2010 Census, and somewhat smaller than those classified as rural by the Census Bureau (95 percent of land area and 19 percent of population) and somewhat larger than those classified as rural by the Office of Management and Budget (72 percent and 15 percent, respectively). There are various ways to define a rural area, and no consistent definition is used across government programs. See Health Resources & Services Administration, *Defining Rural Population*, accessed December 26, 2017, https://www.hrsa.gov/rural-health/about-us/definition/index.html.

[8]See North Carolina Rural Health Research Program, *Rural Health Snapshot (2017)* (Chapel Hill, N.C.: University of North Carolina at Chapel Hill, 2017).

[9]See M. Meit et al., *The 2014 Update of the Rural-Urban Chartbook* (Bethesda, Md.: Rural Health Reform Policy Research Center, 2014), 115.

[10]See North Carolina Rural Health Research Program, *Rural Health Snapshot (2017*).

- **Slow employment growth.** From 2010 through 2015, rural employment grew at 0.8 percent per year, less than half that of urban areas (1.9 percent per year).[11]

Federal Response to Rural Hospital Closures in the 1980s

Rural hospital closures are not a recent phenomenon. For example, we previously reported that between 1985 and 1988, 140 rural hospitals closed—approximately 5 percent of the rural hospitals in 1985.[12] The large number of closures in the 1980s was preceded by a change in how Medicare paid hospitals. Specifically, in 1983, Medicare's inpatient prospective payment system was created, whereby predetermined rates were set for each Medicare hospital discharge. The intent was to control Medicare costs by giving hospitals financial incentives to deliver services more efficiently and reduce unnecessary use of inpatient services by paying a hospital a predetermined amount. However, one consequence of the new payment system was that some small, rural hospitals experienced large Medicare losses and increased financial distress.

Partially in response to the number of rural hospital closures, FORHP was established in 1987 to, among other things,

- advise the Secretary of HHS on the effects of current and proposed policies on the financial viability of small rural hospitals and on access to and quality of health care in rural areas;
- establish and maintain a clearinghouse for information on rural health care issues;
- coordinate rural health activities within HHS; and
- administer grants and other instruments to fund activities to improve health care in rural areas.[13]

[11]See United States Department of Agriculture, Economic Research Service, *Rural America at a Glance*, Economic Information Bulletin 182 (November 2017), 3.

[12]We published a series of products on the increase in rural hospital closures during the late 1980s: GAO, *Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access To Care*, GAO/HRD-91-41 (Washington, D.C.: Feb. 15, 1991), *Rural Hospitals: Factors that Affect Risk of Closure,* GAO/HRD-90-134 (Washington, D.C.: June 19, 1990), and *Rural Hospitals: Federal Leadership and Targeted Programs Needed,* GAO/HRD-90-67 (Washington, D.C.: June 12, 1990). These reports defined rural as non-metropolitan counties.

[13]See Pub. L. No. 100-203, § 4401, 101 Stat.1330, 1330-225 (1987) (codified as amended at 42 U.S.C § 912).

HHS Administers Multiple Payment Policies and Programs That Support Rural Hospitals and Funds Research Centers to Monitor Closures and Access

HHS Administers Payment Polices and Programs That Provide Financial Support to Rural Hospitals, Including Medicare Rural Hospital Payment Designations

HHS officials identified several rural-specific HHS payment policies and programs as providing key financial support to rural hospitals, and in turn, rural residents' access to hospital services. These key HHS payment policies and programs may be placed into three categories: (1) Medicare rural hospital payment designations; (2) rural grants, cooperative agreements, and contracts, and (3) new approaches in rural health care delivery and payment (see table 1).

Table 1: Rural-Specific Department of Health and Human Services (HHS) Payment Policies and Programs Identified by HHS as Providing Key Support to Rural Hospitals

Category	Specific payments and programs
Medicare rural hospital designations	• Critical Access Hospital • Sole Community Hospital • Medicare Dependent Hospital • Low Volume Hospital • Rural Referral Center
Rural grants, cooperative agreements, and contracts	*Grants* • Medicare Rural Hospital Flexibility • Rural Health Network Development • Rural Health Care Services Outreach • Small Rural Hospital Improvement Program • Delta States Rural Development Network • Small Health Care Provider Quality Improvement • Rural Health Network Development Planning *Cooperative agreements and contracts* • Delta Region Community Health Systems Development • Information Services / Technical Assistance Center • Medicare Rural Hospital Flexibility Evaluation • Rural Health Value • Small Rural Hospitals Transition Project • Rural Quality Improvement technical assistance • Frontier Community Health Integration Project Demonstration technical assistance
New approaches in rural health care delivery and payment	• Accountable Care Organization Investment Model • Rural Community Hospital Demonstration • Frontier Community Health Integration Project Demonstration • Pennsylvania Rural Health Model

Source: GAO interviews with HHS officials. | GAO-18-634

Note: These rural-specific payment policies and programs administered by HHS are targeted at areas that are rural or isolated. Because of different definitions of rural, not all hospitals designated as one of the Medicare rural hospital designations are in areas that would meet the definition of rural used by the Federal Office of Rural Health Policy. Because the Low Volume Hospital designation is based on the volume of services provided and does not require formal certification, it is more likely than other payment designations to be applied to a hospital one year and not the next.

- **Medicare rural hospital payment designations.** CMS administers five rural hospital payment designations, in which rural or isolated hospitals that meet specified eligibility criteria receive higher reimbursement for hospital services than they otherwise would have

received under Medicare's standard payment methodology.[14] A rural hospital may qualify as a Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital—each of which has different eligibility criteria and payment methodologies. With the exception of Critical Access Hospitals, rural hospitals may also qualify as Low Volume Hospitals and Rural Referral Centers, in which eligible hospitals receive additional payments or exemptions.[15] The largest of the five designations is the Critical Access Hospital program, which represented 56 percent of rural hospitals in 2017 and pays eligible small, rural hospitals based on their reported costs (instead of the standard rates under the inpatient prospective payment system). (See app. I, table 2, for a description of each of the five Medicare rural hospital payment designations.) CMS was unable to provide estimates of the additional Medicare payments rural hospitals received from each designation in 2017. According to CMS officials, CMS generally does not model the amount of additional Medicare payments resulting from rural hospital payment designations, except in years when there is a related payment policy change going through rulemaking.

- **Rural grants, cooperative agreements, and contracts.** FORHP administers multiple grant programs, cooperative agreements, and contracts that provide funding and technical assistance to rural hospitals. The largest of these is the Medicare Rural Hospital Flexibility grant program, in which FORHP provides funds to states to support Critical Access Hospitals to stabilize their finances, foster innovative models of care, and support other improvement activities. In 2017, 45 states received $25 million in Flex grants. FORHP officials noted that they can provide information to help states determine how to best target Flex grant funds, as there is not enough funding to financially assist all Critical Access Hospitals that are at risk of closing. (See app. I, table 3, for a description of the rural grants, and cooperative agreements and contracts identified by HHS officials.)

[14]These hospital designations are targeted at areas that are rural or isolated. Because of different definitions of rural, not all hospitals designated as one of the 5 Medicare rural hospital designations are in areas that would meet the definition of rural used by FORHP.

[15]Rural hospitals that do not qualify as a Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital are still eligible for these additional designations. Because the Low Volume Hospital designation is based on the volume of services provided and does not require formal certification, it is more likely than other payment designations to be applied to a hospital one year and not the next.

- **New approaches in rural health care delivery and payment.** CMS's Center for Medicare & Medicaid Innovation (Innovation Center) tests new ways to deliver and pay for health care—including some focused on rural areas—with the goal of reducing spending and preserving or enhancing the quality of care for beneficiaries enrolled in Medicare, Medicaid, and the Children's Health Insurance Program.[16] As of June 2018, the largest of these rural models and demonstrations was Medicare's Accountable Care Organization Investment Model. Groups of providers in rural and underserved areas participating in this model, potentially including small hospitals, agree to be held accountable for the cost and quality of care to their Medicare patients. The model tests providing pre-paid shared savings as an incentive for providers in rural and underserved areas to form Accountable Care Organizations and for these organizations to transition to arrangements with greater accountability for financial performance. For fiscal years 2012 through 2018, $96 million had been obligated to organizations participating in the model. Forty-five Accountable Care Organizations were participating in this model as of 2018.[17] (See app. I, table 4, for a description of the new approaches in rural health care delivery and payment identified by HHS officials.)

In addition to the HHS payment policies and programs specifically targeting rural areas, HHS officials also identified broader payment policies and programs that they stated can provide key support to rural hospitals and rural residents' access to hospital services. These HHS payment policies and programs may be placed in four categories:

- **Medicare and Medicaid base payments.** These consist of the standard payments for hospitals services.
- **Medicare and Medicaid uncompensated care payments.** Both Medicare and Medicaid provide multiple types of additional payments to support hospitals that incur costs for services provided to uninsured and other low-income individuals for which the hospitals are not fully compensated. Medicare also provides bad debt payments to hospitals

[16]The Children's Health Insurance Program is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

[17]Of the 45 participating organizations in the Accountable Care Organization Investment Model, 27 include a hospital (which, per investment model eligibility requirements must have 100 or fewer beds), and 36 have at least 65 percent of their delivery sites in rural areas.

to reimburse them for a portion of Medicare's beneficiaries' unpaid deductibles and coinsurance, as long as the hospital makes a reasonable effort to collect the unpaid amounts.[18]

- **Other targeted HHS payment policies and programs.** HHS administers other targeted payment policies and programs that support specific types of providers and areas, including, but not limited to, rural hospitals and areas. In particular, the Health Resources & Services Administration, an HHS agency, administers a drug discount program targeted at certain hospitals and other safety net providers. In addition, CMS administers bonus payments for certain physician services provided to Medicare beneficiaries in areas with a shortage of health professionals.[19]
- **State Innovation Models Initiative.** The Center for Medicare & Medicaid Innovation's State Innovation Models aim to achieve better quality of care, lower costs, and improve health for the population of the participating states or territory. Some states' plans include testing new delivery and payment models specifically targeting rural areas.[20]

HHS Funds Research Centers That Monitor Rural Hospital Closures and Study Access

HHS monitors rural hospitals' financial viability and rural residents' access to hospital services, primarily by funding rural health research centers that track rural hospital closures and study rural residents' access to hospital services.

To monitor rural hospitals' financial viability, HHS funds and conducts several activities:

- **Tracking rural hospital closures and monitoring profitability.** The North Carolina rural health research center, a FORHP-funded rural health research center, tracks rural hospital closures and monitors rural hospitals' profitability and other financial indicators. North Carolina's researchers identify rural hospital closures through a multi-

[18]Specifically, HHS officials identified Medicare's bad debt, disproportionate share hospital, and uncompensated care payments, and Medicaid's disproportionate share hospital payments, upper payment limits, and uncompensated care demonstration payments as providing key support to rural hospitals.

[19]These two programs are the 340 Drug Pricing Program and Health Professional Shortage Area physician bonus payments.

[20]See Rural Health Value, *State Innovation Model Testing Awards from the Center for Medicare & Medicaid Innovation: Highlighting Rural Focus* (Iowa City, Iowa: University of Iowa, July 2017).

party agreement with FORHP, the American Hospital Association, and the National Rural Health Association, each of which alerts the research center once one learns about a closure. Research center staff then confirm the closure and ascertain whether the hospital converted to another facility type by searching the hospital website and calling a community leader, such as the mayor. The North Carolina rural health research center publishes a list of rural hospital closures since 2010 on its website.[21] It also publishes reports on rural hospitals' profitability, including the extent to which profitability varies by rural hospitals' characteristics, and how rural hospitals' profitability compares to the profitability of their urban counterparts.[22]

- **Monitoring Critical Access Hospitals' financial indicators.** The North Carolina rural health research center, through its role as part of the Flex Monitoring Team, develops and monitors various financial indicators for Critical Access Hospitals.[23] Using the hospitals' Medicare cost reports, the research center currently monitors 22 financial indicators under 6 domains—profitability, liquidity, capital structure, revenue, cost, and utilization. These financial indicator data are available to every Critical Access Hospital through an online tool that also helps those hospitals compare their financial performance to peer hospitals.[24] The Flex Monitoring Team also publishes state-level

[21]See http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. The North Carolina rural health research center's list includes all Critical Access Hospitals, regardless of rurality.

[22]For example, see S.R. Thomas et al., *2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2016) and G. H. Pink et al., *Geographic Variation in the 2016 Profitability of Urban and Rural Hospitals* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2018).

[23]The Flex Monitoring Team is a consortium of the rural health research centers located at the Universities of Minnesota, North Carolina, and Southern Maine and is funded by FORHP's Medicare Rural Hospital Flexibility Evaluation cooperative agreement. Monitoring Critical Access Hospitals' finances is the primary focus of Flex Monitoring Team staff from the North Carolina rural health research center. Staff from the Minnesota rural health research center focus on quality and staff from the Southern Maine rural health research center focus on community engagement.

[24]The Flex monitoring team produces fiscal year financial indicator data for all Critical Access Hospitals with at least 360 days in their cost report and complete data. Therefore, some hospitals may be missing financial indicator data in certain years, such as if the hospital is new, had a change in ownership, or had very low or no Medicare utilization.

summary data on Critical Access Hospitals' finances that are available on its website.[25]

HHS also reviews and estimates the financial effect of policy changes on rural hospitals. In particular, FORHP officials review proposed and final rules for Medicare, Medicaid, and the Affordable Care Act's health insurance exchanges to identify concerns from a rural health perspective. Drawing on the research it funds, FORHP officials may suggest policy modifications to CMS, such as exempting certain Medicare rural hospital designations from a proposed policy change.[26] In addition to FORHP officials' review, as required by statute, CMS conducts regulatory impact assessments that estimate the effect of policy changes on payments to hospitals, including small rural hospitals, and publishes key results as part of proposed and final rules.[27] For example, as part of the fiscal year 2018 final rule on Medicare payment for hospital inpatient services, CMS estimated that the expiration of the Medicare Dependent Hospital designation would have decreased the payments to rural hospitals with that designation by 0.9 percent, or approximately $119 million.[28] Subsequent to the final rule, the Medicare Dependent Hospital and Low Volume Hospital designations were both extended.[29]

To monitor rural residents' access to hospital services, HHS relies on research conducted by the FORHP-funded research centers. Examples of recent research on rural residents' access to hospital services conducted by FORHP-funded research centers include the following:

[25]For example, see Flex Monitoring Team, *CAH Financial Indicators Report: Summary of 2016 Indicator Medians by State (Data Summary Report #26)* (Chapel Hill, N.C: University of North Carolina, 2018).

[26]For example, FORHP officials noted that they and other colleagues communicated concerns over the effect of proposed Medicare Part B payment cuts for drugs acquired under the 340B drug pricing program on rural hospitals. CMS excluded rural Sole Community Hospitals from such payment cuts in the final rule. See 82 Fed. Reg. 59216, 59222, 59482 (Dec. 14, 2017).

[27]See 42 U.S.C. §§ 912(b)(1), 1302(b). These regulatory impact assessments estimate the effect of regulatory changes, but do not make assessments on hospitals' financial viability.

[28]See 82 Fed. Reg. 37990, 38558 (Aug. 14, 2017).

[29]See, Bipartisan Budget Act of 2018, Pub. L. No. 115-123, §§ 50204, 50205, 132 Stat. 64, 181, 182 (codified at 42 U.S.C. §§ 1395ww(d)(12) (low-volume hospitals) and (d)(5)(G) (Medicare Dependent Hospitals)).

- **Research on rural residents' access to hospitals.** In 2018 the North Carolina rural health research center published an analysis of populations in rural counties without access to an acute care hospital or other types of primary care facilities. North Carolina's researchers estimated that about 4.4 million rural residents currently live in a county without an acute care hospital.[30]
- **Research on access to specific hospital services.** The Minnesota rural health research center conducted a body of research on declining access to obstetric services in rural counties. These researchers found that between 2004 and 2014, the percent of rural counties without hospital obstetric services increased from 45 to 54 percent, through a combination of hospital and obstetric-unit closures.[31]
- **Research on options for ensuring rural residents' access after a hospital closure.** The Iowa rural health research center published a summary of currently available options for ensuring rural residents' access to hospital services after a hospital closure, and additional policy options under consideration.[32] The National Advisory Committee on Rural Health and Human Services, a 21-member citizens' panel of nationally recognized rural health experts that advises HHS, also examined this topic, with a focus on alternative models to preserve rural residents' access to emergency care in light of the recent surge in rural hospital closures. The committee noted that payments and grants to support rural hospitals were largely effective and stabilized rural hospital financial operations until 2013, when a new wave of rural hospital closures began. The report included recommendations regarding the design of alternative models, including that HHS seek public comments on the use of a

[30]See M. Clawar et al., *Access to Care: Populations with Counties with no FQHC, RHC or Acute Care Hospital* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2018), 2.

[31]See P. Hung et al., *Closure of Hospital Obstetric Services Disproportionately Affects Less-Populated Rural Counties* (Minneapolis, Minn.: University of Minnesota Rural Health Research Center, 2017), 1; and P. Hung et al., "Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-2014," *Health Affairs*, vol.36, no. 9 (2017), 1667.

[32]See, K.J. Mueller et al., *After Hospital Closure: Pursing High Performance Rural Health Systems without Inpatient Care* (Iowa City, Iowa: Rural Policy Research Institute, 2017).

combination of geographic distance and demographic or social determinants of health when setting eligibility criteria.[33]

To supplement the monitoring by FORHP-funded research centers, FORHP officials also track recent rural developments and reports from rural health stakeholders. FORHP officials said this monitoring adds a qualitative component to the quantitative research conducted by research centers. In particular, these activities often provide the first notice of a rural hospital closure or pending closure, and also help track changes to the status of former hospitals over time.

HHS Uses the Results of Its Monitoring Activities to Inform Future Research and Grant Awards, and Disseminates This Information

HHS uses the results of its monitoring activities on rural hospitals' financial viability and rural residents' access to inform related research, primarily conducted by HHS-funded research centers, and to determine future areas of research. For example, the North Carolina rural health research center has used the list of rural hospital closures it compiles and its monitoring of profitability to conduct research on predictors of rural hospitals' financial distress.[34] In addition, FORHP officials stated that, based on this monitoring, they have added topics to research centers' agendas for subsequent years to gather more information on regulatory changes identified in its review of policy changes. Each year, specific research projects for the rural health research center are selected jointly by the center directors and FORHP. Topics are selected to have a timely impact on policy debates and decisions at both federal and state levels. Examples of added topics include North Carolina's research on the financial importance of the Sole Community Hospital and Low Volume Hospital designations and Iowa's research on the engagement of rural providers in Accountable Care Organizations.[35]

[33]See National Advisory Committee on Rural Health and Human Services, *Alternative Models to Preserving Access to Emergency Care* (2016).

[34]For example, see B.G. Kaufman et al., *Trends in Risk of Financial Distress among Rural Hospitals* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2016).

[35]See, S. R. Thomas et al., *The Financial Importance of the Sole Community Hospital Payment Designation* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2016), R.G. Whitaker et al., *The Impact of the Low Volume Hospital (LVH) Program on the Viability of Small, Rural Hospitals* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2016), and A. Salako et al., *Characteristics of Rural Accountable Care Organizations (ACOs) – A Survey of Medicare ACOs with Rural Presence* (Iowa City, Iowa: Rural Policy Research Institute, 2015).

HHS has also used the results of its monitoring activities to update the types of services offered by certain grants and create new cooperative agreements for technical assistance. Specifically, for fiscal year 2016, FORHP officials updated the list of activities that Rural Health Network Development Planning grantees can spend funds on to include implementing innovative solutions to alleviate the loss of local services and enhance access to care in communities that have or are at risk of losing their local hospital. According to FORHP officials, the addition of this activity to the scope of the grant led to 11 of the 47 applicants from fiscal years 2016 and 2017 to come from rural communities with a recent rural hospital closure or perceived risk of closure. As another example, in response to increased funding, in 2018 FORHP announced a new cooperative agreement to provide targeted in-depth assistance to vulnerable rural hospitals within communities struggling to maintain health care services. The awardee of the Vulnerable Rural Hospitals Assistance Program must work with vulnerable hospitals and their communities on ways to ensure hospitals and communities can keep needed care locally, whether it is with a more limited set of services provided by the hospital, or by exploring other mechanisms for meeting community health care needs.

FORHP disseminates the results of this research and successful rural health grants and other projects by funding cooperative agreements to maintain clearinghouses of information about rural health issues.[36] These clearinghouses were originally designed to efficiently disseminate research findings from rural health research centers to the public and to help rural communities identify opportunities and information to provide better healthcare to their residents. According to one of these clearinghouses, since then, the focus has grown to developing evidence-based resources on rural health to share what works in rural communities, including toolkits and case studies.

[36]Most FORHP-funded monitoring and related research is publicly available on the Rural Health Research Gateway (https://www.ruralhealthresearch.org/), which is hosted at the University of North Dakota Center for Rural Health with FORHP funding, and includes research and findings of the FORHP-funded Rural Health Research Centers, 1997-present. The Rural Health Information Hub (https://www.ruralhealthinfo.org/), formerly the Rural Assistance Center, is funded by FORHP to be a national clearinghouse for information, opportunities, and resources on rural health, including, but not limited to, those funded by FORHP.

Recent Increases in Rural Hospital Closures Have Disproportionately Occurred in the South, With Multiple Factors Likely Contributing to These Closures

From 2013 through 2017, More than Twice as Many Rural Hospitals Closed than in the Prior 5 Years

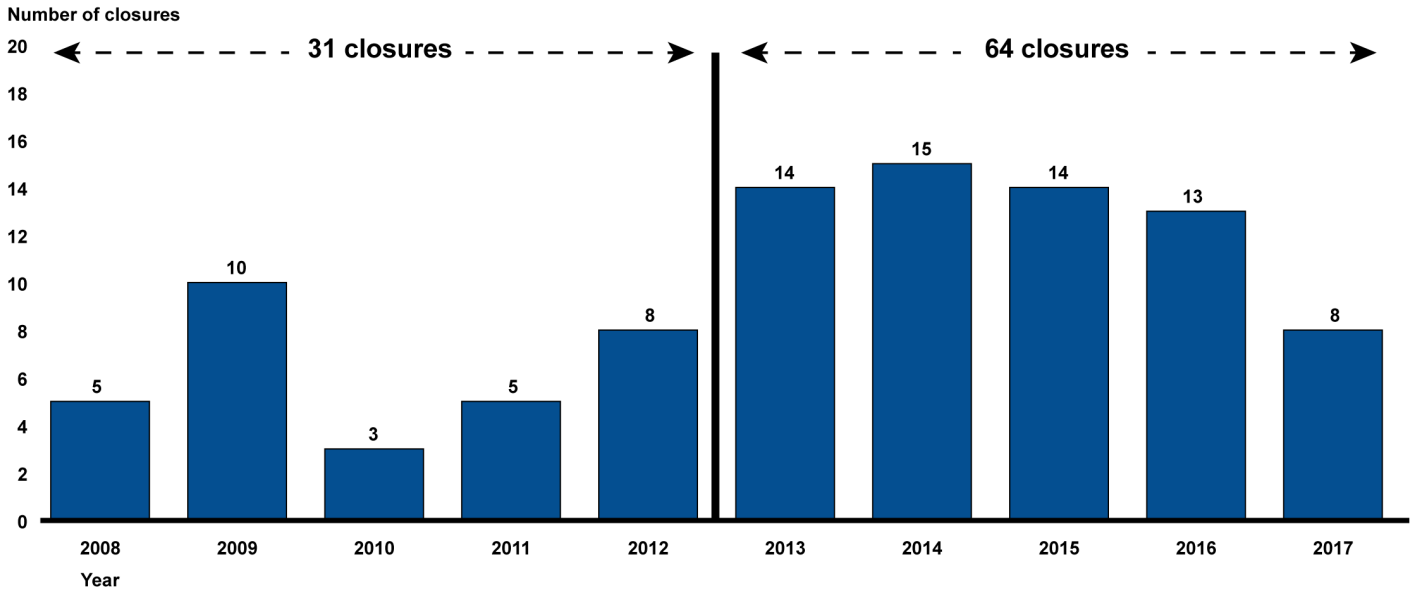
Our analysis of data from the North Carolina rural health research center and CMS shows that, from 2013 through 2017, 64 of the approximately 2400 rural hospitals in the United States closed.[37] These 64 rural hospital closures represented the following:

- **More than twice the number of rural hospitals that closed during the prior 5-year period.** From 2008 through 2012, 31 rural hospitals closed (see fig. 1).
- **More than the share of urban hospitals that closed.** The 64 rural hospital closures from 2013 through 2017—approximately 3 percent of all rural hospitals in 2013—exceeded the 49 urban hospital closures during the same time period—approximately 2 percent of all urban hospitals in 2013.
- **More than the number of rural hospitals that opened.** The 42 rural hospitals closed from 2014 through 2016 exceeded the 3 rural hospitals opened during the same time period.[38]

[37]The 64 hospitals that closed did not include the 8 hospitals that both closed and reopened between 2013 and 2017.

[38]The Medicare Payment Advisory Commission published rural hospital openings for 2014-2016. The Medicare Payment Advisory Commission defined rural as non-urban counties. In comparison, from 2014 through 2016, there were 30 hospital openings in urban counties.

Figure 1: Nationwide Rural Hospital Closures from 2008 through 2012 and from 2013 through 2017



Source: GAO analysis of Department of Health and Human Services-funded data. | GAO-18-634

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3).

Approximately half of the rural hospitals that closed from 2013 through 2017—47 percent—ceased to provide any type of services. The remaining hospitals that closed during this period converted to other facility types, providing more limited or different services, such as urgent care, emergency care, outpatient care, or primary care.

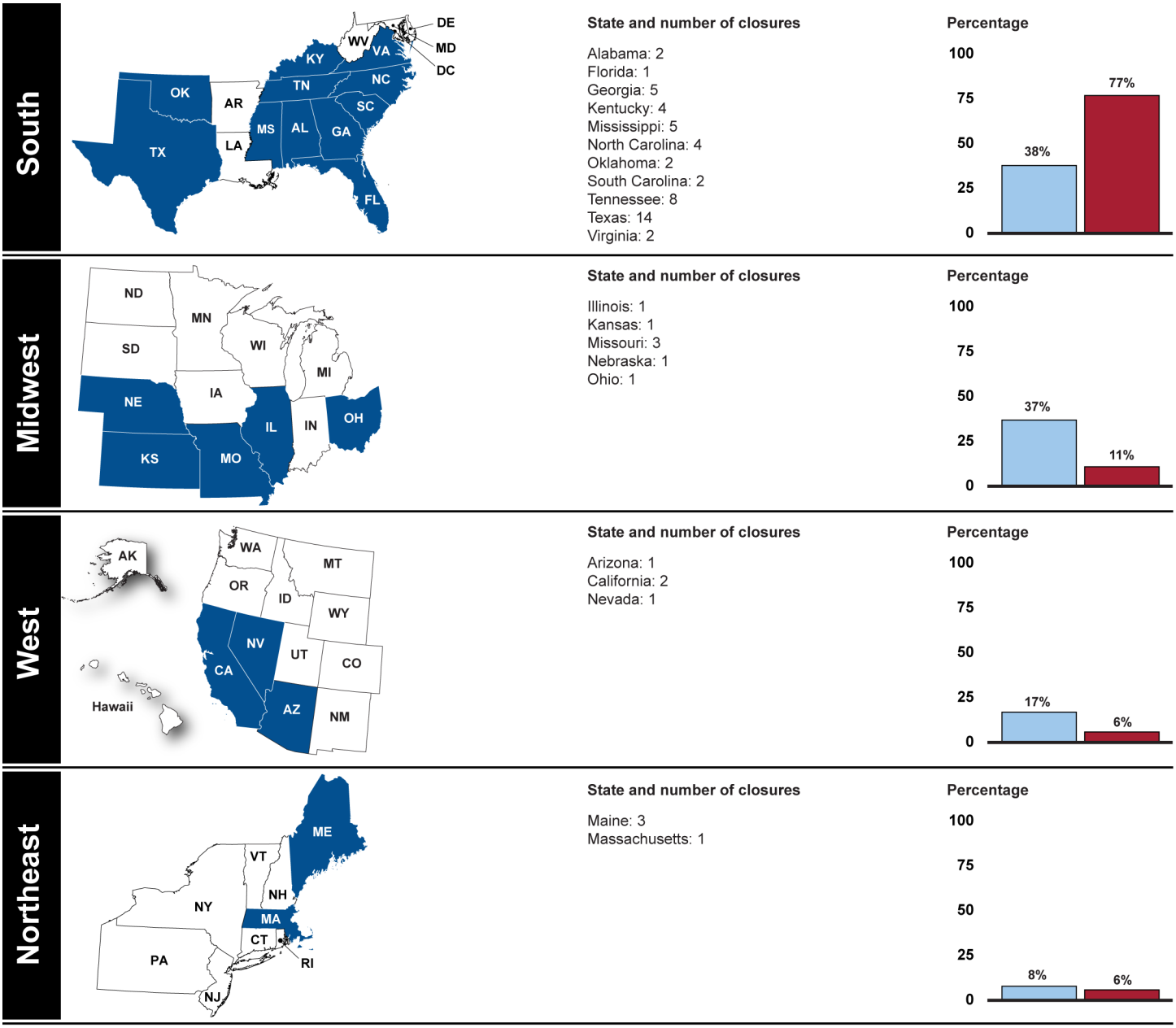
Rural Hospitals with Certain Characteristics—Including Those Located in the South—Accounted for a Disproportionate Share of Closures from 2013 through 2017

Our analysis of data from the North Carolina rural health research center and CMS shows that rural hospitals with certain characteristics—including those located in the South—accounted for a disproportionate share of the 64 closures that occurred from 2013 through 2017.

- **Geography**. Rural hospitals located in the South represented 38 percent of the rural hospitals in 2013, but accounted for 77 percent of the rural hospital closures from 2013 through 2017 (see fig. 2). Texas, one southern state, represented 7 percent of the rural hospitals in

2013, but accounted for 22 percent of the rural hospitals closures from 2013 through 2017.

Figure 2: Percentage of Rural Hospitals in 2013 Relative to Percentage of Rural Hospital Closures from 2013 through 2017, by Region and State



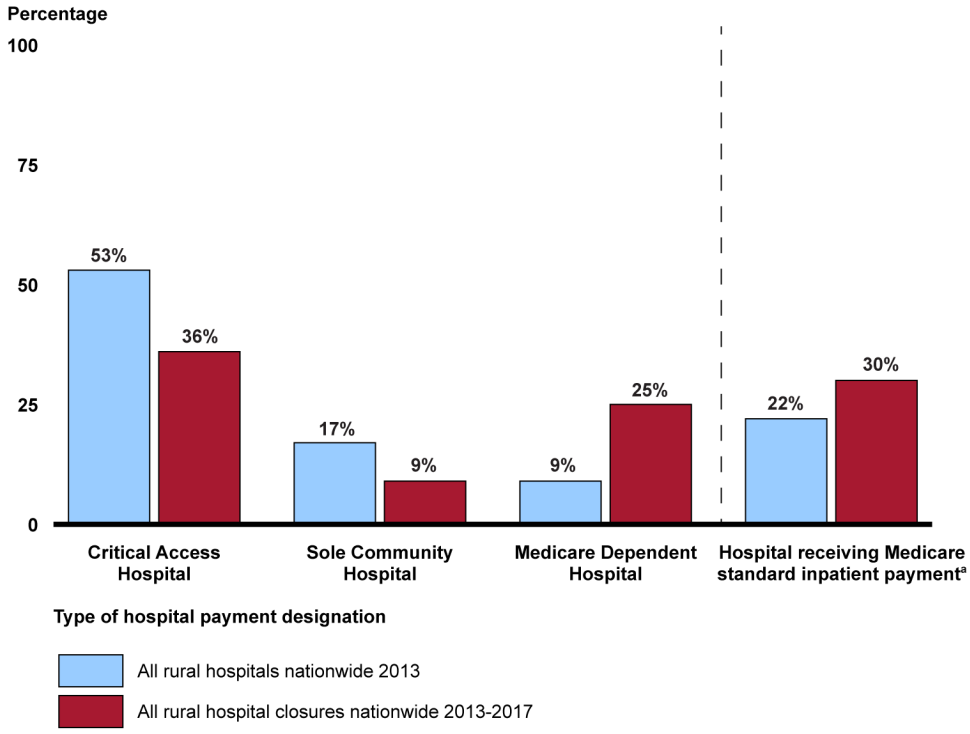
Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3).

- **Medicare rural hospital payment designations.** Medicare Dependent Hospitals – one of three Medicare rural hospital payment designations in which hospitals were eligible to receive a payment rate other than standard Medicare inpatient payment rate – were disproportionately represented among hospital closures. Specifically, Medicare Dependent Hospitals represented 9 percent of the rural hospitals in 2013, but accounted for 25 percent of the rural hospital closures from 2013 through 2017. Rural hospitals that did not receive one of these three Medicare rural hospital payment designations also represented a disproportionate share of the closures (see fig. 3). In addition, hospitals designated as Low Volume Hospitals had a disproportionate share of the rural hospital closures.[39]

[39]Specifically, we found that hospitals designated as Low Volume Hospitals in 2013 represented 22 percent of the rural hospitals in 2013 but accounted for 42 percent of the rural hospital closures from 2013 through 2017. In contrast, hospitals designated as Rural Referral Centers represented 10 percent of all rural hospitals in 2013 but only 2 percent of the rural hospital closures from 2013 and 2017.

Figure 3: Percentage of Rural Hospitals in 2013 Relative to Percentage of Rural Hospital Closures from 2013 through 2017, by Medicare Rural Hospital Payment Designation



Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3)

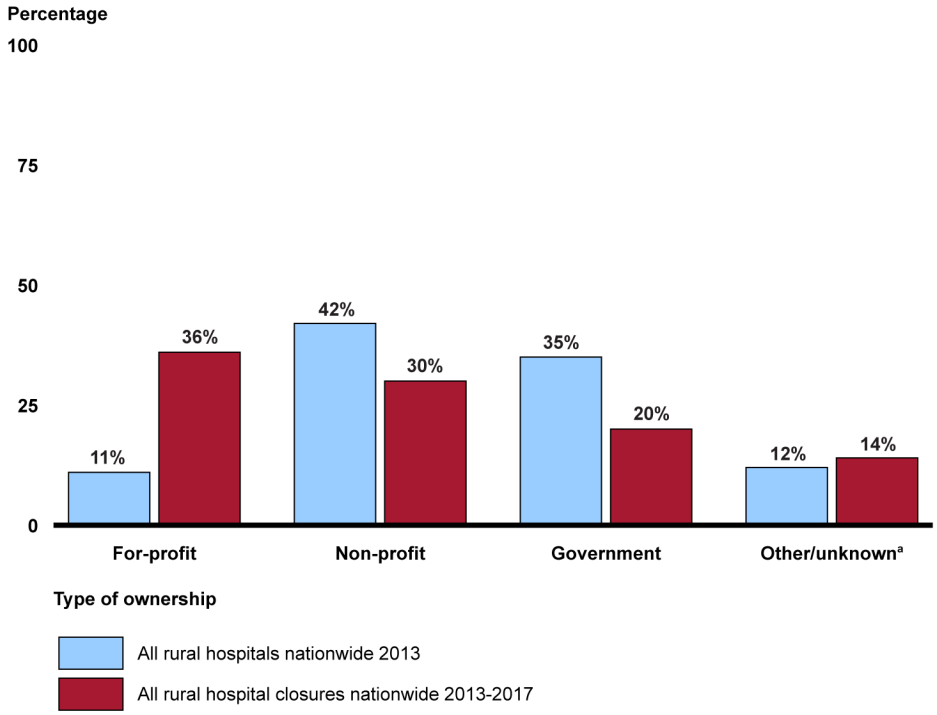
Percentages may not sum to 100 percent due to rounding.

[a]Hospitals that did not qualify as a Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital are included in this figure as hospital receiving Medicare standard inpatient payment. Medicare paid these hospitals for inpatient services based on the inpatient prospective payment system methodology.

- **Ownership.** For-profit rural hospitals represented 11 percent of the rural hospitals in 2013, but accounted for 36 percent of the rural hospital closures from 2013 through 2017 (see fig. 4). According to literature we reviewed, hospitals with for-profit status had a higher probability of financial distress and were more likely to close. For example, a 2017 study found that for-profit hospitals were more than

twice as likely to experience financial distress relative to government-owned and non-profit hospitals from 2000 through 2013.[40]

Figure 4: Percentage of Rural Hospitals in 2013 Relative to Percentage of Rural Hospitals Closures from 2013 through 2017, by Ownership Type



Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3).

[a]The other ownership type code in the Provider of Services files does not specify ownership.

- **Bed size.** Rural hospitals with between 26 and 49 inpatient beds represented 11 percent of the rural hospitals in 2013, but accounted for 23 percent of the rural hospital closures from 2013 through 2017. Critical Access Hospitals have 25 acute inpatient beds or less and make up a majority of the rural hospitals, but were less likely than

[40]See G.M. Holmes et al., "*Predicting Financial Distress and Closure in Rural Hospitals*" *The Journal of Rural Health,* vol. 33 (2017), 244.

other rural hospitals to close. FORHP officials identified the Critical Access Hospital payment designation – in which Medicare pays designated hospitals based on their costs – paired with the related Medicare Rural Hospital Flexibility grant program as the most effective HHS payment policy and program to support rural hospitals' financial viability and rural residents' access to hospital services.[41]

Fewer Patients Seeking Inpatient Care and Reductions in Medicare Payments Have Likely Contributed to Rural Hospital Closures

According to literature we reviewed and stakeholders we interviewed, rural hospital closures were generally preceded and caused by financial distress. In particular, rural hospitals that closed typically had negative margins which made it difficult to cover their fixed costs. For example, one 2016 study found that rural hospitals that closed from 2010 through 2014 had a median operating margin of -7.41 percent in 2009. In contrast, rural hospitals that remained open during the same time period had a median operating margin of 2.00 percent in 2009.[42] In addition, there is evidence that for-profit hospitals have been more sensitive to changes in profitability and more likely to experience financial distress, which could explain the disproportionate number of closures among rural hospitals with for-profit ownership type.[43]

The literature we reviewed and stakeholders we interviewed identified multiple factors that likely contributed to increased financial distress and

[41]According to FORHP officials, from fiscal year 2003 through fiscal year 2007, the percentage of Critical Access Hospitals with a positive operating margin increased steadily. There was a slight decline starting in fiscal year 2008, the same year as the recession, and the percentage leveled out again in fiscal year 2010. See app. I table 2 for a description of the Critical Access Hospital Payment Designation and app. I, table 3, for a description of the Medicare Rural Hospital Flexibility grant program.

[42]Critical Access Hospitals were separated out from these operating margin medians, but were similar. The study found that closed Critical Access Hospitals had a median operating margin of -7.56 percent and those that remained open had a median operating margin of 0.46 percent. According to this study, the operating margin was one of the two variables used to measure profitability in this study and according to this study one of the most consistent predictors of closure and financial distress. See B.G. Kaufman et al., *The Rising Rate of Rural Hospital Closures* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2016), 40.

[43]A 2005 study noted that all hospitals must earn sufficient profits to operate, but found that for-profit hospitals were more likely to respond to the level of profitability than the other types of hospitals. This is consistent with our analysis of rural hospitals' ownership type, which found that for-profit hospitals represented 11 percent of the rural hospitals in 2013, but accounted for 36 percent of the rural hospital closures from 2013 through 2017. See J.R. Horwitz, "Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals," *Health Affairs*, vol.24, no.3 (2005), 796.

closures among rural hospitals. One such factor was a decrease in patients seeking inpatient care at rural hospitals due to the following:

- **Increased competition for the small volume of rural residents.** Rural residents may choose to obtain services from other health care providers separate from the local rural hospital, for example from an increasing number of federally qualified health centers or newer hospital systems outside of the area. The competition for the small volume of rural residents between rural hospitals and other health care providers potentially increased due to the shift to paying for value instead of volume, and technology changes.[44] This increased competition for a small volume of rural residents could explain disproportionate closures among hospitals receiving the Low Volume Hospital Medicare payment designation, hospitals that by definition have a low Medicare volume and that research has found have lower margins than other rural hospitals.[45] In addition, representatives from the American Hospital Association told us that technological advances have allowed more services to be provided in outpatient settings.[46] For example, changes in health care technology have expanded the provision of outpatient surgical procedures.
- **Declining rural population.** The years 2010 through 2016 marked the first recorded period of rural population decline.[47] According to

[44]The transition to paying for value instead of volume involves two shifts: (1) increasing accountability for quality and total cost of care, and (2) a greater focus on population health management as opposed to payment for specific services. A 2016 study found that this shifted investment away from inpatient care and toward outpatient settings, such as preventive and primary care. See J. Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* (Menlo Park, Calif,: Kaiser Family Foundation, 2016), 6.

[45]Low Volume Hospitals—one of the Medicare's additional rural hospital payment designations—are required to have less than 1,600 Medicare inpatient discharges per year. For margins, see Whitaker et al., *The Impact of the Low Volume Hospital (LVH) Program on the Viability of Small, Rural Hospitals* (Chapel Hill, N.C.: North Carolina Rural Health Research Program, 2016), 4. See app. I, table 2, for a description of each of the five Medicare rural hospital payment designations.

[46]Representatives from the American Hospital Association told us that technological advances have affected urban hospitals as well, but urban hospitals, due to their volume of services, have more capability to adjust services, such as by reducing inpatient beds.

[47]Recent population estimates show signs of population recovery in rural area in the United States (2015-2016). Other factors that led to population decline in rural areas include continuous outmigration of young adults, which ages the population, and increased mortality among working-age adults. See U.S. Department of Agriculture, Economic Research Service, "Rural America at a Glance," *Economic Information Bulletin* 182 (November 2017), 2.

literature we reviewed and stakeholders we interviewed, the recent population decline in rural areas was likely associated with the recent decline in rural residents seeking inpatient services.

Another factor highlighted by literature we reviewed and stakeholders we interviewed as contributing to rural hospitals' increased financial distress was across-the-board Medicare payment reductions. Rural hospitals are sensitive to changes to Medicare payments because, on average, Medicare accounted for approximately 46 percent of their gross patient revenues in 2016.[48] A 2016 study found that Medicare Dependent Hospitals' operating margins decreased each year from 2012 through 2014, which could explain the disproportionate number of closures among the Medicare Dependent Hospital payment designation.[49] The literature we reviewed and stakeholders we interviewed highlighted the recent Medicare payments cuts as contributing to rural hospital closures, which included the following:

- **Reductions in nearly all Medicare reimbursements.** Under sequestration – the cancellation of budgetary resources under presidential order implemented pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended – each fiscal year since 2013, nearly all Medicare's budget authority is subject to a reduction not exceeding 2 percent, which is implemented through reductions in payment amounts.[50] According to stakeholders we interviewed, these payment reductions have contributed to negative margins for rural hospitals.
- **Reductions in Medicare bad debt payments.** Under the Middle Class Tax Relief and Job Creation Act of 2012, Medicare bad debt reimbursements for hospitals were reduced beginning in fiscal year

[48]Revenue estimate is from the American Hospital Association, which defined rural as non-metropolitan counties. In comparison, Medicare accounted for approximately 43 percent of urban hospitals' gross revenues in 2016.

[49]One of the eligibility requirements for the Medicare Dependent Hospitals is the hospital must have greater than or equal to 60 percent of inpatient days or discharges from Medicare beneficiaries. See app. I, table 2, for a description of each of the five Medicare rural hospital payment designations. See S.R. Thomas et al., *2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification* (Chapel Hill, N.C.: North Carolina Rural Health Research Program. 2016), 3.

[50]See 2 U.S.C. § 901a(6). Under current law, sequestration of direct spending to achieve budgetary goals may be required every year through fiscal year 2027.

2013.[51] According to stakeholders, Medicare bad debt cuts have been one of the most important factors contributing to the recent increase in rural hospital closures.

The literature we reviewed and stakeholders we interviewed also identified factors that likely strengthened the financial viability of rural hospitals. Chief among these factors was the increased Medicaid eligibility and enrollment under the Patient Protection and Affordable Care Act.[52] A 2018 study found that Medicaid expansion was associated with improved hospital financial performance and substantially lower likelihood of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion.[53] Another 2017 study found that from 2008-2009 and 2014-2015 the drop in uninsured rates corresponded with states' decisions to expand Medicaid on or before January 1, 2014. The increase in Medicaid coverage and decline in uninsured were both largest in the small towns and rural areas of those expansion states.[54] Additionally, our analysis of data from the North Carolina rural health research center and CMS shows that from 2013 through 2017, rural hospitals in states that had expanded Medicaid as of April 2018 were less likely to close compared with rural hospitals in states that had not expanded Medicaid (see fig. 5).

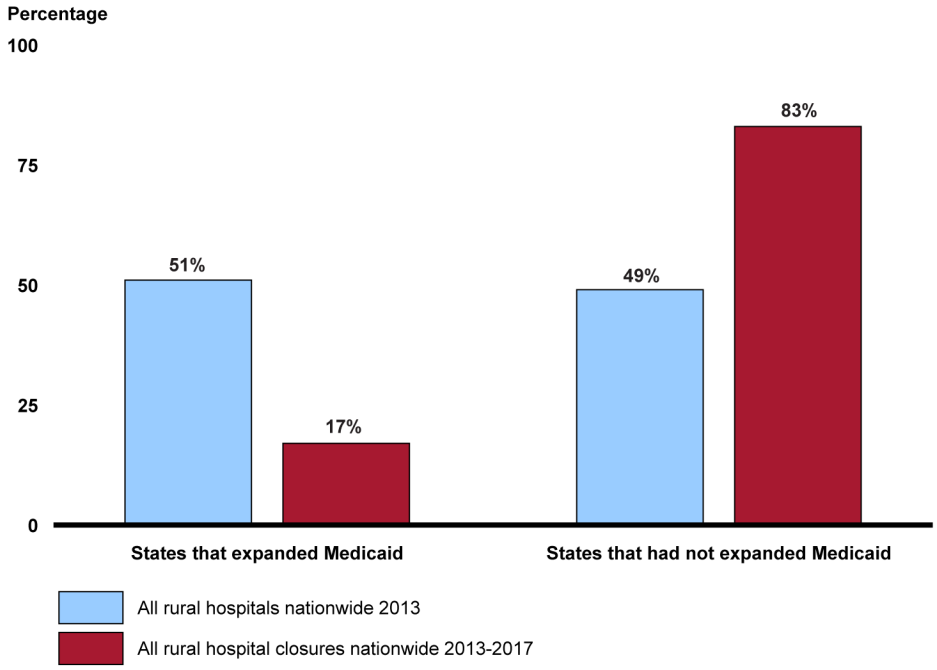
[51]See Pub. L. No. 112-96, § 3201, 126 Stat.156,192 (2012) (codified at 42 U.S.C § 1395x(v)(1)(T), (W)). For most hospitals, reductions in payments for allowable bad debt amounts were increased from 30 to 35 percent beginning in fiscal year 2013. In the case of Critical Access Hospitals, such reductions were subject to a phased increase from 12 to 35 percent over fiscal years 2013 to 2015. See 42 C.F.R. § 413.89(h)(1), (4) (2017).

[52]Beginning in 2014, states could expand Medicaid eligibility under their state plans to nonpregnant, nonelderly adults who were not eligible for Medicare and whose income did not exceed 133 percent of the federal poverty level. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[53]This same study reported that rural hospitals experienced better total margins, operating margins, and Medicaid and uninsured margins because of Medicaid expansion. See R.C. Lindrooth et al., "Understanding the Relationship Between Medicaid Expansions and Hospital Closures," *Health Affairs,* vol.37, no.1 (2018), 116-117.

[54]Specifically, the rate of uninsured adults in rural and small-town counties fell by 11 percent in states that expanded Medicaid on or before January 1, 2014, but only 6 percent in states that did not expand Medicaid. In contrast, during the same time period the rate of uninsured adults in urban areas fell by 9 percent in states that expanded Medicaid on or before January 1, 2014. See J. Hoadley et al., *Medicaid in Small Towns and Rural America: A Lifeline for Children, Families, and Communities* (Washington, D.C.: Georgetown University Center for Children and Families and North Carolina Rural Health Research Program, 2017), 9.

Figure 5: Percentage of Rural Hospitals in 2013 Relative to Percentage of Rural Hospital Closures from 2013 through 2017, by Medicaid Expansion Status



Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3).

Medicaid expansion status is as of April 2018.

Agency Comments

We provided a draft of this report to HHS for comment. The Department provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Administrator of Health Resources & Services Administration, the Administrator of CMS, and other interested parties. In

addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

James Cosgrove
Director, Health Care

Appendix I: Rural-Specific Payment Policies and Programs That Provide Key Support to Rural Hospitals

Officials from the Department of Health and Human Services (HHS) identified several rural-specific HHS payment policies and programs as providing key support to rural hospitals, and in turn, rural residents' access to hospital services. These key HHS payment policies and programs may be placed into three categories:

- Medicare rural hospital payment designations (table 2);
- Rural grants, cooperative agreements and contracts (table 3); and
- New approaches in rural health care delivery and payment (table 4).

Table 2: Medicare Rural Hospital Payment Designations

Name	Eligibility requirements	Payment methodology adjustments	Number of rural hospitals (2017)
Critical Access Hospital[a]	Geographic: meets all of the following requirements: In state with Medicare rural hospital flexibility program Located in rural area or reclassified as rural Either of: (i) > 35 miles from nearest hospital, (ii) > 15 miles via mountainous or secondary roads, or (iii) prior to 2006, deemed by the state as a necessary provider Size: < = 25 acute inpatient beds Other: meet conditions of participation, including 24/7 emergency care and average annual acute care length of stay < 96 hours	Inpatient services: Generally 101 percent of reasonable costs[b] Other services: Generally 101 percent of reasonable costs	1250
Sole Community Hospital[c]	Geographic: meets any of the following requirements: > 35 miles from like hospital;[d] or located in rural area or reclassified as rural, 25-35 miles from like hospital, and <= 25 percent of residents or Medicare beneficiaries who become inpatients in hospitals' service area are admitted to other like hospitals (or admitting criteria would have been met if not for unavailability of necessary specialty services, and hospital has < 50 beds); or located in rural area or reclassified as rural, 15-35 miles from like hospital, and because of topography or weather conditions, like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or located in rural area or reclassified as rural, >= 45 minutes travel time to nearest like hospital, because of distance, posted speed limits, and predictable weather conditions	Inpatient: Operating payments based on higher of (i) standard prospective payment or (ii) hospital-specific rate based on costs as of 1982, 1987, 1996, or 2006 Additional payment adjustment if experiences a >= 5 percent decline in inpatient volume due to circumstances beyond its control Other services: 7.1 percent additional payment for outpatient services	386

Name	Eligibility requirements	Payment methodology adjustments	Number of rural hospitals (2017)
Medicare Dependent Hospital[e]	Geographic: Located in rural area or reclassified as rural Size: <= 100 beds Other: >= 60 percent of inpatient days or discharges were for Medicare beneficiaries	Inpatient: Operating payments based on higher of (i) standard prospective payment or (ii) the standard payment plus 75 percent of the amount by which the standard payment is exceeded by the hospital-specific rate based on costs as of 1982, 1987, or 2002 Same adjustment for decreased volume as Sole Community Hospitals	146
Low Volume Hospital[f]	Geographic: generally > 15 miles from nearest hospital[g] Size: < 1,600 Medicare inpatient discharges per year	Inpatient: Additional percentage based on number of Medicare discharges, up to a maximum of 25 percent for hospitals with <= 200 discharges	529
Rural Referral Center[h]	Geographic: Located in rural area or reclassified as rural Size and referrals: meets any of the following criteria: >= 275 beds Both (i) >= 50 percent of Medicare patients are referred from other hospitals or physicians not on staff of the hospital; and (ii) >= 60 percent of Medicare patients and Medicare services provided to those who live > 25 miles from the hospital >= 50 percent of Medicare staff are specialists, and number of discharges and case-mix exceed certain criteria >= 60 percent of Medicare discharges are for patients who live > 25 miles from the hospital, and number of discharges and case-mix exceed certain criteria >= 40 percent of all patients are referred from other hospitals or physicians not on staff of the hospital, and number of discharges and case-mix exceed certain criteria	Inpatient: Exempt from 12 percent cap on Disproportionate Share Hospital Payments applicable to other rural hospitals Other: Exemptions from certain requirements related to geographic reclassification	223

Source: GAO summary of laws and regulations generally applicable to designated rural hospitals as of 2017, and analysis of Centers for Medicare & Medicaid Services data. | GAO-18-634

Note: These 5 Medicare rural hospital payment designations are targeted at areas that are rural or isolated. A rural hospital may qualify as a Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital. With the exception of Critical Access Hospitals, rural hospitals may also qualify as Low Volume Hospitals and Rural Referral Centers. Because the Low Volume Hospital designation is based on the volume of services provided and does not require formal certification, it is more likely than other payment designations to be applied to a hospital one year and not the next. Because of different definitions of rural, not all hospitals designated as one of the Medicare rural hospital designations are in areas that would meet the definition of rural used by the Federal Office of Rural Health Policy (FORHP). The count of rural hospitals is limited to those that meet FORHP's definition of rural, and include all rural hospitals with each designation (regardless of whether they also received an additional designation). Hospitals were defined as general acute care hospitals in the United States and rural was defined using FORHP's definition of rural. Under sequestration—the cancellation of budgetary resources under presidential order implemented pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended—each fiscal year since 2013, nearly

all Medicare's budget authority is subject to a reduction not exceeding 2 percent, which is implemented through reductions in payment amounts.

[a]Critical Access Hospital: 42 U.S.C. § 1395i-4, 42 C.F.R. §§ 485.601 et seq. (2017) (eligibility requirements); 42 U.S.C. §§ 1395f(l), 1395m(g), (l)(8), 42 C.F.R. § 413.70 (2017) (payment methodology adjustments).

[b]Critical Access Hospitals are paid based on the relevant standard prospective payment system methodologies for inpatient services provided in distinct part psychiatric and rehabilitation units.

[c]Sole Community Hospital: 42 U.S.C. § 1395ww(d)(5)(D), 42 C.F.R. § 412.92 (2017) (eligibility requirements and payment methodology adjustments); 42 U.S.C. § 1395l(t)(13)(B), 42 C.F.R. § 419.43(g) (2017) (payment methodology adjustments).

[d]"Like" hospitals are those that furnish short-term, acute care paid under the inpatient prospective payment system, and are not Critical Access Hospitals.

[e]Medicare Dependent Hospital: 42 U.S.C. § 1395ww(d)(5)(G), 42 C.F.R. § 412.108 (2017) (eligibility requirements and payment methodology adjustments).

[f]Low Volume Hospital: 42 U.S.C. § 1395ww(d)(12)), 42 C.F.R. § 412.101 (2017) (eligibility requirements and payment methodology adjustments).

[g]Low Volume Hospitals may be within 15 miles of certain types of hospitals excluded from Section 1886(d) of the Social Security Act, such as Critical Access Hospitals.

[h]Rural Referral Center: 42 U.S.C. § 1395ww(d)(5)(C)(i), 42 C.F.R. § 412.96 (2017) (eligibility requirements and payment methodology adjustments).

Table 3: Rural Grants, Cooperative Agreements, and Contracts Identified by the Department of Health and Human Services (HHS) as Providing Key Support to Rural Hospitals

Name and description	FY 2017 Awardee(s)	Total FY 17 Award (dollars in millions)
Grants		
Medicare Rural Hospital Flexibility Grant Program: Supports Critical Access Hospitals by providing funding to state governments to encourage quality and performance improvement activities including: stabilizing rural hospital finance; integrating emergency medical services into their health care systems; incorporating population health; and fostering innovative models of health care.	45 states	25
Rural Health Network Development Program: Supports networks (potentially including hospitals) in combining the functions of the entities participating in the network to: achieve efficiencies; expand access, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole. One activity awardees can choose is implementing innovative solutions to alleviate the loss of local services and enhance access to care for communities that may have or are at risk of losing their local hospital.	51 networks	15
Small Rural Hospital Improvement Grant Program: Supports small rural hospitals of 49 beds or less, in doing any or all of the following: purchase equipment and/or training to help hospitals participate in the hospital value-based purchasing program; join or become Accountable Care Organizations, or create shared savings programs; and purchase health information technology, equipment, and/or training to comply with meaningful use, ICD-10 standards, and payment bundling.	46 states	14
Rural Health Care Services Outreach Program: Supports consortia (potentially including hospitals) in expanding delivery of health care services in rural communities.	59 consortia	12
Delta States Rural Development Network Grant Program: Supports the development of integrated health care networks (potentially including hospitals) in eight delta states.a Due to the high disparities in the region, applicants are required to propose a program based on one of the following focus areas: diabetes; cardiovascular disease; obesity; acute ischemic stroke; or mental including related behavioral health and target the program to the services.	12 networks	10
Small Health Care Provider Quality Improvement: Supports rural primary care providers (such as hospitals) in planning and implementation of quality improvement activities.	32 providers	6
Rural Health Network Development Planning Grant Program: Supports development of integrated healthcare networks (potentially including hospitals). One activity awardees can focus on is alleviating the loss of local services and enhancing access to care for communities that may have or are at risk of losing their local hospital.	23 networks	2
Cooperative agreements and contracts		
Delta Region Community Health Systems Development: Supports Health Resources & Services Administration's collaboration with the Delta Regional Authority to develop a pilot program to help underserved rural communities in the Delta region identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance.	National Rural Health Resource Center	2

Name and description	FY 2017 Awardee(s)	Total FY 17 Award (dollars in millions)
Information Services to Rural Hospital Flexibility Grantees Program Cooperative Agreement (Technical Assistance and Services Center): Provides technical assistance to beneficiaries of Federal Office of Rural Health Policy initiatives (such as hospitals) to improve quality and financial viability in rural communities. Assistance will be provided in the areas of quality improvement, quality reporting, performance improvements and benchmarking, community engagement and population health, provision of rural emergency medical services, and building capacity to participate in alternative payment models.	National Rural Health Resource Center	1
Medicare Rural Hospital Flexibility Program Evaluation Cooperative Agreement: Monitors and evaluates the Medicare Rural Hospital Flexibility grant program, and provides resources for the grantees to support quality improvement, financial and operational improvement, and health systems development in rural America.	Flex Monitoring team, led by University of Minnesota	1
Rural Health Value: Analyzes impacts of changes in the health care delivery system, and provides technical assistance to rural providers (such as hospitals) in identifying potential new approaches to health care delivery in their communities.	Rural Health Value team: (University of Iowa and Stratis Health)	0.5
Small Rural Hospital Transitions Project: Assists small rural hospitals in transitioning to value-based care and Alternative Payment Models, as well as preparing for population health management.	Rural Health Innovations, subsidiary of National Rural Health Resource Center	0.5
Rural Quality Improvement Technical Assistance Cooperative Agreement: Provides technical assistance to beneficiaries of the Federal Office of Rural Health Policy's quality initiatives (such as hospitals) to improve quality and health outcomes in rural communities.	Stratis Health	0.5
Frontier Community Health Integration Project Demonstration Technical Assistance, Tracking, and Analysis Program: Provides technical assistance to ten Critical Access Hospitals participating in a model to test new approaches to health care delivery, reimbursement, and coordination in sparsely populated rural areas.	Montana Health Research and Education Foundation	0.5

Source: Interviews with HHS officials and GAO summary of HHS documents and data. | GAO-18-634

Note: Dollar amounts rounded to nearest million (or, if less than 1 million, to nearest 0.5 million).

[a]The eight delta states include Alabama, Arkansas, Kentucky, Illinois, Louisiana, Mississippi, Missouri, and Tennessee.

Table 4: New Approaches in Rural Health Care Delivery and Payment Identified by the Department of Health and Human Services (HHS) as Providing Key Support to Rural Hospitals

Name and description	Participants	Total Obligations (dollars in millions)
Accountable Care Organization Investment Model: Tests the effectiveness of pre-paid shared savings in encouraging new Medicare Shared Savings Program Accountable Care Organizations, which can include hospitals, to form in rural and underserved areas and in encouraging current Medicare Shared Savings Program Accountable Care Organizations to transition to arrangements with greater financial risk.	45 organizations	96[a]
Rural Community Hospital Demonstration: Tests the feasibility and advisability of cost based reimbursement for small rural hospitals that are too large to be Critical Access Hospitals.	30 hospitals	N/A
Frontier Community Health Integration Project Demonstration: Tests new models of integrated, coordinated health care in the most sparsely-populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures.	10 hospitals	N/A
Pennsylvania Rural Health Model: Tests whether multi-payer global budgets will enable participating rural hospitals to invest in quality and preventive care and to tailor the services they deliver to better meet the needs of their local communities.	TBD[b]	TBD[b]

Source: Interviews with HHS officials and GAO summary of HHS documents. | GAO-18-634

Note: amounts rounded to nearest million.

[a]Reflects obligations for fiscal years 2012 through 2018.

[b]Because rural hospitals are scheduled to begin participating in the model in January 2019 and continue through 2024, total hospitals and obligations for this model are not yet finalized. The target is for 6 rural hospitals to participate in the first performance year, increasing to at least 30 rural hospitals by the third performance year of the model.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Greg Giusto (Assistant Director), Alison Binkowski (Analyst-in-Charge), George Bogart, Zhi Boon, Leia Dickerson, Krister Friday, Mike Hoffman, Peter Mann-King, Beth Morrison, Vikki Porter, Merrile Sing, and Chris Woika made key contributions to this report.