American Hospital Association™
Advancing Health in America

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April 3, 2023

The Honorable Bob Casey
United States Senate
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

Dear Senator Casey and Senator Grassley:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is pleased to support the Rural Hospital Support Act (S. 1110).

Rural hospitals are essential access points for care, economic anchors for communities and the backbone of our nation's rural public health infrastructure. These hospitals have maintained their commitment to ensuring local access to high-quality, affordable care during the COVID-19 pandemic and beyond, in spite of unprecedented financial and workforce challenges over the last three years.

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. To support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the Medicare-dependent Hospital (MDH) program in 1987, allowing eligible hospitals to receive the sum of their prospective payment system (PPS) payment rate, plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. Your legislation would make this important program permanent and add an additional base year MDHs could choose when calculating their payments.

In addition, the Rural Hospital Support Act would make the enhanced low-volume Medicare adjustment permanent. Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts.

Although a low-volume adjustment existed in the inpatient PPS prior to fiscal year 2011, the Centers for Medicare & Medicaid Services had defined the eligibility criteria so narrowly that only two or three hospitals qualified each year. The current, improved low-volume adjustment better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers and improves access to care in rural areas. Your legislation permanently extends the low-volume adjustment to ensure that these providers will not again be at a disadvantage and have severe challenges serving their communities.

The sole community hospital (SCH) program plays an important role in maintaining access to care in rural communities. SCHs must show they are the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible for the program. They receive increased payments based on their cost per discharge in a base year. By allowing SCHs to choose an additional base year from which payments can be calculated, your legislation provides the increased support needed now by many rural hospitals.

Again, we are pleased to support this legislation and look forward to working with you and your colleagues to achieve its passage.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President
Advocacy and Political Affairs