Written Testimony to the U.S. Senate Committee on Finance

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Keith J. Mueller, Ph.D.
Gerhard Hartman Professor of Health Management and Policy
Director, Rural Policy Research Institute (RUPRI)
Chair, RUPRI Health Panel and
Director, RUPRI Center for Rural Health Policy Analysis
College of Public Health, University of Iowa

Chairman Wyden, Ranking Member Crapo, members of the Finance Committee, thank you for holding this hearing on rural health and giving me the opportunity to share my perspective on key issues and related policy considerations. Since I last spoke to this Committee in 2018 intractable challenges in hospital finance, meeting workforce needs, and addressing leading causes of death in rural communities remain. Yet we have seen the resilience of rural health providers and organizations as they rose to meet the challenges of the COVID-19 pandemic and now keep their focus on improving health for members of their communities. In my brief formal comments I will focus on rural hospital evolution, rural activities of Medicare Advantage, MA, plans, and Accountable Care Organizations, ACOs. I'll close with observations about sharp points demanding immediate attention.

As we move to the health care delivery system of the future, which takes full advantage of advances in chronic care management and changing sites of acute care, the roles of rural hospitals have evolved. They are now comprehensive care centers, with a much higher percentage of total activities and revenues tied to outpatient services. Transitioning to institutions that best serve rural residents may require modernizing facilities, investing in new information systems and technologies, and collaborating with community-based organizations to address living conditions related to chronic health problems. An obvious requirement is capital enabling significant investments; and the USDA is a leading source of that capital, within the rural development agency, community facilities program.

Additional capital investments in information systems, including in cyber security protecting the information, and new technology, can stretch capabilities of small hospitals who have operated on very thin total margins and therefore lack reserves for large investments. They can find themselves needing to join hospital networks to centralize administrative functions and negotiate payment contracts. The networks can be across rural hospitals, as well

as affiliations with urban-based systems. In networks or on their own rural hospitals can be a position of strength in any negotiations because of their primary care base and integration into their communities. In a payment environment shifting to the importance of addressing *health*, rural hospitals and primary care clinics can be advantaged. Rural hospital administrators and their limited senior staff may lack experience and data analytics to leverage their position in negotiations; programs providing technical assistance supported by USDA and HRSA make a difference for those institutions.

Shifting to MA, I'll use work from the RUPRI Center for Rural Health Policy Analysis which was formed in 2000 funded by the Health Resources and Services Administration Federal Office of Rural Health Policy. We have tracked rural enrollment in MA plans since October of that year when 201,655 beneficiaries were enrolled in Medicare+Choice plans. As of March of this year there are 4,734,003 rural beneficiaries enrolled MA plans, 45.1% of all rural beneficiaries, see Table 1.

Table 1: Enrollment in Medicare Advantage Plans, 2019 and 2024

	National Enrollment	Percent of Eligibles	Rural Enrollment	Percent of Eligibles
2019	21,912,432	40.3%	2,876,598	29.1%
2024	31,177,866	52.3%	4,734,003	45.1%

SOURCE: RUPRI Center for Rural Health Policy Analysis, preliminary analysis based on Centers for Medicare and Medicaid Services (CMS) data, as of March 2024

Note: Excludes enrollees in US territories (due to data incompatibilities).

Growth in rural enrollment in many states has been dramatic since 2019; Table 2 shows the percent of beneficiaries enrolled in 2019 and 2024. As evident in the table, enrollment growth is quite dramatic, with only Alaska still having lower than 10% total, and nearly all states well above 20% to as high as more than 60%. More of the story of what is happening may revealed by examining specific counties in states with high numbers of rural Medicare beneficiaries. We have developed some early maps showing the contrast from 2019 to 2024, presented in this document after Table 2. The changes are obvious in observing the increased number of counties in the darkest shade and the near disappearance of the lightest shade in four of the six states illustrated.

Table 2: Enrollment in Medicare Advantage Plans, by State, 2019 and 2024

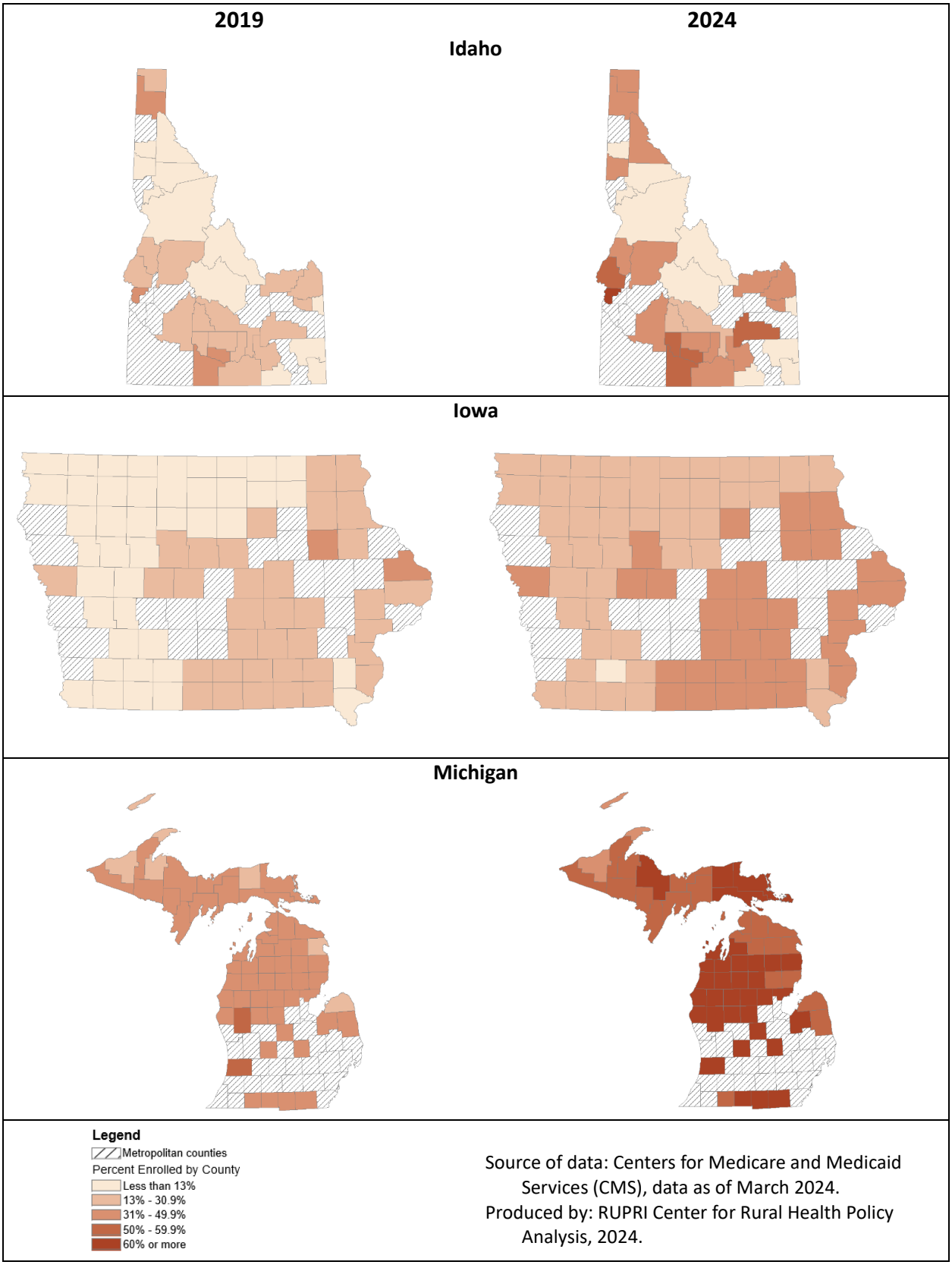
State	2019 Total		2019 Rural		2024 Total		2024 Rural	
	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled
Alaska	81,415	2.1%	26,240	1.9%	97,413	2.8%	30,891	2.5%
Alabama	962,963	44.8%	259,680	36.3%	1,024,371	64.0%	267,977	62.2%
Arkansas	588,083	28.1%	261,456	25.9%	626,168	48.2%	268,805	47.0%
Arizona	1,200,467	44.0%	67,426	26.6%	1,358,579	54.9%	76,508	47.1%
California	5,510,735	49.0%	195,542	8.3%	6,126,479	56.6%	206,172	16.6%
Colorado	809,098	46.0%	130,909	21.8%	929,919	57.2%	150,275	38.0%
Connecticut	605,051	45.1%	38,160	40.6%	628,847	52.4%	40,135	47.9%
Dist. of Columbia	76,328	22.7%			79,455	39.6%		
Delaware	190,089	17.4%			222,068	34.4%		
Florida	4,220,918	48.8%	147,368	33.8%	4,754,205	59.9%	162,353	52.7%
Georgia	1,565,339	42.9%	357,563	39.5%	1,757,771	59.9%	387,396	60.3%
Hawaii	233,551	53.3%	52,018	41.3%	263,746	61.7%	61,250	54.7%
Iowa	576,499	24.0%	274,989	15.7%	633,761	39.6%	293,193	31.5%
Idaho	306,090	36.4%	106,860	23.6%	360,795	51.9%	123,636	40.7%
Illinois	1,996,966	30.0%	318,054	21.9%	2,161,795	47.3%	332,033	39.5%
Indiana	1,158,322	34.1%	294,909	31.0%	1,266,994	52.9%	316,209	50.9%
Kansas	486,599	20.2%	178,760	7.8%	537,221	36.0%	189,024	22.5%
Kentucky	850,777	35.8%	409,180	32.1%	903,748	57.6%	422,097	59.3%
Louisiana	796,623	40.9%	144,855	24.1%	864,806	59.8%	152,244	49.3%
Massachusetts	1,180,663	27.8%	22,809	19.0%	1,294,557	39.4%	25,984	27.9%
Maryland	886,137	14.2%	35,533	6.4%	977,374	27.4%	38,450	19.7%
Maine	309,503	37.7%	139,759	33.9%	345,647	61.5%	154,242	60.6%
Michigan	1,915,848	44.4%	431,580	38.6%	2,087,568	65.6%	472,829	63.1%
Minnesota	931,818	49.4%	275,226	45.4%	1,052,916	63.9%	301,844	58.9%
Missouri	1,124,181	39.9%	337,902	28.4%	1,222,114	57.1%	356,050	49.1%
Mississippi	561,054	21.4%	326,577	16.7%	595,420	45.0%	338,429	43.0%
Montana	209,413	21.1%	141,333	19.0%	239,102	31.8%	161,829	29.8%

State	2019 Total		2019 Rural		2024 Total		2024 Rural	
	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled
North Carolina	1,841,513	39.4%	490,858	32.3%	2,054,364	58.9%	524,956	56.8%
North Dakota	118,630	20.3%	65,155	15.9%	133,809	37.0%	71,564	33.3%
Nebraska	313,805	18.0%	134,159	8.2%	349,046	36.5%	144,642	27.3%
New Hampshire	263,499	20.4%	114,649	19.5%	303,679	38.6%	131,117	38.6%
New Jersey	1,415,809	33.3%			1,548,262	45.4%		
New Mexico	376,869	40.1%	127,411	23.4%	417,414	54.1%	135,919	44.8%
Nevada	467,819	42.2%	61,596	24.9%	534,651	56.4%	69,540	38.5%
New York	3,213,675	45.9%	293,266	41.4%	3,527,243	56.6%	317,176	56.8%
Ohio	2,134,329	46.6%	480,827	35.4%	2,321,531	59.8%	515,972	52.3%
Oklahoma	668,082	23.8%	259,105	13.4%	727,493	44.0%	272,142	35.7%
Oregon	783,740	49.7%	169,107	22.1%	865,671	59.1%	184,192	32.2%
Pennsylvania	2,477,094	46.6%	336,514	43.7%	2,679,216	57.5%	356,654	59.4%
Rhode Island	192,558	51.8%			215,587	65.8%		
South Carolina	994,370	31.9%	173,617	34.6%	1,130,161	48.5%	186,418	53.6%
South Dakota	158,706	23.4%	82,557	21.3%	179,370	39.0%	91,025	35.4%
Tennessee	1,250,487	42.9%	357,326	37.1%	1,358,749	56.5%	378,039	53.6%
Texas	3,739,559	43.6%	602,788	33.1%	4,277,896	58.5%	647,669	50.6%
Utah	355,224	41.6%	48,758	19.8%	415,102	56.9%	58,418	40.1%
Virginia	1,341,435	24.1%	264,255	25.6%	1,496,450	42.2%	276,702	47.6%
Vermont	132,806	13.0%	95,552	12.7%	150,400	35.0%	107,058	33.1%
Washington	1,220,424	37.2%	178,496	15.6%	1,370,121	53.4%	198,876	32.7%
Wisconsin	1,082,360	46.4%	342,196	41.8%	1,219,762	60.5%	383,009	56.0%
West Virginia	407,206	35.8%	168,723	34.7%	420,214	57.3%	171,386	58.3%
Wyoming	99,394	5.1%	69,107	4.9%	116,022	18.5%	81,593	17.4%

SOURCE: RUPRI Center for Rural Health Policy Analysis, preliminary analysis based on Centers for Medicare and Medicaid Services (CMS) data, as of March 2024

Note: Excludes enrollees in US territories (due to data incompatibilities).
The states of Delaware, New Jersey, and Rhode Island and the District of Columbia contain no rural counties.

Percent of Eligible Rural Medicare Beneficiaries Enrolled in Medicare Advantage, March 2024



Source of data: Centers for Medicare and Medicaid Services (CMS), data as of March 2024.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2024.

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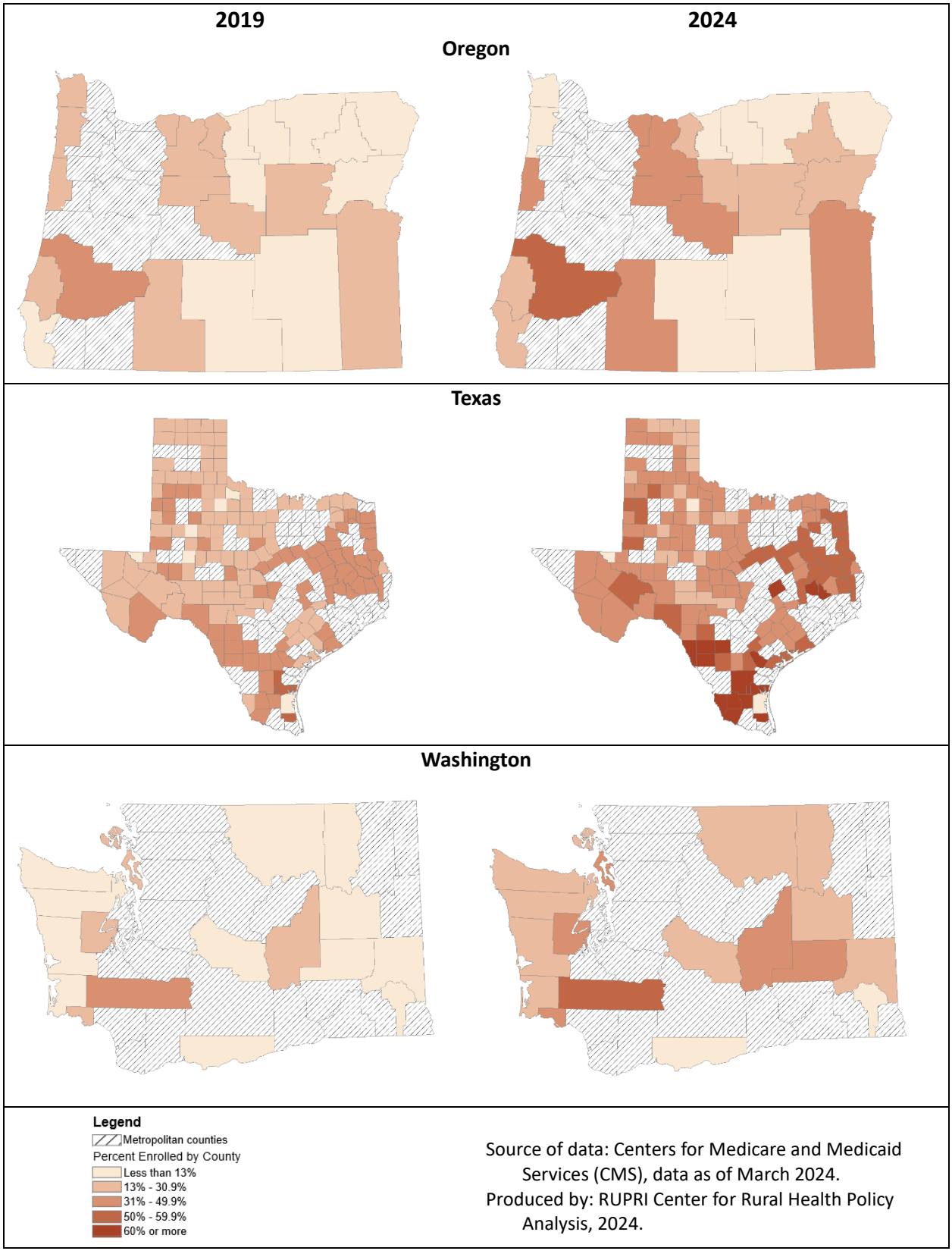

Source of data: Centers for Medicare and Medicaid Services (CMS), data as of March 2024.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2024.

What are the consequences of the growth in MA plan enrollment? Well, it is a two-sided coin. On one side, as RUPRI has shown in annual reports and periodic policy briefs, there are many more choices for rural beneficiaries. This includes more widespread availability of additional health benefits including vision, hearing, fitness, and dental – as of 2022 all are available in more than 90% of rural counties. There are differences in expanded benefits such as in-home support services (54% in remote compared to 82% in metropolitan counties) and in special supplemental benefits such as food and produce – available in 91% of metropolitan counties and 64% of remote counties. On the other side of the coin, MA plan payment to rural provides is set through contracts, not the pricing system of traditional Medicare. Consequently, payment is not cost-based or other special payment as it is traditional Medicare, and strategies private insurance companies use to control spending will apply – claims denial (can be appealed), prior approval, and variable deductibles and copayments. This coin metaphor brings to mind the term "managed competition" – that in health care there is value to competition, but given compelling objectives of access and equity, some public policy management may be needed.

The number of ACOs grew from 456 in 2023 to 480 in 2024, and included 276 low revenue ACOs, a jump from 252 in 2023. The number of beneficiaries is holding somewhat steady at 10.8 million. There are more than 2,500 participating Rural Health Clinics and 513 participating CAHs. Rule changes promulgated in 2022 that took effect in 2023 and 2024 may influence more rural participation: up to 7 years in an upside risk only model, and an advanced investment payment – 19 started with the advanced payment in 2024. RUPRI has followed ACO development in rural places and impacts on rural providers, including finding a positive impact on rural hospital revenues. The CMS Shared Savings Program Fast Facts show the data regarding participants and assigned lives, including a map showing assigned beneficiaries by county.

The RUPRI Health Panel, supported by the Helmsley Charitable Trust, has commented on proposed rules and requests for information, including from this Committee and from the House Committee on Ways & Means. Based on those letters, Panel papers, and discussions with my Panel colleagues, I will close with what I characterize as "sharp point" concerns in rural health that demand attention. The first is long-standing, but with new twists thanks to changes in delivery models; securing the workforce needed to sustain rural services. A modern patient health team now includes community health workers, lay health navigators, behavioral health providers, and of course medical care providers. All are in short supply and high demand. We need a multi-pronged approach to meeting this needs, from pipeline training programs, to better pay and benefits, to improving workplace environments. A second sharp point is maintaining essential services in rural communities. As already discussed today, this includes OB/GYN – perinatal and postnatal women must have equitable access to high quality care. Other essential services include emergency care, primary care, and public health. Other services could be included, but these are fundamental building blocks in the continuum of care. Finally, providing the range of services needed by an aging population is a critical need in rural communities – recent closures of rural nursing homes is creating a service gap that needs attention.

Thanks again for this opportunity to discuss critical issues and policy considerations that would strengthen and sustain essential health services in the nation's rural communities.