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Chairman Wyden, Ranking Member Crapo, members of the Finance Committee, thank you for holding this hearing on rural health. 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 hospitals, Medicare Advantage, and Accountable Care Organizations, ACOs.

Rural hospitals 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. Additional capital investments in information systems including in cyber security, and in new technology can stretch capabilities of small hospitals who have operated on very thin total margins and therefore lack reserves for large investments. In a payment environment shifting to the importance of addressing *health*, rural hospitals and primary care clinics can be advantaged. However, rural hospital administrators and their limited senior staff may lack experience and data analytics to leverage their position in negotiations; programs providing technical assistance make a difference for those institutions.

Shifting to MA, the RUPRI Center for Rural Health Policy Analysis, with funding from HRSA's Federal Office of Rural Health Policy, has tracked rural enrollment since October 2000 a little over 200,000 beneficiaries were enrolled in Medicare+Choice plans. As of March of this year there are nearly 4.8 million rural beneficiaries enrolled MA plans, 45.1% of all rural beneficiaries. Growth in rural enrollment in many states has been dramatic since 2019, when it was 29%.

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. On the other side of the coin, MA plan payment to rural providers is set through contracts, not the pricing system of traditional Medicare. Consequently, 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 to 480 in 2024, including 276 low revenue ACOs. The number of beneficiaries is holding somewhat steady at 10.8 million nationally. There are more than 2,500 participating Rural Health Clinics and 513 participating CAHs. Rule changes allowing up to 7 years in an upside risk only model, and an advanced investment payment are likely to result in more rural participation. RUPRI has followed ACO development in rural places and impacts on rural providers, including finding a positive impact on rural hospital revenues.

The RUPRI Health Panel, supported by the Helmsley Charitable Trust, has written extensively on policy choices since 1993. Based on Panel products 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 securing the workforce needed to sustain rural services. A modern patient health team 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 these 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.

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.