Statement for the Record of Ranking Member Mike Crapo
Rural Health Care: Supporting Lives and Improving Communities
Senate Committee on Finance
May 16, 2024

Thank you, Mr. Chairman.

For more than 46 million Americans, including more than one in every four Idahoans, rural communities offer a vibrant, culturally rich way of life, bolstered by strong social bonds and a shared appreciation for the natural surroundings that make this country so exceptional.

Federal health programs, including Medicare and Medicaid, have an obligation to serve the unique needs of rural communities.

This means addressing the challenges facing rural hospitals and providers as they deliver high-quality medical care to families in environments with more limited resources.

The perspectives presented today will help us not only to identify hurdles and barriers, but also to build on meaningful, sustainable solutions aimed at ensuring remote communities can access care as close to home as possible.

This hearing comes at a critical time, as a number of provisions—from telehealth flexibilities to continued financial support for rural hospitals and ambulance providers—expire at the end of this year.

The Finance Committee has come together numerous times in recent years to extend these and other must-pass policies, which ensure seniors and working families from all walks of life can continue to access the care they need.

In 2022, nearly one-third of Medicare beneficiaries relied on telehealth services. For rural areas in particular, where clinician shortages continue to rise, cutting off this lifeline is not an option.

But, while telehealth can bridge access gaps, particularly for specialty and mental health services, we must also maintain and expand in-person options in rural communities.

Creative workforce growth and retention strategies have the potential to bolster the number and types of providers in rural areas. Evidence shows that doctors, nurses and other health professionals who train in rural areas are more likely to remain in these regions to practice. It is critical that the programs within our Committee's jurisdiction ensure that there are ample training opportunities for these health professionals.

Remote frontline providers often face substantial financial strain once in practice, frequently driven by factors entirely outside their control. In addition to serving patients, rural hospitals are often critical to local economies, employing hundreds of individuals and supporting regional business development. Unfortunately, since 2005, more than 105 rural hospitals have closed, with numerous others forced to fend off constant closure risks.

Medicare's existing strategies to preserve access to health care in rural areas often rely on special reimbursement programs that supplement payment rates to account for the unique geographic and patient needs in rural America. We must prioritize the continuation of these essential designations later this year.

However, even with a wide range of targeted payment adjustments, some rural hospitals still struggle to achieve financial stability.

For example, small rural hospitals continue to be more heavily dependent on inpatient volume as part of their total revenues. At the same time, the health care system is experiencing a steady, nationwide shift away from inpatient care to outpatient services. Although this transition often improves patient outcomes and lowers costs, it can leave hospitals ineligible for certain federal government programs and without a reliable revenue stream.

For some communities, Medicare's current payment structures may actually stifle innovations that could pave the way for more sustainable rural health care delivery systems.

Resolving these issues is no easy task. Rural communities need the federal government to support data-driven state and local modernizations that have the promise to achieve results--increasing access to medical care, lowering costs and improving patient outcomes.

Alternative payment models, if well-designed, offer one potential avenue for mitigating rural providers' financial challenges, but bureaucratic barriers and insufficient payment arrangements can complicate efforts to leverage these models to their fullest potential. As our Committee continues exploring clinician payment policy reforms, bridging these gaps will remain a priority.

Fortunately, across the country, leaders and innovators from all sectors and backgrounds continue to spearhead partnerships, strategies and initiatives aimed at driving improved outcomes in rural communities, often building from the ground up. Federal programs should facilitate these efforts and learn from providers and patients on the ground.

Thank you to our witnesses for being here today. I look forward to your testimony. Thank you, Mr. Chairman.