Statement

of the

American Hospital Association

800 10th Street, NW

Two CityCenter, Suite 400

Washington, DC 20001-4956

for the

Committee on Finance

Subcommittee on Health Care

of the

U.S. Senate

"Improving Health Care Access in Rural Communities: Obstacles and Opportunities"

May 17, 2023

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, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Committee on Finance Subcommittee on Health Care examines obstacles and opportunities to improve health care access in rural communities.

We appreciate the Subcommittee's interest in ensuring rural Americans have access to high-quality, affordable health care.

OBSTACLES AND CHALLENGES FACING RURAL COMMUNITIES

Rural hospitals and health systems are the lifeblood of their communities and are committed to ensuring local access to health care. At the same time, these hospitals are experiencing unprecedented challenges that jeopardize access and services. These include the aftereffects of a worldwide pandemic, crippling workforce shortages, soaring

costs of providing care, broken supply chains, severe underpayment by Medicare and Medicaid, and an overwhelming regulatory burden.

Rural hospitals make up about 35% of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby. As a result, in rural hospitals, the acute care occupancy rate (37%) is less than two thirds of their urban counterparts (62%). Compared to their non-rural counterparts, a significantly higher percentage of rural hospitals are owned by state and local governments — 35% compared to just 13% of urban hospitals.

Trends Affecting Rural Hospital Financial Sustainability

There are a number of trends driving rural health care challenges and rural hospital closures, forcing hospitals to take a wide variety of approaches in addressing them. Despite myriad challenging circumstances, there are many pathways for rural hospitals' sustainability. We appreciate the Committee's focus on better understanding the obstacles to maintaining and improving access to care in rural communities because that is an essential step in developing policy responses to support rural hospitals and the patients and communities they serve.

Patient Volume and Health

Population densities are categorically lower in rural areas, and as a consequence, rural hospitals have much lower patient volumes. Lower patient volumes makes it challenging for rural hospitals to maintain fixed-operating costs.

Lower patient volumes also can impede rural hospitals participation in performance measurement and quality improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement.

Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. This can limit rural hospitals' participation in innovative payment models that can help improve patient outcomes and provide alternative streams of revenue.

In addition to lower patient volumes, rural hospitals often treat patient populations that are older, sicker and poorer compared to the national average. For example, a higher percentage of patients in rural areas are uninsured. A 2016 Department of Health and Human Services Assistant Secretary for Planning and Evaluation issue brief found that 26% of uninsured, rural patients delayed seeking care due to cost. These delays contribute to sicker, and subsequently more costly, patients seeking care. Indeed, this challenging patient mix and lower volumes strains rural health systems as the resources

needed to provide care are more varied and intense than those in other regions.These delays in care are further worsened by the fact that people in rural areas face geographic isolation and limited access to transportation to receive care at medical facilities.

Overcoming Low Reimbursement

The bulk of rural hospital revenue comes from government payers, of which Medicare comprises nearly half. Yet, both Medicare and Medicaid reimburse less than the cost of providing these services. This resulted in rural hospitals incurring $5.8 billion in Medicare underpayments and $1.2 billion in Medicaid underpayments in 2020, on top of $4.6 billion in uncompensated care provided by rural hospitals. For Medicare reimbursements in particular, these underpayments grew by nearly 40% from 2016 to 2020. Medicare sequester cuts, which fully resumed July 1, 2022, have further strained rural hospital finances and that would be further compounded if Medicaid DSH cuts were allowed to go into effect Oct. 1, 2023. Additionally, any proposal for site-neutral policies would have a detrimental effect for rural communities.

, Two programs designed to address rural financial issues, the Medicare-dependent Hospital (MDH) and enhanced Low-volume Adjustment (LVA) program — which provide vital support to rural hospitals to offset financial vulnerabilities associated with being rural, geographically isolated and low-volume — are scheduled to expire Sept. 30, 2024. COVID-19 relief prevented many closures over the last several years but now that assistance has expired, the financial position of many rural hospitals, especially MDH and LVA hospitals, is more precarious. In 2020, one in five rural closures were MDHs. Extending these programs or making them permanent will be critical to these rural hospitals moving forward.

In the commercial insurance market, rural hospitals are often forced to accept below average rates or are left out of plan networks entirely. Rural hospitals with low commercial patient volume and a lack of market power are often forced to “take it or leave it” when large insurers refuse to negotiate. In cases where rural hospitals are, in effect, excluded from certain plan networks due to unfair insurer negotiation tactics, patient access can be negatively affected.

Many patients residing in rural areas may already have to drive long distances to seek in-network care. Health plan practices that restrict access to network providers in rural areas further exacerbate these challenges by impeding timely patient access to care, compromising the stability of rural health care providers, and circumventing the intent of network adequacy requirements.

Additionally, affordable coverage remains a pressing challenge facing the health care system. Lack of health insurance coverage in rural areas results in high uncompensated care costs for hospitals. Medicaid expansion is one policy that has helped rural hospitals remain viable. The majority (74%) of rural closures happened in states where Medicaid expansion was not in place or had been in place for less than a year.

Research has found that Medicaid expansion has been associated with improved hospital financial performance and lower likelihood of closure, especially in rural areas that had many uninsured adults prior to expansion.

Managing Staffing Shortages

Rural hospitals face significant staffing shortages that predated the pandemic but have been significantly exacerbated over the last three years. Only 10% of physicians in the United States practice in rural areas and over 65% of primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.

The shortage of primary care services has detrimental effects on the overall health of rural populations. For example, health outcomes in rural areas are significantly lower compared to more densely populated regions. Additionally, while clinical care shortages exist across the care continuum, the shortage of behavioral health and substance abuse professionals in rural populations is immense. Recent research finds that 65% of rural counties do not have a psychiatrist; 47% do not have a psychologist; and 81% do not have a psychiatric nurse practitioner. Clinician shortages are difficult to fill as rural hospitals find it challenging to recruit and retain qualified practitioners.

Recruitment and retention of health professionals has long been a persistent challenge for rural providers. Acute workforce shortages and increasing labor expenses resulting from the pandemic have placed additional pressure on rural hospitals. Many rural providers are seeking novel approaches to recruit and retain staff. Existing federal programs, such as the National Health Service Corps, work to incentivize clinicians to work in rural areas. Other programs, such as the Rural Public Health Workforce Training Network Program, help rural hospitals and community organizations expand public health capacity through health care job development, training and placement. Additional and continued support to help recruit and retain health care professionals in rural areas is needed from the federal governments.

Increased Cost of Caring - Rising Input Costs

Hospitals and health systems are facing significant financial challenges due to the increased cost of caring for patients. Expenses for labor, drugs, purchased services and personal protective equipment have all increased compared to pre-pandemic levels.

Hospitals have seen a 17.5% increase in overall expenses between 2019 and 2022, according to data from Syntellis Performance Solutions, a health care data and consulting firm. Further exacerbating the situation is the fact that the staggering expense increases have been met with woefully inadequate increases in government reimbursement. Specifically, hospital expense increases between 2019 and 2022 are more than double the increases in Medicare reimbursement for inpatient care during that same time. Because of this, margins have remained consistently negative, according to Kaufman Hall’s Operating Margin Index throughout 2022.

In fact, over half of hospitals ended 2022 operating at a financial loss — an unsustainable situation for any organization in any sector, let alone hospitals. So far, that trend has continued into 2023 with negative median operating margins in January and February. According to a recent analysis, the first quarter of 2023 saw the highest number of bond defaults among hospitals in over a decade. This also is one of the primary reasons that some hospitals, especially rural hospitals, have been forced to close their doors. Between 2010 and 2022, 143 rural hospitals closed — 19 of which occurred in 2020 alone. Finally, despite these cost increases, hospital prices have grown modestly. In fact, in 2022, growth in general inflation (8%) was more than double the growth in hospital prices (2.9%).

The explosive growth in contract labor expenses in large part fueled a 20.8% increase in overall hospital labor expenses between 2019 and 2022. Even after accounting for the fact that patient acuity (as measured by the case mix index) has increased during this period, labor expenses per patient increased 24.7%. These increases are particularly challenging, because labor on average accounts for about half of a hospital's budget.

Increased drug and medical supply costs have also contributed to ongoing financial challenges. For the first time in history, the median price of a new drug exceeded $200,000 — a staggering figure that implies a double-digit year-over-year price growth. Department of Health and Human Services (HHS) found that drug companies increased drug prices for 1,216 drugs — many used to treat chronic conditions like cancer and rheumatoid arthritis — by more than the rate of inflation, which was 8.5% between 2021 and 2022. Increased expenses extend to medical supplies and equipment as well and hospitals have seen per patient costs increased by 18.5% between 2019 and 2022, outpacing increases in inflation by nearly 30%.

Overcoming Regulatory Barriers

Rural hospitals face a number of regulatory burdens that impact their ability to provide care. According to an AHA study, the nation’s hospitals, health systems and post-acute care providers spend $39 billion each year on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for larger facilities. For example, while Medicare’s Conditions of Participation (CoPs) and other compliance metrics are important to ensure the safe delivery of care, future CoPs should be developed with more flexibility and alignment with other laws and industry standards. Rural hospitals can protect their communities’ access to health care by receiving relief from outdated and unnecessary regulations.

OPPORTUNITIES TO IMPROVE HEALTH CARE FOR RURAL COMMUNITIES

To mitigate rural hospital closures and improve health care in rural communities, hospitals continue to explore strategies that allow them to remain viable. Although

rural hospitals have long faced circumstances that have challenged their survival, those dangers are more severe than ever. As a result, rural hospitals require increased attention from state and federal government to address barriers and invest in new resources in rural communities. The AHA continues to support policies that would help address these challenges, including:

Support Flexible Payment Options
As the health care field continues to change at a rapid pace, flexible approaches and multiple options for reimbursing and delivering care are more critical than ever to sustain access to services in rural areas.

- **Extend the Medicare-dependent Hospital (MDH) and Low-volume Adjustment (LVA).** MDHs are small, rural hospitals where at least 60% of admissions or patient days are from Medicare patients. MDHs receive the inpatient prospective payment system (IPPS) rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. AHA supports making the MDH program permanent and adding an additional base year that hospitals may choose for calculating payments. The LVA provides increased payments to isolated, rural hospitals with a low number of discharges. AHA also supports making the LVA permanent. The MDH designation and LVA protect the financial viability of these hospitals to ensure they can continue providing access to care. AHA urges Congress to pass the **Rural Hospital Support Act (S. 1110)** to extend these important programs.

- **Reopen the Necessary Provider Designation for Critical Access Hospitals (CAHs).** The CAH designation allows small rural hospitals to receive cost-based Medicare reimbursement, which can help sustain services in the community. Hospitals must meet several criteria, including a mileage requirement, to be eligible. A hospital can be exempt from the mileage requirement if the state certified the hospital as a necessary provider, but only hospitals designated before Jan. 1, 2006 are eligible. AHA urges Congress to reopen the necessary provider CAH program to further support local access to care in rural areas.

- **Strengthen the Rural Emergency Hospital (REH) Model.** REHs are a new Medicare provider type that small rural and critical access hospitals can convert to in order to provide emergency and outpatient services without needing to provide inpatient care. REHs are paid a monthly facility payment and the outpatient prospective payment system (OPPS) rate plus 5%. AHA supports strengthening and refining the REH model to ensure sustainable care delivery and financing.

- **Rebase Sole Community Hospitals (SCHs).** SCHs must show they are the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible. They receive increased payments based on their cost per discharge in a base year. AHA supports adding an additional base year

that SCHs may choose for calculating their payments as included in the **Rural Hospital Support Act (S. 1110)**.

Ensure Fair and Adequate Reimbursement
Medicare and Medicaid each pay less than 90 cents for every dollar spent caring for patients, according to the latest AHA data. Given the challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of care.

- **Reverse Rural Health Clinic (RHC) Payment Cuts.** RHCs provide access to primary care and other important services in rural, underserved areas. AHA urges Congress to repeal payment caps on provider-based RHCs that limit access to care.

- **Extend Ambulance Add-on Payments.** Rural ambulance service providers ensure timely access to emergency medical care but face higher costs than other areas due to lower patient volume. We support permanently extending the existing rural, "super rural" and urban ambulance add-on payments to protect access to these essential services.

- **Flexibility for Critical Access Hospitals (CAHs).** We urge Congress to pass legislation to extend the COVID-19 public health emergency waiver providing flexibly for the 96-hour average length of stay CoP. Many CAHs have had to increase their average length of stay because of challenges transferring patients to other sites of care, among other factors outside their control. We also support permanently removing the 96-hour physician certification requirement for CAHs. Removing the physician certification requirement would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours.

- **Wage Index Floor.** AHA supports the **Save Rural Hospitals Act (S. 803)** to place a floor on the area wage index, effectively raising the area wage index for hospitals below that threshold with new money.

- **Commercial Insurer Accountability.** Systematic and inappropriate delays of prior authorization decisions and payment denials for medically necessary care are putting patient access to care at risk. We support regulations that streamline and improve prior authorization processes, which would help providers spend more time on patients instead of paperwork. We also support a legislative solution to address these concerns. In addition, we support policies that ensure patients can rely on their coverage by disallowing health plans from inappropriately delaying and denying care, including by making unilateral mid-year coverage changes.

- **Maternal and Obstetric Care.** We urge Congress to continue to fund programs that improve maternal and obstetric care in rural areas, including supporting the

maternal workforce, promoting best practices and educating health care professionals. We continue to support the state option to provide 12 months of postpartum Medicaid coverage.

- **Behavioral Health.** Implementing policies to better integrate and coordinate behavioral health services will improve care in rural communities. We urge Congress to: fully fund authorized programs to treat substance use disorders, including expanding access to medication assisted treatment; implement policies to better integrate and coordinate behavioral health services with physical health services; enact measures to ensure vigorous enforcement of mental health and substance use disorder parity laws; permanently extend flexibilities under scope of practice and telehealth services granted during the COVID-19 PHE; and increase access to care in underserved communities by investing in supports for virtual care and specialized workforce.

Bolster the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. Nearly 70% of the primary HPSAs are in rural or partially rural areas. Targeted programs that help address workforce shortages in rural communities should be supported and expanded. Workforce policies and programs also should encourage nurses and other allied professionals to practice at the top of their license.

- **Graduate Medical Education.** We urge Congress to pass the **Resident Physician Shortage Reduction Act of 2023 (S. 1302**), legislation to increase the number of Medicare-funded residency slots, which would expand training opportunities in all areas including rural settings to help address health professional shortages.

- **Conrad State 30 Program.** We urge Congress to pass the **Conrad State 30 and Physician Access Reauthorization Act (S. 665)** to extend the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in federally-designated underserved areas.

- **Loan Repayment Programs.** We urge Congress to pass the **Restoring America's Health Care Workforce and Readiness Act (S. 862)** to significantly expand National Health Service Corps funding to provide incentives for clinicians to practice in underserved areas, including rural communities. AHA also supports the **Rural America Health Corps Act (S. 940)** to directly target rural workforce shortages by establishing a Rural America Health Corps to provide loan repayment programs focused on underserved rural communities.

- **Boost Nursing Education.** We urge Congress to invest $1 billion to support nursing education and provide resources to boost student and faculty

populations, modernize infrastructure and support partnerships and research at schools of nursing. AHA also supports expanding the National Nurse Corps.

- **Health Care Workers Protection.** We urge Congress to enact federal protections for health care workers against violence and intimidation, and to provide hospital grant funding for violence prevention training programs and coordination with state and local law enforcement

Support Telehealth Coverage
The pandemic has demonstrated telehealth services are a crucial access point for many patients. We urge Congress to build on the practices that have proven successful in recent years, including:

- **Permanently eliminating originating and geographic site restrictions**
- **Permanently eliminating in-person visit requirement for behavioral telehealth**
- **Removing distant site restrictions on federally-qualified health centers and clinics**
- **Ensuring reimbursement parity based on place of service where the visit would have been performed in-person**
- **Continuing payment and coverage for audio-only telehealth services**
- **Permanently expanding the eligible provider types**
- **Removing unnecessary barriers to licensure**
- **Establishing DEA Special Registration Process for Telemedicine for administration of controlled substances**
- **Expanding cross-agency collaboration on digital infrastructure and literacy initiatives**

CONCLUSION

Rural hospitals are the cornerstones of their towns and cities and are committed to continuing to serve their patients and communities. The AHA appreciates your efforts to examine ways to improve health care access in rural communities and looks forward to working with you on this important issue.