American Hospital Association™
Advancing Health in America

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October 5, 2023

The Honorable Jason Smith
Chairman
Ways and Means Committee
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Re: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith and the Ways and Means Health Subcommittee:

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) welcomes the opportunity to comment on ways to improve access to care in rural and underserved areas. We share the subcommittee's interest in ensuring that Americans in these rural and underserved areas have high-quality, affordable health care.

Hospitals and health systems are the lifeblood of their communities and are committed to ensuring local access to health care. At the same time, many hospitals including those in rural and underserved areas 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 overwhelming regulatory burdens.

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.

Below are a series of proposals and suggestions for the Ways and Means Committee to consider as it looks for avenues to broaden access to health care for patients in rural and underserved regions.

Sustainable Provider and Facility Financing

To mitigate rural hospital closures and improve health care in rural communities, sustainable financing for rural hospitals and health systems is imperative. 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.

Providing certainty and stability in rural Medicare hospital payments is essential to creating a sustainable rural financing system. Low reimbursement, low patient volume, sicker patients and challenging payer mix common at many rural hospitals puts added financial pressure on those facilitates. The AHA supports **policies that support sustainable hospital and health system financing models, including flexible payment options that address financing challenges faced by the full spectrum of rural hospitals, including the following.**

- **Making Permanent 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.

- **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.

- **Improve Access to Capital.** Access to capital is important to stabilizing a vulnerable hospital or advancing innovations in others. AHA supports expanding the USDA Community Facilities Direct Loan & Grant Program and creating a new Hill-Burton like program to update rural hospitals to ensure continued access in rural communities.

- **Strengthen the Rural Emergency Hospital (REH) Model.** REHs are a new Medicare provider type to which small rural and critical access hospitals can convert 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.

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.

AHA supports the following policies to ensure fair and adequate reimbursement.

- **Medicare Advantage Payment Parity for Critical Access Hospitals.** The Medicare Advantage (MA) program has grown significantly in the past decade. MA enrollment, which traditionally has grown slower in rural areas, is now surpassing the growth rate in urban areas. For example, MA enrollment quadrupled between 2010 to 2023 in rural counties, compared to metropolitan areas which doubled in enrollment during the same period. Yet, MA plans are not required to pay rural providers, such as critical access hospitals, at the same cost basis as fee-for-service Medicare; and they are increasingly paying below costs, straining the financial viability of many rural providers. Further, MA plans also have the additional burden of prior authorization and other health plan requirements with which rural providers must increasingly contend — requirements that do not exist to nearly the same extent in fee-for-service Medicare and add additional costs for rural providers to comply. We support policies that support the long-term health of providers and facilities that care for patients in rural areas, which will need to consider the impact of MA enrollment in those communities.

- **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.

- **Make the Ambulance Add-on Payments Permanent.** 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.

- **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.

- **Flexibility for CAHs.** We urge Congress to pass legislation to extend waiver flexibility for the 96-hour average length of stay condition of participation. 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.

- **Commercial Insurer Accountability.** Systematic and inappropriate delays of prior authorization decisions and payment denials for medically necessary care by commercial insurers 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 public health emergency; and
  - increase access to care in underserved communities by investing in supports for virtual care and specialized workforce.

Bolstering the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. Nearly 70% of the primary health professional shortage areas 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. Below are listed a variety of different proposals and pieces of legislation Congress should consider enacting to tackle the workforce shortage crisis.

- **Graduate Medical Education.** We urge Congress to pass the **Resident Physician Shortage Reduction Act of 2023 (H.R. 2389/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 (H.R. 4942/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.
- **International Workforce.** The AHA supports the recapture of and **expedited visas for foreign-trained nurses and doctors.**
- **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 (H.R. 1711/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 significant resources to support nursing education and provide resources to boost student, faculty and preceptor 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 the **Safety from Violence for Healthcare Employees Act (H.R. 2584/S. 2768)** to provide federal protections for health care workers against violence and intimidation.

Metropolitan Anchor Hospitals (MAHs)

The AHA urges Congress to create a special statutory designation for MAHs to ensure that patients served by these hospitals can continue to receive vital services and remain sustainable. To be designated as a MAH, a hospital must be located in a core-based statistical area (CBSA), have a Medicaid Inpatient Utilization Rate (MIUR) greater than the statewide average, and meet at least one of the requirements: have a disproportionate patient percentage (DPP) of 70% or higher; have a DPP of at least 35% and average uncompensated care costs (UCC) of at least $35,000 per bed (averaged over the last three years); or be designated by the state as a "necessary provider" of health care services to residents in the area.

Metropolitan Anchor Hospitals (MAHs) would serve as a lifeline to communities who have a significant proportion of Medicare, Medicaid and underinsured patients who are often challenged in accessing comprehensive, quality health care. MAHs are in areas dealing with sustained hardships and whose patient populations have historically been marginalized. Seventy-five percent of MAHs are in counties where uninsured and poverty rates exceed the national average. MAHs are critical access points for primary care, preventive services and specialized health care services, including trauma and burn care, neonatal and pediatric intensive care, substance use disorder treatment, and HIV/AIDS care. MAHs bring tremendous value to the patients and communities they serve and to the nation's health care system overall.

Telehealth Extensions

At the outset of the COVID-19 pandemic, the federal government moved quickly to ensure hospitals and health systems were able to respond efficiently and effectively to a wave of unprecedented need. These actions included CMS waiving certain regulatory requirements and Congress providing significant legislative support to ensure hospitals and health systems could manage the numerous challenges facing them, including by an increased ability to administer virtual care. These swift actions provided hospitals and health systems with critical flexibilities to care for patients throughout the pandemic.

Spurred in large part by these waivers and legislative support, virtual care and telehealth services have increased dramatically. A report from the Department of Health and Human Services found that in 2020, telehealth services increased by over 51 million encounters, representing a 63-fold increase from 2019.[1] There is a growing body

[1] https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicaretelehealth-utilization-during-pandemic

of evidence to suggest that for most specialties, telehealth services provided during the pandemic were not duplicative of in-person services. For example, most recently, a study of over 35 million records by Epic found that for most telehealth visits across 33 specialties, there was not a need for an in-person follow-up visit within 90 days of the telehealth visit.[2] In many cases, telehealth served as an effective substitute for in-person care and did not result in duplicative care.

Expansion of virtual care has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients. There also are significant projected shortages of physicians and allied health and behavioral health care providers, which will likely be felt even more strongly in areas serving structurally marginalized urban and rural communities. Telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. **We applaud efforts by Congress to reduce barriers to care delivery by extending many telehealth flexibilities through the end of 2024 as a part of the Consolidated Appropriations Act that passed in December 2022. AHA continues to urge that certain of these telehealth waiver provisions be made permanent.**

We thank you for the opportunity to comment on ways to improve access to care in rural and underserved areas and look forward to continuing to work with you on this important issue. Please contact me if you have questions or feel free to have a member of your team contact Devin Gerzof, AHA's senior associate director of federal relations, at dgerzof@aha.org.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President
Advocacy and Political Affairs

[2] https://epicresearch.org/articles/telehealth-visits-unlikely-to-require-in-person-follow-up-within-90-days