

August 31, 2020

President Donald J. Trump
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear President Trump:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including more than 1,400 rural hospitals across the country, the American Hospital Association (AHA) appreciates the Administration's attention to the circumstances of rural hospitals and their communities, especially in light of the COVID-19 pandemic.

Rural communities depend upon their hospitals as an important – and often only – source of care. However, the sustained and concerning trend of rural hospital closures threatens access to health care services across the country. Since 2010, 130 rural hospitals have closed – with 13 closures through July this year. It is likely more will shut their doors given the dire impact the COVID-19 crisis has had on the financial health of hospitals. This will force people in rural areas to travel even farther to receive the care they need, and in some cases, to delay or forgo care entirely.

In addition, since rural hospitals are often the largest employer in their communities, closures frequently lead to extensive local unemployment. The health and economic consequences after the loss of a rural hospital can be devastating to the individuals living in these communities.

As such, we were pleased by your Aug. 3 Executive Order on improving rural health and telehealth access. The order underscored the imperative to advance rural health with its call for a new rural payment model, investment in rural health care infrastructure, and initiatives to improve rural health outcomes; it also called for regulations that would extend certain telehealth flexibilities, input on which AHA provided comments Aug. 19 in a [separate letter](#) to you.

As your Administration works to implement strategies to achieve the aims of your Executive Order on Improving Rural Health and Telehealth Access, we stand ready to assist. Below, we recommend actions that the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and others should take in order to advance rural health.



Specifically, we urge your Administration to take steps to:

- **establish a new Medicare designation that would allow rural hospitals to provide emergency and observation services without the provision of inpatient services;**
- **re-open the necessary provider Critical Access Hospital (CAH) program;**
- **extend payment programs to support rural hospitals, such as the low-volume adjustment;**
- **create a Rural Design Center within the Center for Medicare & Medicaid Innovation to allow for the development, testing, improvement and scaling of voluntary, rural-specific models;**
- **test and expand voluntary payment models for rural providers that offer financial certainty and are less vulnerable to volume shifts, such as global budgets;**
- **extend the Rural Community Hospital and Frontier Community Health Integration Project programs;**
- **increase funding for physical and communications infrastructure, including additional funds for the Federal Communications Commission Rural Health Care Program;**
- **develop and implement initiatives that improve patient access to behavioral and maternal health services, including increased coverage;**
- **expand current workforce recruitment and retention programs that aid rural areas;**
- **develop additional strategies to address workforce shortages, such as investing in pipeline programs and community partnerships;**
- **lift Medicare-funded residency slot caps to expand training opportunities and help address health professional shortages; and**
- **provide regulatory relief to promote rural health care access including flexibilities to share treatment space, removal of restrictive conditions of payment for CAHs, and improvements to the Physician Self-Referral (Stark) Law and Anti-Kickback Statute.**

The AHA has long recognized the difficulties of providing health care in rural settings. In 2016, we issued a [report](#) identifying nine strategies to ensure access to essential services in vulnerable communities; in 2019, we released a separate [report](#) that described numerous, unique challenges facing rural hospitals, as well as policy recommendations to address them. Last summer, we assembled a Future of Rural Health Care Task Force, a group of rural hospital leaders from across AHA's membership to identify sustainable payment and care delivery models for the future of rural health care.

We have worked closely with your Administration to help address rural health care concerns, and appreciate your responsiveness and innovation, especially through numerous waivers and flexibilities provided to respond to the COVID-19 public health emergency.

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We are encouraged by goals set by your recent executive order, and urge your Administration to take targeted action in the near term to support rural hospitals and their communities. In our attached comments, we recommend several policies and strategies that would build on the Administration's efforts and advance rural health.

Thank you for your consideration of these recommendations. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

cc: The Honorable Alex M. Azar
The Honorable Seema Verma

ESTABLISH NEW PAYMENT MODELS AND EXTEND EXISTING MODELS TO PRESERVE RURAL ACCESS

As the health care system has been changing at a rapid pace, rural hospitals have been saddled by reimbursement approaches that do not reflect the realities of delivering care in their communities. For example, the shift from inpatient to outpatient care, coupled with longstanding low patient volume, has made it difficult for rural providers to cover their high fixed costs. Over time, such financial instability can lead to service reduction or complete closure, putting the community at risk of having no access to emergency services or other necessary care.

One emerging model that would transform service lines to maintain access to care is the Rural Emergency Hospital (REH) model. The REH model would allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient services, which are often associated with high fixed costs and low patient volume in these areas. Specifically, a rural hospital converting to REH would eliminate inpatient care; be required to provide emergency services and transportation; and would have the flexibility to align additional outpatient and post-acute services with local needs. REHs would receive enhanced Medicare reimbursement to support these key services and promote financial stability. While the recently announced Community Health Access and Rural Transformation (CHART) Model would offer flexibilities to allow a participating hospital to focus solely on outpatient and emergency care, additional reimbursement remains a crucial component to maintain service availability.

We believe the REH model would sustain access to care in rural areas, and we urge CMS to support legislative efforts to establish a new designation under the Medicare program to allow rural hospitals to cease inpatient services, but continue providing necessary emergency and observation services (at enhanced reimbursement rates). Importantly, by focusing on community need and providing enhanced financial support, this designation would directly align with the Executive Order's call for innovative payment mechanisms "to ensure that rural health care providers are able to provide the necessary level and quality of care."

To further maintain access to care in rural areas, we also urge CMS to support legislative efforts to re-open the necessary provider Critical Access Hospital (CAH) program. 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, in order to be eligible.

Previously, a hospital could be exempt from the mileage requirement if its state certified the hospital as a necessary provider; however, the necessary provider designation expired on Jan. 1, 2006. [Government officials](#) have highlighted the CAH designation, along with the related Medicare Rural Hospital Flexibility grant program, as "the most effective HHS payment policy and program to support rural hospitals' financial viability and rural residents' access to hospital services." Providing such opportunity for rural hospitals to become CAHs will offer crucial financial support to keep services available locally.

In addition, given the clear link between low patient volume and rural hospital viability, we urge CMS to support legislative efforts to extend the current Low-volume Hospital Adjustment (LVA) program payment structure beyond FY 2022. The program, which provides an add-on payment to inpatient discharges for low-volume providers, has faced continued threats of retrenchment despite its effectiveness in assisting hundreds of rural hospitals (excluding CAHs, which are not eligible). Moreover, the current, more flexible structure is set to expire in FY 2022, leading to many program participants no longer being eligible due to more restrictive requirements. The LVA program should be maintained with the more flexible eligibility criteria to support low-volume providers in rural areas and preserve local access to care.

CREATE A BROADER FRAMEWORK TO TEST INNOVATION IN RURAL AREAS

The CMS Center for Medicare & Medicaid Innovation (CMMI) has significant authority and funding to test, and scale if successful, innovative models to improve health care quality and value in rural settings. While the Administration recently announced the CHART Model for rural communities, many CMMI models are not typically designed in a way that allows broad rural participation. For example, they often require substantial patient volumes that are not feasible in less populated areas or they may not align with realities of delivering care in more isolated locations. The unintended consequence is that large swaths of the country are unable to participate in care transformation models because they do not meet the minimum number of patients required to participate or due to the often burdensome reporting requirements.

The AHA recommends that CMS create a Rural Design Center within CMMI to allow for voluntary rural-specific models to be developed, tested, improved and scaled.

In addition to creating rural-specific models, the rural design center could also consult with internal CMMI model teams to create separate tracks/options within new or existing models that allow for small/rural participation, specifically tailored to meet the needs of rural communities. The AHA's Future of Rural Health Care Task Force is considering several potential models for the proposed CMMI Rural Design Center and will make recommendations for consideration in the coming months. We look forward to working with the Administration to implement these ideas to build on the foundation set by the President's Executive Order.

Because fluctuations in patient volume contribute to financial instability in fee-for-service payment systems, demonstration projects, such as the Pennsylvania Rural Health model, are testing new payment approaches that would maintain consistent payment regardless of changes in volume. These multi-payer global budget models provide a predictable funding stream and incentives that contain cost growth and improve quality. Such payment structures also can provide flexibility for hospitals in vulnerable communities to provide care in a manner that best fits their communities' needs. Anecdotally, global budgets also have largely sheltered hospitals participating in the model from the financial uncertainty stemming from COVID-19, indicating the utility of this payment structure even in atypical circumstances.

We urge CMS to utilize CMMI authority and capabilities to test and expand payment models for rural providers - on a voluntary basis - that offer financial certainty and are less vulnerable to volume shifts, such as global budgets. We are encouraged by CMS' recognition of the importance of predictable payments for rural hospitals and we stand ready to provide input to CMMI as the Center puts the new CHART Model into practice.

Other recent CMMI models targeting rural hospitals should also be extended. For example, Congress has previously extended the rural community hospital (RCH) program to allow hospitals with 25-50 beds (i.e., hospitals too large to meet CAH criteria) to test the feasibility of cost-based Medicare reimbursement for inpatient services. A 2018 evaluation of this program found that RCHs maintained access to quality care and largely benefitted from the demonstration reimbursement structure.

In addition, the Frontier Community Health Integration Project (FCHIP) Demonstration, which expired in July 2019, tested several care delivery innovations for CAHs including cost-based reimbursement for telehealth and ambulance services as well as increased beds for skilled nursing care. Given the small number of participants (10 hospitals), an extension and/or expansion of the demonstration would increase data availability and allow for a more comprehensive evaluation of performance.

CMS should seek opportunities, including support of legislative efforts or building on existing authorities, to extend the RCH and FCHIP programs and continue to evaluate their impact for rural communities.

ENSURE STRONG AND STABLE RURAL HEALTH CARE INFRASTRUCTURE

As the hospital field engages in significant transformation, rural hospitals are seeking ways to adapt while continuing to meet patient needs. The Aug 3. Executive Order acknowledges the need to strengthen both physical and communications healthcare infrastructure for rural America, and we encourage the Administration to take action in the near term to support these pillars of care.

For most rural providers, tackling healthcare transformation will require significant capital investments, and the COVID-19 public health emergency has further demonstrated the importance of readiness for facility modifications. However, narrow financial margins limit rural providers' ability to retain earnings and secure access to capital or qualify for U.S. Department of Agriculture (USDA) or the U.S. Department of Housing and Urban Development mortgage guarantees.

We urge the Administration to support congressional efforts to provide infrastructure funding for hospitals that restructure their facilities and services offered to match community needs. Additional financial support – including flexible loans and grants – will help ensure that vulnerable communities are able to preserve access to essential health care services.

In addition, access to high quality broadband is a critical enabler for connected health tools. The usage and reliance on broadband is even more paramount as providers seek to deliver

care given the realities of COVID-19. However, according to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband.

The AHA has long- supported full funding of the FCC Rural Healthcare Program as a mechanism for meeting the broadband connectivity needs of rural areas. While we applaud recent efforts by the FCC and the USDA to provide more funding opportunities to support telehealth in rural and underserved areas, **we continue to urge Congress to appropriate at least an additional \$2 billion for the FCC Rural Health Care Program to ensure every hospital in every community has the broadband infrastructure needed to leverage 21st century technologies in patient care. We strongly encourage HHS, CMS, and other federal agencies to support this effort.**

Lastly, HRSA'S 340B drug pricing program, since 2010, has provided financial help to rural hospitals serving vulnerable communities to manage rising prescription drug costs. Rural hospitals such as Critical Access Hospitals, rural referral centers and sole community hospitals make up nearly half of all eligible 340B hospitals. These rural hospitals are the lifelines of their community, and the discounts they receive through the program allow these 340B hospitals to stretch scarce resources to not only reduce the price of outpatient pharmaceuticals for patients but allow hospitals to expand health services for their communities. For example, hospitals use 340B savings to provide free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication and disease management programs. **We urge the Administration to safeguard the 340B program from efforts to scale it back and ensure that these rural hospitals can continue to serve their vulnerable communities.**

ADDRESS BEHAVIORAL AND MATERNAL HEALTH NEEDS

Access to behavioral health and maternal health services remains challenging in most rural communities. While clinical workforce shortages exist across specialties, the limited numbers of behavioral health and maternal care providers are particularly striking. Coverage limitations for these services also exacerbate difficulties in accessing appropriate care.

We urge the Administration to develop, support, and implement initiatives that improve patient access to – including increased coverage for – behavioral and maternal health services.

For behavioral health, practice restrictions may exacerbate behavioral health specialist shortages. For example, state licensure restrictions may prohibit a practitioner from caring for a patient who resides just over a state border, despite the nearest in-state clinician being more than one hundred miles away. Limits on the medication-assisted therapy prescribing for substance use disorder also cap the number of patients a clinician can serve. Some approaches to resolving these issues include: easing licensure restrictions to allow for multi-state practice and programs that can share resources; allowing other types of practitioners and paraprofessionals to train and provide behavioral health services; and collaborating

with universities and hospital systems to provide telephonic assistance where broadband-based virtual communications are challenging.

For maternal health, low reimbursement rates and low volume often hinder clinician recruitment and service availability including prenatal, obstetric, and postpartum care. In our [response](#) to CMS' request for information on rural maternal health, we outlined a number of policy improvements that the Administration's agencies could make to advance maternal health in rural America, including: strengthening the maternal care workforce through incentive programs and additional graduate medical education slots; disseminating Medicaid strategies that support maternal care; increasing telehealth opportunities to boost access to care and support clinician training; enhancing opportunities for obstetrics simulation training; improving coverage for maternal care; supporting efforts to reduce disparities; and facilitating public/private, cross-sector partnerships to address social determinants of health for mothers.

BOLSTER THE RURAL WORKFORCE

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. While almost 20% of the U.S. population lives in rural areas, less than 10% of U.S. physicians practice in these communities. Health care professional shortages are troublingly widespread across rural America. As of June 2020, two-thirds of the nation's [Health Professional Shortage Areas](#) (HPSAs) were in rural or partially rural areas. Some rural providers utilize locum tenens arrangements to help with temporary physician and other professional absences, but the benefit of such arrangements is limited because Medicare restricts payment for locum tenens clinicians to only 60 days. **CMS should consider opportunities to provide more flexibility for these temporary workforce arrangements for rural providers.**

Medicare graduate medical education (GME) funding is critical to maintain the physician workforce and sustain access to care across the nation. The Balanced Budget Act of 1997 (BBA) imposed caps on the number of residents for which each teaching hospital is eligible to receive GME reimbursement. While we appreciate the agency's policy finalized in FY 2020 to allow GME programs to include residents training at CAHs in their full-time equivalent (FTE) count, the number of trainees exposed to rural health care settings remains low. **The AHA continues to urge Congress to lift the cap on the number of Medicare-funded residency slots, which would expand training opportunities and help address health professional shortages. We urge the Administration to support this effort.**

Because residents are more likely to stay in localities where they train, HHS should also consider opportunities to support partnerships and pipeline programs that could incentivize or leverage interest in practicing in rural communities. For example, grants could be offered to support development programs in which hospitals provide training/apprenticeship programs that help build technical skills locally and earlier in the education process. Grant funds could also support partnership programs between health care providers and higher education entities (community colleges, universities, nursing

schools, etc.) to tailor programs and promote exposure to – and interest in – practicing in rural areas.

Nurse practitioners (NPs), midwives, physician assistants (PAs), and other advanced practice professionals have helped to address the shortages. However, many state licensure laws limit the ability of advanced practice clinicians to practice at the top of their license, limiting the services they may offer to patients. In addition, physician supervision regulations may hinder maximal use of these practitioners.

Thus, we appreciate CMS' recent proposal to provide supervision flexibilities including permitting NPs, PAs, clinical nurse specialists and certified nurse-midwives to supervise the performance of diagnostic tests. We also appreciate the proposal to allow direct supervision to be provided using real-time, interactive audio and video technology through the end of 2021, but as we note in our [recent letter](#) to the Administration, we urge HHS and CMS to make this policy permanent.

Some existing programs work to ameliorate rural workforce deficits by incentivizing clinicians to work in rural areas. These include the Conrad State 30 and the National Health Service Corps programs, which are administered by federal agencies with funding from Congress. In addition, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 established a loan repayment program for substance use disorder treatment professionals in mental health professional shortage areas or counties hardest hit by drug overdoses.

Continued support for these programs is important to address workforce gaps in rural areas. Yet despite the promise of these programs, with only one percent of medical residents and fellows indicating a preference for practicing in a small town or rural area, designers of rural recruitment programs will have to consider additional, unique ways to attract the next generation of clinicians.

These recruitment and retention programs are important to support a sustainable rural health care workforce and should be expanded; moreover, we urge the Administration to develop additional solutions to address workforce shortages and challenges in rural areas.

In addition, advancements in telehealth can address workforce challenges by connecting patients and their providers to specialists in other locations. Our [letter to the Administration](#) outlines several policy proposals that would support continued patient access to telehealth, including a recommendation to cover and pay for audio-only telehealth services, given the essential role of such services in rural communities.

PROVIDE RELIEF FROM REGULATORY BARRIERS

According to "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers," a [study](#) conducted by the AHA, the nation's hospitals, health systems and post-acute care providers spend \$39 billion each year on non-clinical regulatory requirements. These costs include the staff required to meet the

demands of the regulations concerning physicians, nurses, legal, management, health information technology professionals and others.

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. As such, complying with regulations could result in reduced local access to services. CMS has acknowledged the regulatory burden on providers and continues to review the effectiveness of current regulation through its Patients over Paperwork initiative, which we urge the agency to accelerate those efforts.

Beyond the costs of compliance, some existing regulations can impede access to care in rural areas because they do not take the unique rural context into consideration, including low availability of certain services, clinician recruitment challenges, and limited staff and resources. We appreciate CMS' recognition of regulatory burden on rural hospitals and the proposed waivers to provide more operational and regulatory flexibility in the forthcoming CHART model.

We continue to encourage HHS, CMS, and other federal agencies, to use a “rural lens” when developing regulatory actions – not only when reviewing them after they have already been formed.

Some specific examples of particularly challenging regulations for rural hospitals are described below.

Co-location. Many hospitals share treatment space with other providers in order to offer a broader range of medical services and better meet patient needs. In rural areas, hospitals may lease space to visiting specialists several days per month to make certain services locally available. These types of agreements are crucial for those small and rural hospitals that may have limited clinical staff and/or rely on visiting physicians to provide specialty services (e.g., cardiology, oncology) that would otherwise require patients to travel long distances in order to obtain such care. Last year, CMS issued draft guidance on allowing hospitals to co-locate with other hospitals and health care entities. AHA submitted a [letter](#) in response to encourage the agency to make several revisions so that co-location arrangements can enable hospitals to serve their patients in a more efficient and effective manner. **We urge CMS to offer flexibility to providers who wish to share treatment space as a means to fill gaps in patient access to care.**

96-hour Condition of Payment. Critical access hospitals (CAHs) must maintain an annual average length of stay of 96 hours as a condition of participation in the Medicare program, yet some may offer certain critical medical services that have standard lengths of stay greater than 96 hours. In recent years, CMS enforced a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission.

This additional step and limitation drives CAHs to eliminate “96-hour-plus” services, reducing local access in rural areas and forcing patients to travel longer distances for care. The AHA appreciates CMS's recognition that this condition of payment could stand in the

way of promoting essential health care services to rural America, as well as CMS' effort to relax this requirement in the upcoming CHART model.

We continue to recommend that CMS issue a permanent enforcement moratorium on the 96-hour condition of payment. The AHA also will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs, and we urge CMS to work with us to support that effort.

Physician Self-Referral (Stark) Law and Anti-Kickback Statute (AKS). The Stark law prohibits physicians from referring patients to a hospital with which they have a financial relationship, unless the relationship is specifically protected by a statutory or regulatory exception. The statute applies to both ownership and compensation arrangements. While the law has generally worked as intended with respect to the prohibitions on ownership, the compensation rules have created enormous challenges for the delivery of modern medicine, especially for rural providers.

Among other challenges, recruiting physicians to rural communities typically requires hospitals to offer higher salaries, which could run afoul of the Stark law's fair market value requirements. Policymakers should remove these and other barriers to service availability and care transformation in rural areas.

Like the Stark law, the AKS is targeted to preventing fraud and abuse. The AKS prohibits the exchange of remuneration (anything of value provided by a hospital) intended to influence a physician's ordering of services or the purchase of items that are paid for by a federal health care program. Enforcement of the law has effectively made any financial relationship between hospitals and physicians subject to regulatory scrutiny and serious punishment.

Rural hospitals have certain unique conditions that may make them more susceptible to AKS violations. For example, limited patient volume and workforce shortages may necessitate the need to share specialists with non-affiliated providers; as a result, ongoing patient referrals to these facilities could implicate the AKS. This law can also hinder efforts to utilize telehealth by prohibiting providers from giving virtual care tools, such as tablets, to patients.

We continue to urge the Administration to adopt final regulations for the Stark and Anti-kickback laws that would enable rural providers to preserve access and deliver coordinated care in their communities. These improvements could also help address the challenges rural hospitals face in complying with these laws in light of their unique conditions. AHA will also continue to urge Congress to eliminate compensation from the Stark Law, to return its focus to governing ownership arrangements, and allow Anti-kickback law to govern all compensation arrangements. We encourage the Administration to support these efforts.