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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Finance

of the

U.S. Senate

"Rural Health Care: Supporting Lives and Improving Communities"

May 16, 2024

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 policies to ensure rural patients continue to receive access to high-quality care.

Hospitals and health systems are the lifeblood of their communities and committed to ensuring local access to health care. At the same time, many hospitals, including those in rural areas, continue to experience unprecedented challenges that jeopardize access and services. These include workforce shortages, high costs of prescription drugs, and continued severe underpayment by Medicare and Medicaid.

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%).

Below are a series of proposals and suggestions for the Finance Committee to consider as it seeks to ensure financial stability of providers, maintain critical flexibility to protect access and services, build the workforce of tomorrow and improve infant and maternal care in rural communities.

FLEXIBLE PAYMENT OPTIONS

To improve health care in rural communities, sustainable financing for rural hospitals and health systems is imperative. As a result, rural hospitals require flexible payment options to address barriers and invest in new resources in rural communities.

Providing certainty and stability in rural Medicare hospital payments is essential. Low reimbursement, low patient volume, sicker patients and challenging payer mix, common at many rural hospitals, puts added financial pressure on those facilities. **The AHA supports policies that promote flexible payment options and address financial challenges faced by the full spectrum of rural hospitals, which will allow them to continue providing high-quality care for their patients.**

- **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 and AHA supports the **Rural Hospital Support Act (S. 1110)** and the **Assistance for Rural Community Hospitals Act (H.R. 6430)** to extend those important designations.

- **Extend Telehealth Flexibilities.** The expansion of telehealth services has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients, especially those with transportation or mobility limitations. Given current health care challenges, including major clinician shortages nationwide, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. AHA supports the **CONNECT for Health Act (S. 2016 / H.R. 4189)** to make permanent coverage of certain telehealth services made possible during the pandemic, including lifting geographic and originating site restrictions, allowing Rural Health Clinics and Federally Qualified Health Centers to serve as distant sites, expanding practitioners who can provide telehealth, and allowing the continuation of audio-only telehealth services, among others.

- **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 to which small rural and critical access hospitals can convert to provide emergency and outpatient services without needing to provide inpatient care. **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. **AHA supports the Rural Hospital Support Act (S. 1110) to add an additional base year that SCHs may choose for calculating their payments**.

- **Improve Access to Capital.** Access to capital is important to stabilize a vulnerable hospital or advance 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.**

FINANCIAL STABILTY – FAIR, TIMELY AND ADEQUATE REIMBURSEMENT

Medicare and Medicaid each pay less than 90 cents for every dollar spent caring for patients — with Medicare hitting a historic low of 82 cents for every dollar — according to the latest AHA data. Given the unique financial 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, timely and adequate reimbursement.

- **Medicare Advantage Payment Parity for CAHs.** 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 CAHs 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 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 legislation to ensure CAHs receive cost-based reimbursement for MA patients**.

- **Prompt Pay**. Ensuring prompt payment from insurers for medically necessary, covered health care services is important for ensuring financial stability of rural hospitals and health systems. Delayed payments are particularly problematic for rural hospitals given their low patient volume and often challenging financial position. **We support policies to increase oversight and accountability of health plans including establishing more stringent standards for timely payment to address certain commercial insurer tactics to delay and deny payment to health care providers.**

- **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**. AHA asks Congress to pass the Protecting Access to Ground Ambulance Medical Services Act of 2023 (S. 1673 / H.R. 1666) to maintain those enhanced ambulance payments**.

- **Commercial Insurer Accountability.** Systematic and inappropriate delays of prior authorization decisions and payment denials by commercial insurers for medically necessary care are putting patient access to care at risk. **We support regulations and legislative solutions that streamline and improve prior authorization processes, including the Improving Seniors' Timely Access to Care Act, which would codify many of the reforms in the Interoperability and Prior Authorization Final Rule. 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.**

- **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 with new money for hospitals below that threshold**.

- **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.

- 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 many hospitals. Nearly 70% of the primary health professional shortage areas are in rural or partially rural areas. Hospitals and health systems need a robust and highly qualified staff to handle medical care in emergency situations. To achieve this goal, 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 licenses. 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 (S. 1302 / H.R. 2389)**, 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 / H.R. 4942)** to extend and expand 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 urges Congress to pass the **Healthcare Workforce Resilience Act (S. 3211 / H.R. 6205)**, bipartisan legislation that would recapture 25,000 unused employment-based visas for foreign-born nurses and 15,000 for foreign-born physicians to help address staffing shortages.

- **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 / H.R. 1711)** 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 (S. 2768 / H.R. 2584)** to provide federal protections for health care workers against violence and intimidation.

IMPROVING MATERNAL HEALTH IN RURAL COMMUNITIES

The AHA and its hospitals and health systems are dedicated to eliminating maternal mortality and reducing maternal morbidity to provide mothers and babies with the opportunity to lead healthy and productive lives. Last year, we released a comprehensive set of federal public policy and legislative solutions for improving maternal health. In addition, the AHA has shared tools and resources and promoted the fields' efforts through case studies, webinars and podcasts.

Over the last decade, more than 200 rural hospitals have closed obstetric (OB) units. The decision to close an OB unit is not made lightly. Hospitals and health systems consider various factors, including patient care, staffing challenges, declining patient volume and inadequate reimbursement, in addition to the important role they play in their communities and the lives of their patients. A recent Government Accountability Office study[1] estimated that half of all rural counties lack access to this essential care.

As Congress examines this issue more closely, we would encourage legislative approaches that focus on:

- **Increasing reimbursement for obstetric services.** For example, some states have implemented add-on payments for labor and delivery - paid directly to the hospital - by their state Medicaid programs; a federal match could be helpful in maintaining and expanding the use of these payments.

- **Reducing regulatory barriers to encourage partnerships and innovative approaches to delivering care**. Partnerships between smaller rural hospitals and larger health systems can allow systems to share staff, connect patients with complex health needs to specialists, and in some cases, transfer high-risk pregnant women to other facilities.

- **Encouraging state Medicaid graduate medical education (GME) programs to support expanding capacity of existing workforce.** States have broad authority to create Medicaid GME programs that meet the needs of their state, including through fee-for-service and Medicaid managed care programs. In some states, primary care or family practitioners have received training in labor and delivery, including performing cesarean sections, to offer care as part of a broader clinical team that includes obstetricians and gynecologists. CMS could assist with guidance and encourage state Medicaid agencies to develop Medicaid GME programs focused on rural hospitals that provide maternity care.

[1] https://www.gao.gov/products/gao-23-105515

- **Requiring state Medicaid programs to cover telemedicine for maternal care.** Telehealth can provide support throughout the perinatal period as well to allow for consultations with specialists and access to care for rural areas that do not have obstetric providers.[2] A study by the CDC examined work done by 13 state maternal mortality review committees to identify contributing factors and strategies to prevent future pregnancy-related deaths, which included addressing personnel issues at hospitals by providing telemedicine for facilities with no obstetric provider on-site.[3] In addition, the use of remote patient monitoring, such as with blood pressure cuffs weekly glucose review, both lowered pregnancy-related stress and improved patient satisfaction with their treatment. While the use of telemedicine for obstetric services has increased over the last few years, not all states may be requiring Medicaid to reimburse for these services.

CONCLUSION

We thank you for the opportunity to comment on ways to improve rural health care and strengthen the communities that rely on the services provided by their local hospitals and health systems. We look forward to continuing to work with you on this important issue.

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9639859/#bib5
[3] https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w&T3_down