

December 6, 2019

The Honorable Danny Davis
United States House of Representatives
2159 Rayburn House Office Building
Washington, DC 20515

The Honorable Terri Sewell
United States House of Representatives
2201 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
United States House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
United States House of Representatives
1029 Longworth House Office Building
Washington, DC 20515

RE: Rural and Underserved Communities Health Task Force Request for Information

Dear Members of the *Rural and Underserved Communities Health Task Force*:

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 provide input on the House Ways & Means Committee Rural and Underserved Communities Health Task Force request for information (RFI). The RFI solicits comments on factors that contribute to health outcomes in these areas, examples of successful models and lessons from the field that address access and outcomes, and considerations for the unique circumstances of rural and underserved communities.

The AHA has long recognized the significant pressures on health care providers in rural and underserved settings. In 2016, we issued a [report](#) identifying nine strategies to ensure access to essential services in vulnerable urban and rural communities, and earlier this year, we released a [report](#) outlining the unique challenges facing rural hospitals, as well as policy recommendations to address them. In July, we assembled 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 also soon will launch a group of AHA member hospital leaders to discuss solutions to the pressing challenges facing large, urban hospitals in vulnerable communities. As the AHA continues our efforts to improve health care access and identify viable solutions, we applaud the Committee's attention to advancing health in rural and underserved areas.



As your Task Force continues its work to support health care in rural and underserved communities, we urge the committee to consider that:

- **Comprehensive coverage, including for behavioral health, should remain the focus;**
- **Medicare should cover telehealth for all services that are safe to provide;**
- **More funding opportunities to support telehealth in rural and underserved areas should be provided;**
- **Policies and regulations should not put undue burden on health care providers that already are grappling with limited resources;**
- **Payment programs to support rural hospitals, such as the low-volume adjustment, should be maintained;**
- **The necessary provider critical access hospital program should be re-opened;**
- **New payment models that offer financial certainty should continue to be tested on a voluntary basis for providers in rural and other underserved communities;**
- **Congress should make funds available for hospitals working to improve aging infrastructure and carry out service-line transformation;**
- **A new designation under the Medicare program should be established that allows rural hospitals to provide emergency and observation services without the provision of inpatient services;**
- **Medicare-funded residency slot caps should be lifted to expand training opportunities and help address health professional shortages;**
- **Workforce programs, such as the Conrad State 30 and National Health Service Corps loan repayment programs, should be supported and expanded; and**
- **The unique contexts of rural and underserved communities should be considered when designing and implementing quality improvement and/or reporting programs.**

We appreciate your consideration of these issues. Our detailed comments are attached. 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/

Thomas P. Nickels
Executive Vice President

Enclosure

FACTORS THAT INFLUENCE HEALTH OUTCOMES IN RURAL AND UNDERSERVED COMMUNITIES

The millions of Americans living in vulnerable rural and inner city communities depend upon their hospital as an important, and often the only, source of care. The nation's nearly 2,000 rural community hospitals and more than 2,000 urban community hospitals frequently serve as the anchor for their area's health-related services, often providing prevention and wellness services, as well as community outreach and employment opportunities. Many serve as cornerstones of their communities, working to advance population health and supporting local economies.

However, these communities and their hospitals face many challenges. Rural hospitals often struggle with their remote location, limited workforce and constrained resources. Inner-city urban hospitals serving vulnerable populations strive to achieve financial stability while pursuing their charitable mission. As the hospital field engages in its most significant transformation to date, many of these hospitals are fighting to survive – potentially leaving their communities at risk for losing access to local health care services. For example, as of October 2019, [119 rural hospitals](#) have closed since 2010, forcing many people in rural communities to travel even further to receive care that they need, and in some cases causing people to delay or forgo health care entirely. One recent study found that such closures were associated with [higher local mortality](#).

Characteristics of vulnerable communities that influence health outcomes. The AHA's [Ensuring Access in Vulnerable Communities report](#) outlined attributes that characterize vulnerable communities, such as a lack of access to primary care, cultural differences, and low education/health literacy levels. Although some of these factors lie outside of the health care system, each can contribute to health outcomes in rural and underserved areas. For example, poverty may result in the purchase of processed food instead of fresh produce, which could lead to hypertension, obesity or diabetes.

Importance of comprehensive coverage. Affordable health coverage is one of the most pressing challenges facing rural and underserved communities. As described in AHA's [Importance of Coverage Report](#), comprehensive coverage is associated with improved health outcomes, better access to and more appropriate care, and general improvements in wellbeing. When the rate of uninsurance is high, providers may restrict the provision of certain services, shorten their hours or be forced to shut their doors.

Uninsured rates are particularly high in states that chose not to expand Medicaid under the Affordable Care Act. Indeed, the vast majority of rural hospital closures since 2014 have occurred in non-expansion states. Researchers have found an [association between Medicaid expansion and improved hospital financial performance](#), especially in rural areas. **We continue to urge Congress to focus on comprehensive coverage and to promote policies that close the coverage gap.**

Broadband access and telehealth. Telehealth expands access to services that may not otherwise be sustained locally. **Medicare should cover telehealth delivery for all services that are safe to provide, eliminate geographic and setting requirements, and expand the**

types of technology that may be used. Payers also should provide payment parity with services delivered in-person. Moreover, Congress should pass legislation to facilitate virtual care across state lines and to allow eligible hospitals to pilot and test telehealth services for Medicare patients.

Congress should also address the disparity between the actual cost of providing care at the site where the patient is located (originating site) and the originating site fee. Even in cases where originating sites are eligible to bill Medicare for a telehealth facility fee, rates are marginal compared to the overall costs. Congress needs to ensure adequate reimbursement in the Medicare program for hospitals serving as originating sites.

The AHA [supports](#) passage of the CONNECT for Health Act of 2019. **This includes the expansion of telehealth for mental health services and emergency medical care, along with the ability to waive restrictions on the use of telehealth during national and public health emergencies.** This legislation also would appropriately expand the ability of rural health clinics and federally qualified health centers to provide telehealth services.

In addition, access to high quality broadband is a critical enabler for connected health tools. 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 United States Department of Agriculture ([USDA](#)) to provide more funding opportunities to support telehealth in rural and underserved areas, we urge Congress to appropriate significant federal dollars to ensure every hospital in every community has the broadband infrastructure needed to leverage 21st century technologies in patient care.**

Regulatory barriers. According to the AHA's [Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers](#) report, the nation's hospitals, health systems and post-acute care providers spend \$39 billion each year on non-clinical regulatory requirements. The costs of complying with regulations could result in reduced local access to services, ultimately affecting outcomes. 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. In our [comments responding to the Health Resources and Services' Administration's recent RFI](#), we outlined several regulatory issues that may limit rural health care access. For other underserved areas, such as inner city communities, providers may struggle to spread limited resources to address regulatory compliance while also serving patients with complex health conditions, providing substantial charity care and grappling with a challenging payer mix. **We continue to urge Congress to acknowledge the regulatory burden on providers. We also urge the Centers for Medicare & Medicaid Services (CMS) to accelerate its Patients over Paperwork initiative.**

LOW PATIENT VOLUME IN RURAL HOSPITALS

In the [AHA's Rural Report](#) released in February 2019, we outlined a number of challenges facing rural hospitals that can contribute to financial and organizational hardship. Low patient

volume is considered to be a persistent challenge¹ for these providers. Given the clear link between volume and hospital viability, Congress established the Low-volume Hospital Adjustment (LVA) program in 2003. However, the program continues to face threats of retrenchment despite [its effectiveness](#) in assisting hundreds of rural hospitals (excluding critical access hospitals (CAHs), which are not eligible). **The LVA program should be maintained to support low-volume providers in rural areas and preserve local access to care. We also urge Congress to sustain other Medicare designations for rural hospitals (see below).**

In addition, to further support access to care in rural areas, we urge Congress to re-open the necessary provider CAH program. [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.

Because patient volume is a contributing factor for viability, 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 [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. **New payment models, such as global budgets, that offer financial certainty and are less vulnerable to volume shifts, should continue to be tested on a voluntary basis for providers in rural and other underserved communities.**

Low patient volume also can be a hindrance to participating in performance measurement and improvement activities, as noted in the “Advancing Quality and Patient Safety” section of this letter. **The unique contexts of rural and underserved communities should be considered when designing and implementing quality improvement and/or reporting programs.**

SERVICE TRANSFORMATION TO MAINTAIN ACCESS TO CARE

The RFI requests comments on service-line changes that hospitals may undertake, as well as approaches to forming networks to regionalize services. Rural and underserved communities have diverse challenges and opportunities that may change over time. In response, providers are seeking ways to transform their care delivery in order to continue meeting their community’s needs. **Policy approaches to improving access should promote community-driven solutions and remain flexible for variable characteristics, needs and preferences across localities.**

Some providers also are modifying service lines in order to maintain access. For example, as more care delivery has shifted from inpatient to outpatient settings, some hospitals are transforming their services to align with this trend. **Specifically, hospitals may reduce their**

¹ Persistent challenges encompass the longstanding realities of rural health care, including geographic isolation, a heavy reliance on government payers and an older population with more chronic conditions, among others.

inpatient capacity (e.g., the number of licensed beds) and shift those resources to support more outpatient care. As one of the AHA's nine [strategies](#) to ensure access in vulnerable communities, inpatient/outpatient transformation can help the providers more precisely meet the community's service needs and optimize its resources. For example, Atrium Health Anson (formerly Carolinas HealthCare System Anson) in North Carolina reduced its inpatient capacity and shifted resources to offer enhanced outpatient and primary care services to the community – including a patient-centered medical home, increased emergency department capacity and increased behavioral health services. In another example, Mount Sinai Health System in New York City is transforming its Mount Sinai Beth Israel hospital from a 799-bed facility to a 220-bed acute care hospital, which will be a part of the “Mount Sinai Downtown” health care network. The hospital will be accompanied by a network of greatly expanded primary, specialty, urgent, behavioral and outpatient surgery services that seeks to address the health care needs of its community today and the future. **Congress should make funds available for hospitals working to improve aging infrastructure and carry out service-line transformation in order to improve access to care.**

Another emerging model that would transform service lines to maintain access to care is the Rural Emergency Hospital (REH) model. As a new designation under the Medicare program for rural hospitals, 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, an REH would 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. **The AHA supports legislation that would 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).**

In addition, certain providers are broadening the definition and parameters of “community” by regionalizing specialty services. For example, in light of the quality and efficiency gains associated with higher volumes, some providers are testing regionalization models in which particular services (e.g., oncology, urology) are provided by certain providers within a determined distance. This means that a service may not be available within an immediate area but is accessible for the broader community. While this model may not be appropriate for services such as primary or emergency care, it offers promise to preserve access to specialized services. The state of Alaska has employed this approach to [improve access to perinatal care](#) and has experienced reduced neonatal mortality rates as a result. For some areas, this approach may be an appropriate, preferable means of organizing specialty care and making it accessible, especially if some providers would not be able to sustain the service on their own.

MEETING PATIENT NEEDS: SUCCESSFUL MODELS FROM THE HOSPITAL FIELD

The RFI also solicits examples of successful initiatives that have a positive impact on health outcomes. Hospitals and health systems have been leading the way in exploring new

approaches to deliver care, develop partnerships and innovate to meet the health needs of their communities. The following are examples of successful hospital initiatives to improve service provision and health outcomes, all of which demonstrate the importance of thinking beyond the four walls of a provider to meet patient needs.² Policies and investments should support these types of innovative and resourceful approaches.

Addressing food insecurity. To combat food insecurity, ProMedica Health System in Ohio developed a food insecurity screening tool embedded in its electronic health record (EHR). Patients who screen positively receive one day's worth of shelf-stable food, as well as a community resource guide that includes information on food resources specific to the patient's local community. ProMedica also provides nutrition education programs at local schools and created the ProMedica Food Pharmacy where patients can obtain nutrition counseling and prescriptions through one of ProMedica's primary care practices. For patients in immediate need, the patient can be supplied with an "emergency food bag" that contains a day's worth of shelf-stable food for their entire family. From January through April 2016, the pharmacy provided healthy, nutritious food to nearly 5,000 individuals representing almost 2,000 households.

Building a telehealth network. The [Illinois Telehealth Network](#) (ITN) is a member-based, voluntary network of independent organizations working together to address widespread workforce shortages in rural, underserved and disadvantaged areas in Illinois. It currently consists of 28 members – including hospitals, physician organizations and an accountable care organization – collaborating to help eliminate barriers to health care access. Members participate in needs assessments and voluntarily plan and collaborate on initiatives to drive change in health care delivery by evaluating, choosing and implementing telemedicine solutions that support their organizational business model and serve their patients. The ITN provides support to its network members through training, resource sharing, technical support, collaborative grant efforts, networking and sharing economies of scale for purchasing.

Managing the needs of medically and socially complex patients. Kalispell Regional Healthcare in Montana teamed with Mountain-Pacific Quality Health Improvement Organization to introduce a modified transitional care model, which is intended to provide comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. Specifically, Kalispell is implementing multidisciplinary "[ReSource teams](#)," which work to coordinate medical and non-medical services (e.g., "Meals on Wheels"), and educate the patient on condition management. By the conclusion of its second year, this project is projected to reach 65 patients and reduce inappropriate visits to the emergency department by 1 per patient for savings of approximately \$83,400. This would translate to almost \$1 million in savings to Medicare, Medicaid and the Indian Health Service through reduced readmissions.

Connecting clinicians virtually. Project ECHO (Extension for Community Healthcare Outcomes) in New Mexico dramatically increases access to specialty treatment in rural and underserved

² For more case studies and examples from the field, see the AHA's [Ensuring Access to Care in Vulnerable Communities Report](#), the AHA's [Rural Health Services Case Studies](#), the Health Research & Educational Trust's [Hospital-Community Partnerships to Build a Culture of Health: A Compendium of Case Studies](#), and the Health Resources and Service Administration's [Flex Program's Innovative Models Program Report](#).

areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex medical conditions. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub. As the ECHO model expands, it is helping to address some of the health care system's most intractable problems, including inadequate or disparities in access to care, rising costs, systemic inefficiencies, and unequal or slow diffusion of best practices.

WORKFORCE ISSUES IN RURAL AND UNDERSERVED AREAS

Recruitment and retention of health care professionals remain among the top challenges for hospitals in rural and underserved areas. While there are shortages in both rural and urban communities, some clinician shortages may be felt more acutely in rural settings. For example, in the most urban areas, there are roughly 28 general internal medicine [physicians per 10,000 Medicare beneficiaries](#), and this declines to 3.85 per 10,000 beneficiaries in the most rural areas.

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. **Congress should lift the cap on the number of Medicare-funded residency slots, which would expand training opportunities and help address health professional shortages.** Accordingly, AHA [supports](#) the Resident Physician Shortage Reduction Act of 2019 (H.R. 1763).

Health care leaders in rural and underserved communities are using creative strategies to address professional shortages. Studies show that primary care providers are more likely to practice where they receive training. Thus, one possible approach to increase rural providers is to train students who are in these rural communities who will stay and practice in their home communities. The "Grow Your Own" path to increase providers is a promising practice.

Nurse practitioners, midwives and physician assistants have been pivotal in addressing physician shortages across the U.S. Nurse practitioners and physician assistants currently account for 19% and 7%, respectively, of the [primary care workforce](#). However, many state licensure laws limit the ability of advanced practice providers to practice at the top of their license. Over the years, several approaches to mitigating these issues have been raised, such as easing licensure restrictions to allow for multi-state practices to share resources.

Another strategy to address physician shortages is the use of locum tenens arrangements for temporary physician absences. Yet, Medicare limits the benefit of such arrangements because it restricts payment for locum tenens clinicians to only 60 days. Other existing programs that work to ameliorate rural workforce deficits by incentivizing clinicians to work in rural areas include the Conrad State 30 and the National Health Service Corps programs, which are administered by federal agencies with funding from Congress. New legislation for a Rural America Health Corps has also been proposed to provide loan repayment to physicians that train in rural areas. **These programs should be supported and expanded.** In addition, advancements in telehealth can address workforce challenges by connecting patients and their providers to specialists in other locations; however, state licensure restrictions often limit the

reach of telehealth services. And in very remote areas where broadband access is a challenge, another viable option is to encourage collaboration and strategic affiliations with larger providers and systems to provide telephonic assistance to providers in rural areas.

In light of physician shortages, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) play important roles in meeting service needs, especially in rural areas.

Funding should be made available to expand rural FQHC and RHC urgent care and triage services as a way to enhance access to care in these communities.

BEHAVIORAL HEALTH NEEDS

Rural communities face three major obstacles to behavioral health and substance use care: accessibility, availability and acceptability. Our members work closely with academic and state-led programs to organize networks of care uniquely suited to rural residents. These networks facilitate remote communication between providers and patients, including through telehealth encounters and crisis hotlines staffed by workers with training in mental health who can provide support, information and referrals without the patient leaving his or her home. Some states address coverage limitations by providing vouchers that allow rural residents to obtain services from a range of providers rather than what is explicitly covered in their benefits package. **The AHA supports legislation that would strengthen and broaden coverage requirements for behavioral health.**

Successful programs leverage the workforce they have to better meet the needs of the community. Many hospitals deploy their staff psychiatrists and other paraprofessionals to circuit practices across the region to see patients in primary care offices, community mental health centers, nursing homes and other hospitals. Rural communities often develop strategic plans to improve staff recruitment and retention, including specifically recruiting foreign medical graduates through J-1 visas or providing unique incentives (loan repayment, low-interest home loans or practice set-up costs, for example). **The AHA supports legislation that would fill gaps in the behavioral health workforce specifically and increase access to behavioral health care.**

POST-ACUTE CARE

Post-acute care (PAC) services, including home health (HH), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospitals (LTCH), provide critical value by, in general, augmenting care provided during an acute care stay. PAC services focus on enabling patients to return to their home or community and, in some PAC settings, to maintain or prevent worsening of health status.

In rural and frontier areas, access to care is a particular challenge for higher-acuity patients requiring the hospital-level PAC services provided by IRFs and LTCHs, as most are located in urban and suburban areas. As a result, most rural and frontier PAC services are delivered by HH agencies and SNFs. It is important to note that the SNF and HH Medicare prospective payment systems are currently undergoing transformative reforms that are requiring significant operational changes to adapt to the new models, such as admissions, coding, clinical staffing

and other modifications. **It will be critically important for policymakers to closely monitor the impact of these HH and SNF payment reforms on access to care, especially since smaller providers in rural areas may struggle to support such extensive operational adjustments.**

We also note that the ongoing phase-out of the HH rural add-on payment, as mandated by the BiBA of 2018, will likely provide additional stress on access to care for rural patients requiring HH care and facing limited alternatives. In addition, these sources of stress on rural HH providers are incongruent with the separate policy track focused on testing and implementing alternative payment models to improve outcomes and lower costs for hospital-PAC episodes of care, which often focus on expanding utilization of HH services.

Further, to provide continuity of care for patients transitioning from urban and suburban hospitals to rural post-acute care settings, **it is important to support cross-setting partnerships and efforts to improve transitions of care and access to telehealth, all of which can help ensure high-quality care for the entire episode of care.**

ADVANCING QUALITY AND PATIENT SAFETY

America's hospitals and health systems are deeply committed to providing high quality, safe and person-centered care to all of the patients and communities they serve. As detailed in our 2018 *TrendWatch* [report](#), the entire hospital field's progress on quality can be accelerated through aligned federal policies that prioritize: "Measures that Matter" the most to improving outcomes; modernized quality standards and Medicare Conditions of Participation that enable innovation while protecting patients; and federal support for quality improvement initiatives that help identify and spread best practices.

As the committee considers potential new quality-related policies for hospitals serving rural and underserved communities, we urge it to be especially attentive to the following issues:

- **A level playing field in measurement programs.** Hospitals serving rural and underserved areas tend to care for patients that are sicker and poorer. For this reason, risk adjustment must be rigorous, and where appropriate, include adjustment for sociodemographic factors.
- **Voluntary participation in quality reporting and value programs for rural and low-volume providers.** As we recently [shared](#) with HRSA, small case volumes, the vast heterogeneity of the services provided and geographic isolation pose enormous technical challenges for such providers. Prematurely mandating participation in programs without addressing these challenges first could lead to misleading portrayals of quality.
- **Expediting standards guidance.** CMS's recent [delays](#) in issuing interpretive guidance are severely hampering our members. The lack of clear guidance around co-location may especially jeopardize access to specialists in rural areas. Congress should work with CMS to promote a more nimble and responsive approach to issuing standards guidance.