Ascension

The Honorable Richard E. Neal
Chairman
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Ways and Means Committee
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

November 29, 2019

Submitted electronically via: Rural_Urban@mail.house.gov

Re: Rural and Underserved Communities Health Task Force Request for Information (RFI)

Dear Chairman Neal, Ranking Member Brady, and Co-chairs of the Task Force:

Ascension appreciates the opportunity to submit comments in response to the *Rural and Underserved Communities Health Task Force Request for Information (RFI)* recently issued by the Ways and Means Committee's Rural and Underserved Communities Health Task Force (Task Force).[1]

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As one of the leading non-profit and Catholic health systems in the U.S., Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2019, Ascension provided $2 billion in care of persons living in poverty and other community benefit programs. Ascension includes approximately 150,000 associates and 40,000 aligned providers. The national health system operates more than 2,600 sites of care – including 150 hospitals and more than 50 senior living facilities – in 20 states and the District of Columbia, while providing a variety of services including clinical and network services, venture capital investing, investment management, biomedical engineering, facilities management, risk management, and contracting through Ascension's own group purchasing organization.

Systems or Factors That Influence Health Outcomes

In vulnerable communities, even if quality care is available, social and economic factors often impede individuals from being able to obtain healthcare services or achieve health goals. These can include: food security; housing; employment and income/poverty level; domestic and community violence; crime/public safety; environment (*e.g.*, clean water and air); healthy workplaces, schools, and transportation; literacy, educational attainment, and early childhood development; and social cohesion or civic engagement.

While there are many ways providers work to help address the underlying social conditions affecting their patients' health, the American Hospital Association has identified three general paths – which may provide a guide for considering how best to support rural providers working to address risk factors among

[1] https://waysandmeans.house.gov/rural-and-underserved-communities-health-task-force-request-information

patients:

- *Screening and information*: Providers systematically screen patients, either remotely or in person, for health-related social needs and discuss with patients the impact this may have on their health.

- *Navigation*: Providers offer navigation services to assist patients in accessing community services.

- *Alignment*: Providers partner with community stakeholders to align more closely local services with the needs of patients.

Addressing Workforce Shortages in Rural and Underserved Areas

Addressing the physician and nurse workforce shortage is a priority for all Ascension hospitals. Rural hospitals face unique recruitment challenges; increasing the availability and accessibility of opportunities for physicians to train in rural hospitals would allow more medical residents to see the effect they can have on rural communities and the benefits of rural locations. Increasing the number of residency slots and adding support for rural training will be necessary to ensure a stable and sufficient pipeline of clinicians who understand and appreciate the practice of rural-based healthcare.

One measure of healthcare services access in rural communities is a Health Professional Shortage Area (HPSA) designation. These designations are based only on healthcare provider shortages in primary care, dental health, or mental health. There is otherwise no evaluation of the availability of specialty provider access (*e.g.*, rheumatology, psychiatry, dermatology, neurology etc.) for purposes of designating a HPSA.

However, the Centers for Medicare & Medicaid Services (CMS) does consider specialty providers and facilities for purposes of determining access in other parts of its programs. For example, Medicare Advantage Organizations must meet network adequacy requirements with respect to 23 different facility specialty types, including cardiac surgery programs, mammography, and heart transplant programs. Updating the HPSA designation methodology to look more comprehensively at the availability of *all* services will be important for measuring sufficient access to community-tailored healthcare services in rural communities.

Institutional, Policy, and Programmatic Efforts to Further Strengthen Patient Safety and Care Quality

Not every rural community will have the same healthcare needs, nor will those needs remain static over time. Communities should be able to tailor available services to their specific needs and circumstances, which may be driven by a variety of factors including demographic shifts. Today, rural hospitals serve as both a healthcare access point and anchor within our communities. These hospitals can identify and accommodate shifts in community needs and circumstances – from increased demand for specialty or long-term care, to opportunities to furnish more services via telehealth, and even unmet community services needs that are impacting patients' health outcomes.

Enabling the Provision of Community-Tailored Healthcare Services Through Accurate Reimbursement Mechanisms

To ensure ongoing access to services, and to support transformations that account for changing community and population needs or demands, healthcare providers must have a fair opportunity to achieve financial stability while carrying a manageable and appropriate regulatory burden. As the

healthcare system continues to transform at the national level, rural hospitals are seeing inpatient volumes appropriately decrease while demographics also continue to shift and patient populations age. As rural providers rely more heavily on Medicare and Medicaid reimbursement, it is increasingly necessary that payers and communities support the long-term sustainability of rural hospitals by maintaining accurate and steady reimbursement models. And in circumstances where a rural community can no longer support an inpatient facility, we would recommend that Congress examine policy options to allow facilities to transition to a robust outpatient facility or freestanding emergency department option, while still recognizing the need for appropriately tailored reimbursement to ensure facilities remain viable.

One example of a largely successful reimbursement model that was designed to promote rural provider stability is the enhanced cost-based reimbursement for critical access hospitals (CAHs). This reimbursement structure aims to account for the unique challenges of operating a CAH, including low patient volume and high acuity of populations served. In addition to traditional inpatient beds, CAHs utilize "swing beds" to provide access to 24/7 nursing care for patients who may qualify for skilled nursing home admission. In communities without adequate access to skilled nursing facilities, CAHs close that gap for patients who require higher-touch levels of care but wish to remain close to home. This service is also critically important for patients who need 24/7 nursing care that is not available at a skilled nursing facility. The enhanced cost-based reimbursement for CAHs was designed to ensure these facilities are able to maintain appropriate staffing, reasonably updated facilities, and services and supplies that are necessary to meet patient needs. We encourage Congress to work with the Department of Health and Human Services (HHS) and with stakeholders to ensure this payment approach continues to meet its underlying goals.

Other rural provider reimbursement structures have become significantly outdated and should be modernized. For example, the Rural Health Clinic (RHC) program was created over 40 years ago to improve access to healthcare in rural, underserved areas. RHCs use a team approach to care and must be staffed at least 50 percent of the time by a nurse practitioner, physician assistant, or certified nurse midwife. RHCs are reimbursed through a bundled reimbursement rate that was intended to reflect the costs associated with providing care in rural areas. This kind of reimbursement structure can certainly incent providers to deliver efficient, high-quality care when calibrated appropriately. Unfortunately, the reimbursement structure has not been substantively updated since the creation of the RHC program. The current bundled rate is tied to an historical base rate that does not appropriately reflect the costs associated with delivering care for most RHCs. This outdated payment methodology creates uncertainty and instability for these providers and their communities.

These and other payment structures established for rural providers must inherently account for limited volume, unique patient demographics, and cost differentials. Maintaining and enhancing appropriate reimbursement, including developing a long-term solution for the Medicare wage index disparity, and ensuring long-term financial stability, will help ensure rural providers can continue to identify, adapt to, and offer high quality services that meet the current and future needs of our communities.

Enabling the Provision of Community-Tailored Healthcare Services Through Appropriately Flexible Statutory and Regulatory Constructs

While facing operational constraints driven by geographic limitations, rural healthcare providers also are often subject to complicated and limiting federal regulatory constructs. For example, CAHs must demonstrate an annual length of stay of 96 hours or less to maintain their designation. However, in recent years CMS has enforced a condition of payment for CAHs that requires a physician to certify that each

Medicare beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This individual-level certification unnecessarily complicates admission, creates administrative burden, stretches already limited physician availability, and is unnecessary because of the 96-hour length of stay requirement that already applies. Such regulatory burdens divert provider resources away from patient care and diminish the value of the enhanced reimbursement structure, creating added financial uncertainty over time.

As communities' needs and circumstances shift over time, rural hospitals may identify a need for increased access to specialty services but lack the patient volumes to support full-time specialists. Many rural hospitals, especially CAHs, do not have an on-campus physician office building more typical of urban settings where space could be traditionally leased. Providing clear regulatory flexibility to permit co-location would support rural hospitals that are seeking to provide access to physician specialists within the CAH.

Similarly, advancements in technology have opened the door to improved access to care, training, and peer-to-peer engagement through virtual care and telehealth services. In practice today, telehealth services can include virtual visits originating at a patient's home or at a medical facility, remote patient monitoring, and specialist consults between hospitals. Because rural healthcare facilities are often located an hour or more from the nearest full-service hospital or clinic, supporting the increased utilization of telehealth provides an opportunity to address these barriers to care.

Ascension appreciates the steps Congress and HHS have taken and continue to take toward enhancing the availability of telehealth services. We have embraced the promise of telehealth services as a way to bring care to our patients, when and where they need it most. However, existing laws and regulations put complicated limitations on and barriers to utilizing these services. Specifically, patient originating site (POS) limitations remain a significant barrier to expanding access to telehealth services. Rural providers would be better equipped to meet rural patients' needs if additional regulatory flexibilities were provided, including:

- Providing reimbursement of telehealth services at the same rate as face-to-face services;
- Expanding existing definitions to allow patients to receive services in their homes and at other POS locations;
- Increasing investment in high-speed broadband access; and
- Authorizing RHCs to be "distant sites" for telehealth services.

Innovation is happening in the way care delivery is designed, as well. The healthcare system continues to move towards value-based healthcare at a national level, rendering current regulations outdated and limiting. Rural hospitals feel the impacts of transformation even more acutely and face unique challenges given their geographies and low patient volumes. Our rural hospitals rely on enhanced reimbursement to be able to offer key outpatient services, despite low patient volumes. Statutes and regulations should offer the flexibilities necessary to support transformation while maintaining important care access points. Modernization of physician self-referral and anti-kickback statute regulations, especially the positive impact it can have on rural providers, will be helpful in promoting the move to value-based care.

Conclusion

We sincerely appreciate your consideration of these comments. If you have any questions, or if there is any additional information we can provide, please do not hesitate to contact Mark Hayes, Senior Vice

President for Policy and Advocacy for Ascension, at 202-898-4683 or mark.hayes@ascension.org.

Sincerely,

Peter M. Leibold
Chief Advocacy Officer
Ascension

cc:
The Honorable Danny Davis (D-IL)
The Honorable Terri Sewell (D-AL)
The Honorable Brad Wenstrup (R-OH)
The Honorable Jodey Arrington (R-TX)