Federation of American Hospitals®

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The Honorable Danny Davis
U.S. House of Representatives
2159 Rayburn House Office Building
Washington, DC 20515

The Honorable Terri Sewell
U.S. House of Representatives
2201 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
U.S. House of Representatives
1029 Longworth House Office Building
Washington, DC 20515

Submitted Electronically to Rural_Urban@mail.house.gov
Re: Rural and Underserved Communities Health Task Force (Task Force) Request for Information

Dear Task Force Co-Chairs Davis, Sewell, Wenstrup, and Arrington:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching full-service community hospitals in urban and rural parts of America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We appreciate the opportunity to respond to the Ways and Means Committee's Rural and Underserved Communities Health Task Force (Task Force) Request for Information.

We commend the Committee and its Task Force for exploring bipartisan policies that will expand access to care and improve health outcomes in rural and underserved communities. Our country faces a serious challenge in seeking to maintain and expand quality health care in rural areas. Meeting that challenge requires an understanding of the current and evolving way in which

care is delivered in these areas and the alignment of federal policy to support all providers of care in rural areas.

The FAH membership includes investor-owned rural hospitals serving the neediest populations in the country with a mission and purpose aligned with that of the Task Force. In this letter, we identify several opportunities to improve the delivery of health care services in rural communities, including identifying a number of federal rural health programs and grant opportunities – as related to nursing workforce and broadband - that arbitrarily limit eligibility of investor-owned rural hospitals from participation.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional systems or factors outside of the health care industry that influence health outcomes within these communities?

Patients in underserved and rural communities face unique and significant challenges such as: addressing the opioid epidemic, geographic isolation, lack of broadband, workforce shortages, capacity challenges, increased need for behavioral health services, aging infrastructure, provider retention and payer mix, to name a few. In addition, patient care in these communities is often limited by transportation challenges including extreme distances and lack of access to a primary care provider and specialists.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Telehealth is pivotal to bringing personalized care to rural America. New technological advancements can increase timely access to patient-centered care, enhance patient choice and, through early intervention, can help prevent long-term, costly health events for many Americans who call rural America home.

Telehealth can reduce geographic challenges and provide patients convenient and more timely access to providers. As the utilization of telehealth continues to grow, the FAH believes that such modalities should be reimbursed by Medicare, Medicaid, private insurance and other payers at the same level as when those services are delivered in person. Reimbursements should not discriminate based on the technology used.

Using telehealth in rural areas expands access to and improves the quality of health care millions of Americans receive. However, there is often a lack of infrastructure in place to achieve the expansion of telehealth – namely, a lack of broadband internet. While broadband is used in everything from agriculture to education, expanding rural America's access to reliable internet service is pivotal to increasing access to quality health care for rural communities.

While not under the Committee's jurisdiction, the Federal Communications Commission's (FCC) Connected Care Pilot Program, designed to support the delivery of telehealth services to low-income Americans, is an example where the definition of a provider - as determined by the

Rural Health Care Program (RHCP) - would make investor-owned hospitals ineligible for participation in the Connected Care Pilot Program. This lack of parity unjustly penalizes patients living in rural communities across the United States that are served by an investor-owned hospital.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Rural hospitals serve more than 60 million Americans who live in rural regions, representing approximately 20% of the entire U.S. population. Rural hospitals are often the sole provider of comprehensive medical care in their communities and are the largest or second largest employer and economic engine in these areas.

Rural hospitals traditionally serve older, low-income populations. This unique patient demographic in rural regions often lends to a dichotomy: a high volume of Medicaid as well as Medicare-dependent patients, but a lower volume of commercially insured and total patients overall. As such, the Medicare Dependent Hospital (MDH) and the Low Volume Hospital (LVH) payment programs should be made permanent to ensure patient access to hospitals in rural America. These programs, which currently sunset in 2022, are essential to ensure the financial viability of rural hospitals. We urge policymakers to permanently extend these vital programs.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

As policymakers consider opportunities to improve the delivery of services via telehealth, the FAH recommends the following principles to guide future legislative and regulatory activity:

- Medical and behavioral health services that can be appropriately delivered via telehealth technology should be reimbursed by Medicare, Medicaid, private insurance, and other payers at the same level as when those services are delivered in person
- Support efforts for providers to participate in multi-state telemedicine programs
- Originating site restrictions should be updated continually as new technologies develop with the goal of eliminating originating site restrictions in order to make telehealth services available to patients where most convenient for them
- Access for telehealth services should not be restricted by geography, and all patients, whether in rural, suburban or urban areas, should be able to avail themselves of medical and behavioral health services via telehealth
- Reimbursement should not discriminate based on the technology used and should encourage the use of real-time secure bi-directional audio and video, home health monitoring technologies, store-and-forward technologies, and other synchronous, asynchronous, and remote monitoring technologies
- The federal government, through its role in oversight of the Medicaid program, should encourage states to broadly adopt telehealth services in state Medicaid programs
- Health care providers and practitioners engaged in the delivery of services via telehealth should continually strengthen safeguards that ensure the privacy and security of patient data.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The FAH applauds the passage of *H.R. 728, Title VIII Nursing Workforce Reauthorization Act of 2019*, which extends critical nursing workforce development programs that invest in the education and training of our nation's nurses. This legislation will help ensure that nurses continue to provide high-quality care to patients, including in rural and underserved communities, by supporting nursing education, practice, recruitment, and retention.

The FAH is particularly appreciative of the legislation's inclusion of an amendment from Rep. Matsui, which ensures that all nurses practicing in critical shortage facilities, regardless of tax status, have the opportunity to benefit from the Section 846 loan repayment program. Otherwise, nurses practicing at an investor-owned facility would not be eligible to benefit from the loan repayment program. Congress should explore ways to similarly remove arbitrary restrictions on loan repayment and other workforce programs that limit opportunities for providers to practice in underserved areas based on the facility's tax status.

In that same vein, grant eligibility criteria for the Health Resources & Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) is limited to "nonprofit and public entities", which curtails FORHP's ability to further the goal of increasing access to quality care in rural communities. The FAH urges Congress to amend Section 330A(e) of the Public Health Service Act to allow investor-owned entities an equal opportunity to participate in FORHP-administered community grant programs and improve care in rural America. The current limitation on eligibility criteria serves no useful purpose and arbitrarily prevents these critical providers of care (i.e., investor-owned rural hospitals) from accessing the resources to maintain and expand their ability to provide quality rural health care.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

<u>Rural Health Agenda:</u>

The FAH is encouraged that Members of Congress have introduced bipartisan legislation to address a wide array of issues that will improve the quality, safety, and availability of health care in rural America. In particular, we urge Congress to examine three bills, including: *H.R. 4899, Rural America Health Corps Act*; *H.R. 4900, The Telehealth Across State Lines Act*; and *H.R. 4898, The Rural Health Innovation Act.* In addition, Congress should re-examine current laws that arbitrarily limit Medicare Disproportionate Share Hospital program payments to rural hospitals

<u>Parity for Investor-Owned Hospitals:</u>

The FAH strongly urges Congress to re-consider existing federal laws and regulations that arbitrarily prohibit investor-owned hospitals from participating in federal rural health programs and grant opportunities. Such limitations harm patients served by these hospitals. In some

instances, an investor-owned hospital may very well be the only or most accessible facility in a particular rural community, especially in times of an emergency.

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The FAH appreciates the opportunity to comment. We look forward to partnering with the House Committee on Ways and Means, in conjunction with the Task Force, as we strive for a continuously improving health care system in rural areas and nationally. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1531.

Sincerely,

cc: The Honorable Richard Neal, Chairman, Committee on Ways and Means
The Honorable Kevin Brady, Ranking Member, Committee on Ways and Means