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November 27, 2019

To the co-chairs of the Rural and Underserved Communities Health Task Force:

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

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

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

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

RE: Committee on Ways and Means Rural and Underserved Communities Health Task Force's Request for Information Regarding Priority Topics Affecting Health Status and Outcomes

Dear Co-chairs Arrington, Davis, Sewell, and Wenstrup:

On behalf of New York's hospitals and health systems statewide, thank you for your interest in improving healthcare outcomes in rural and underserved communities. HANYS is committed to preserving and bolstering access to care and appreciates the opportunity to highlight key proposals that we believe would help achieve this goal.

Rural and small community hospitals in underserved areas face unique workforce recruitment and retention challenges. They struggle to attract clinicians and management, finance and technology staff.

With fewer resources and lower patient volumes, these facilities face serious operational efficiency challenges. This can complicate the management of projects, such as the implementation of complex and costly health information technology systems.

Often, Medicare reimbursement does not cover the cost of the care hospitals provide to Medicare patients. In 2017, total Medicare margins for New York's rural hospitals averaged *minus* 10.6%.

In New York's rural hospitals, 56% of all inpatient days are Medicare days; therefore, Medicare's underpayment for services has a profoundly negative effect on these institutions.

Bolster graduate medical education funding

Increased Medicare-supported GME funding could help address barriers to care in rural and underserved communities. These HANYS-supported bipartisan bills currently under consideration would advance this crucial priority:

- the Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) would add 15,000 Medicare residency slots in teaching hospitals over five years;
- the Opioid Workforce Act (H.R. 3414/S. 2892), advanced by the Committee earlier this year, would add 1,000 residency positions during the next five years in hospitals that have or are in the process of establishing accredited residency programs in substance use disorder medicine, psychiatry or pain management; and
- the Advancing Medical Resident Training in Community Hospitals Act (H.R. 1358), also approved by the Committee earlier this year, would make a technical adjustment to Medicare Graduate Medical Education policy to ensure hospitals establishing new medical residency training programs are not penalized for having hosted medical resident rotators for short durations.
- The Conrad State 30 and Physician Access Reauthorization Act (H.R.2895) would provide incentives to physicians to practice in rural and medically underserved communities.

Reject site-neutral payment reductions

The Bipartisan Budget Act of 2015 and subsequent regulations finalized by the Centers for Medicare and Medicaid Services have subjected certain off-campus, hospital-based outpatient departments to deep site-neutral payment reductions, without a policy basis.

These cuts threaten access to care in urban, suburban and rural communities. Hospital clinics are often the only place for patients, including those covered by Medicare and Medicaid, to access needed physician services. The impact of this payment reduction will grow over time as new off-campus HOPDs are opened to serve community needs. Some grandfathered sites have begun to lose their protected status simply because they were forced to change their address due to absentee landlord issues or a need to secure new clinic space.

HANYS urges members of Congress to support the Protecting Local Access to Care for Everyone Act (H.R. 2552), which would prevent CMS from expanding site-neutral payment cuts to grandfathered facilities — a policy that reduces funding to New York's off-campus HOPDs by \$816 million over the next decade. HANYS also asks Congress to reject any new efforts to expand the site-neutral concept to other provider settings.

Preserve rural and small community hospital payments/programs

Recognizing the important role rural and small community hospitals play in maintaining healthcare services, Medicare has special designations and therefore payments for certain hospitals. HANYS urges Congress to protect these critical designations to ensure access to care in the rural and underserved communities that these hospitals serve.

Critical Access Hospitals

New York state has 18 CAHs, which are limited-service, acute care facilities of up to 25 beds in rural areas. In general, CAHs must be located more than 35 miles from similar hospitals or 15 miles in areas with mountainous terrain or where only secondary roads are available.

HANYS supports the Critical Access Hospital Relief Act of 2019 (H.R. 1041/S. 586), legislation that would repeal Medicare's so called "96-hour rule" physician certification requirements for CAHs as a condition of payment.

Currently, CAHs are required to maintain a 96-hour annual average length of stay to maintain their Medicare designation. However, in recent years, CMS has enforced a condition of payment that requires physicians to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within four days of admission.

This additional, burdensome requirement could place CAHs in the difficult position of having to eliminate "96-hour-plus" services, ultimately affecting access to appropriate care for Medicare beneficiaries in these facilities.

Sole Community Hospitals

There are 20 SCHs in New York, six of which are also classified as Rural Referral Centers. These hospitals must be rural and at least 35 miles from other like hospitals; or must have fewer than 50 beds, be between 25 and 35 miles from the nearest like hospital and have limited access to nearby hospitals due to distance, weather conditions or topography.

Rural Referral Centers

New York has 24 RRCs. This program helps support high-volume hospitals that treat a large number of complicated cases and the greater intensity and costs these facilities may have.

Medicare Dependent Hospital Program and Low Volume Hospital payments

The MDH Program and LV payments, critical to small community and rural hospitals, are set to expire at the end of September 2022. MDHs are small hospitals for which Medicare beneficiaries comprise a significant percentage of their patients and, hence, their revenue. They are considered more financially vulnerable than hospitals that are reimbursed for patient care under a wider mix of private and public insurance. Hospitals eligible for LV payments are essential to their rural communities, have a modest volume of patients and are located at least 15 miles from the next nearest hospital.

Congress has extended these programs/payments several times, but more must be done to provide long-term certainty to these vulnerable providers. HANYS urges Congress to support the permanent extension of the MDH program and LV payments before Sept. 30, 2022.

Enhanced payment model for rural providers

HANYS urges members of Congress to support the reintroduction of the Rural Emergency Medical Center Act. This legislation would create a new designation for CAHs or hospitals with less than 50 beds located in a rural county to transition to become a 24-hour emergency medical center and receive enhanced reimbursement. This designation would be voluntary

and emergency care could not exceed an average of 24 hours or one midnight. The enhanced payment model would allow CAHs the flexibility to meet community needs and ensure that patients in rural areas have access to essential emergency and outpatient services.

Medicare volume decrease adjustment

Medicare VDA payments are a lifeline that help SCHs and MDHs maintain core staff and services when these facilities experience a significant decrease in patient volume due to circumstances beyond their control.

Unfortunately, a bureaucratic mess has resulted in unfair recoupments of VDA payments as well as flaws in VDA payment calculations, placing an enormous strain on the ability of already financially vulnerable institutions to provide necessary healthcare services in isolated rural populations. This jeopardizes access to care for families — especially seniors.

Specifically, 16 small rural hospitals in New York have faced or continue to face recoupments that could total \$15 to \$20 million, with a punitive interest rate of more than 9%.

HANYS urges Congress to address this issue by passing the Access for Rural Communities Act (H.R. 3672), bipartisan legislation that would restore and protect critical VDA payments for these small rural hospitals.

Enable expanded use of telemedicine

Telemedicine enables hospitals to leverage the resources of their neighboring facilities or tertiary centers hundreds of miles away and access the best specialty care for their patients without the need for patients to travel or experience long wait times. Telemedicine has been shown to reduce readmissions by electronically monitoring the vital signs and other health indicators of patients in their homes. It also provides necessary peer education and support for physicians and other practitioners working in remote areas of New York.

Medicare only reimburses for telemedicine services in certain geographic areas; for example, outside a Core-based Statistical Area or within a rural health professional shortage area. The Chronic Care Act of 2017, passed as part of the Bipartisan Budget Act of 2018, offers more pathways for telehealth reimbursement for Accountable Care Organizations. It allows Medicare Advantage plans to include more telehealth options and expands telestroke care and telemedicine for dialysis care. The CCA also removes the geographic limitations for originating sites for telestroke and for telemedicine programs within an ACO. While this is a step in the right direction, HANYS will continue to urge Congress to remove all geographic restrictions to ensure proper payment for Medicare services provided via telemedicine.

Promote strategies to address social determinants of health

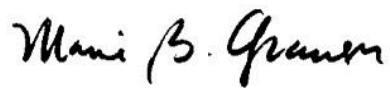
Hospitals and health systems across New York are increasingly deploying SDH strategies to help manage costs and improve health outcomes. HANYS encourages Congress to support the Social Determinants Accelerator Act of 2019 (H.R. 4004), bipartisan legislation that seeks to improve health outcomes by addressing SDH.

The bill would establish a federal grant program to empower states and local governments to tackle persistent economic and social conditions such as limited access to healthcare providers, stable housing, reliable transportation and healthy foods, which often hinder health outcomes.

Thank you for your interest in improving healthcare outcomes within rural and underserved communities. We look forward to working with you toward this shared goal.

Please feel free to contact Cristina Batt, vice president, federal relations, at (202) 488-1272 or Elyse Oveson, senior director, federal relations, at (202) 488-1275 with any questions.

Sincerely,

A handwritten signature in black ink that reads "Marie B. Grause". The signature is written in a cursive, flowing style.

Marie B. Grause, RN, JD
President