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November 29, 2019

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  
2159 Rayburn House Office Building  
Washington, DC 20515

Submitted Electronically to [Rural\\_Urban@mail.house.gov](mailto:Rural_Urban@mail.house.gov)

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

Dear Co-Chairs of the Rural and Underserved Communities Health Task Force:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Rural and Underserved Communities Health Task Force Request for Information.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

We appreciate the opportunity to provide feedback on what we believe will advance high-quality, high-value health care in both underserved rural and urban communities. Rather than responding to each of your twelve questions, we have identified what we believe are the biggest areas for your task force to explore.

### **Addressing Workforce Shortages**

With an aging population and workforce, workers at either end of the training spectrum are the most difficult to find. Entry-level workers, like nursing assistants, climb career pathways in search of higher pay and more fulfillment to fill higher professions like nurses and advanced practice clinicians. Hospitals and health systems have initiated their own training programs to draw in new nursing assistants, but are hindered by an inability to find instructors, due to the requirement for long-term care experience, and are limited in the number of students they can accept in some communities because nursing homes are prohibited from being clinical sites due to punitive and arbitrary penalty limits. Allowing acute care experience to qualify an instructor, and determining what types of violations should really bar nursing homes as clinical sites (ie. findings related to nursing assistant duties, training or resources) would help grow this desperately needed portion of our health care workforce.

At the far end of the career pathway, physicians spend twelve years or more in training, and as the physician workforce ages and retires, there are not enough new physicians to replace them. There are individuals interested in becoming physicians, and medical school enrollments are increasing. However, the availability for the final step in physician training, a graduate medical education (GME) residency, is lagging, and becomes a limiting factor for graduate physicians. A decades-old cap on the number of residencies that a program can receive federal funding for provides a disincentive for programs to expand. Lifting or re-calculating this cap would create more residency positions for future physicians and address a physician shortage that is worsening and may hit crisis proportions as the impact of the aging of the baby boom generation peaks in the middle of the next decade.

### **Patient Volume Adequacy in Rural Areas**

As your work group correctly understands, patient volume adequacy is a huge concern in rural areas. While our critical access hospitals are paid based on the cost of providing care under Medicare, these payments do not account for the entire costs, and sequestration cuts have further increased the gap between what Medicare pays and how much it costs rural hospitals to provide that care. Additionally, rural hospitals often care for a higher ratio of Medicaid patients which pays even less for care than Medicare. We often call this gap in payments a “hidden health care tax” as these costs get passed onto employers and the general public in the form of higher premiums and charges for those with private commercial insurance.

This creates unique challenges for rural hospitals that often cannot rely on a high volume of commercial patients to make up for that gap in government underfunding. For instance, in 2018, Wisconsin saw 42 hospitals lose money, including 13 Critical Access Hospitals, and overall hospital margins decreased for the third straight year. Driving these losses is the continued population shift with more patients leaving private insurance and being reimbursed lower amounts under Medicare. However, the problem is not unique to rural hospitals, as some urban hospitals that serve a very high number of Medicaid patients also deal with a patient mix that does not have enough private-pay patients.

For these reasons, Congress could consider special designations for both rural and urban hospitals that serve a disproportionately high ratio of Medicaid and Medicare patients without a sufficient pool of private-pay patients to offset these losses. While states currently may use Medicaid Disproportionate Share (DSH) payments to offset these losses, rural hospitals that do not perform obstetrics services are ineligible, leading states to create other supplemental payments to account for this. With CMS and Congressional leaders signaling a desire to decrease the reliance on supplemental payments, now would be a good time for Congress to explore special designations that can help ensure state and federal under-reimbursement in the Medicare and Medicaid programs does not jeopardize the ability of hospitals to stay afloat in underserved communities.

### **Quality Initiatives**

Wisconsin hospitals are proud to have a reputation for providing some of the highest-value, highest-quality health care in the nation. This is no accident; WHA coordinates a number of quality initiatives that help hospitals collaborate to improve quality. One such initiative is the Superior Health Quality Alliance (SHQA), a collaboration among the four state hospital associations of Wisconsin, Illinois, Michigan, and Minnesota, the Quality Improvement Organizations in Minnesota, Michigan, and Wisconsin, and the End-Stage Renal Disease Network #12. As one of the Network of Quality Improvement and Innovation Contractors, SHQA was recently awarded its first task order: a five-year contract to promote patient safety in Medicare beneficiary settings across the region. Each of the task orders will require contractors to engage providers and beneficiaries in rural and underserved areas.

One of the first initiatives SHQA is expected to work on is to decrease opioid use and misuse in nursing home and community settings. Beyond that, SHQA will also work to improve behavioral health outcomes, increase patient safety, increase chronic diseases self-management, increase the quality of care transitions, and

improve nursing home quality. CMS's support of these quality initiatives really helps improve care on a global basis.

For instance, CMS's Transitional Care Management program has enabled providers to ensure safe, effective transitions of care for patients. Communication between care settings is even more difficult in rural areas and this program has allowed those providers to place additional emphasis and resources on improving communication and processes outside of their organizational walls. Emergency Department (ED) Medication Assisted Treatment (MAT) programs are also showing progress in the battle against Opioid abuse. Treatment coaches in the ED in conjunction with an increase in the number of X-waivered providers (review the list of clinicians that are allowed to receive this type of training) in underserved areas will continue to decrease the use of opioids in areas that see few providers available to help. More resources should be dedicated to these types of initiatives in the future CMS contract work to build healthier communities.

All of these efforts are data driven. Data Collection still remains at the heart of understanding what challenges we face in health care. Supporting the collection, comprehension and dissemination of what our population health represents is key to designing appropriate programs, and has been key in understanding the social determinants of health and other factors that impact population health.

### **Social Determinants of Health**

While our quality initiatives have helped improve care in measurable ways, we must still collect better data on patients to truly understand the full picture of their health care. This would help us better understand residents without access to care and/or lack of health insurance, reliable transportation and the inability to navigate the health system due to poor health literacy. Health disparities within these populations are likely greater and different than those that are currently included in the data. It's important to include these populations in our data analysis and decision-making processes.

Major factors influencing patient outcomes in rural and urban underserved areas include workforce conditions, access to health care, underinsured residents, and lower levels of education leading to lower income opportunities. On the provider side, there is an unequal distribution of primary care physicians in underserved areas. There are only 68 per 100,000 practicing in rural areas compared with 84 per 100,000 in urban areas. This goes back to the need to address workforce shortages through GME, and also scholarships and financial incentive programs to draw providers to these underserved areas. Additional considerations include unique community needs, access to and availability of resources such as fresh, healthy foods, and lack of transportation to and from medical appointments.

To address these challenges, some hospitals and health systems have begun engaging community health workers to provide education, referral and follow-up, case management, home visiting, and other collaborative methods for those at high risk for poor health outcomes. Additional future opportunities include better utilizing technology such as telehealth (particularly for behavioral health care) and expanding successful models like ECHO hubs that allow for the delivery of consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care.

### **Telehealth**

As mentioned previously, telehealth is one proven method to improve the quality of care, and also address workforce shortages and the maldistribution of providers. WHA recently championed a comprehensive revamp of how Medicaid treats telehealth services in Wisconsin, an initiative that passed with unanimous support in the state legislature and was recently signed into law by Governor Tony Evers. This telehealth reform package was the result of four recommendations that came from WHA's Telemedicine Task Force which met a number of times over the last few years. The four main changes to Medicaid's coverage of telehealth in Wisconsin include:

1. Requiring Medicaid to cover any service that is currently a covered benefit as a face-to-face service, if it can be provided in an equivalent manner via telehealth.
2. Catching up and keeping pace with Medicare in adding new telehealth services that are not currently covered benefits.
3. Requiring telehealth care provided at home or in another non-clinical setting to be covered.
4. Removing a duplicative and unnecessary requirement that behavioral health providers receive a state-approved telehealth certification.

The goal of this legislation is to remove unnecessary barriers to telehealth so that health care providers can innovate and improve health care delivery without government regulations getting in the way. Unfortunately, Medicare still contains significant barriers that prevent telehealth from being covered if the patient is not located in a rural, health professional shortage area. Over the last few years, Congress has allowed certain services, including treatment for end-stage renal disease, telestroke, and opioid treatment, to be covered by Medicare regardless of the patient's location. **WHA supports any and all efforts to allow more services to be exempted from these site restrictions, and supports their eventual removal.**

While we understand Congress is concerned about the cost to the Medicare program, a growing body of evidence suggests that allowing services to be covered via telehealth need not increase health care expenditures. This is because telehealth is really just another way to access services that are largely already available. In cases where telehealth breaks through workforce shortages and leads to more patients accessing services, it also can decrease overall expenditures by providing treatment in a more efficient manner, and often preventing the need for expensive procedures that would otherwise result due to lack of timely care.

### **Post-acute care**

The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. Below are three recommendations for the task force to explore on unnecessary regulations that make it harder to provide proper post-acute care in underserved areas:

- Primary instructors for nurse aide training programs - 42 CFR § 483.152 (a)(5) (i) requires the training of nurse aide must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long-term care facility services. Consider deleting the requirement that 1 of the 2 years of nursing experience must be in long-term care, as it places unnecessary barriers to finding qualified instructors.
- Nurse aide training program sites - 42 CFR § 483.151 (b)(2) provides that nursing homes who are training sites may not have a civil monetary penalty (CMP) assessed within the last two years that exceeds \$5000. This requirement restricts qualified nursing homes from acting as training sites. H. R. 6986 would raise the CMP threshold to \$10,483 and permit a nursing home to be a training site once the deficiencies have been corrected. These changes would open up additional nurse aide training sites.
- Three midnights - Current federal law requires a patient to have a 3-midnight inpatient stay requirement to qualify for a Medicare-covered admission to nursing home. Hospital average lengths of stay are vastly shorter today than when this statute was created (14.2 days in 1965 compared to 5.2 days in 2017). This statute creates a barrier to post-acute care, and clearly needs to be updated to reflect modern hospital care.

It is also worth noting that the previously mentioned telehealth site restrictions limit telehealth's ability to provide more efficient post-acute care. For instance, some patients may stay at a hospital longer than

necessary for fear of having insufficient supports at home in either their rural or urban community. If hospitals could use telehealth to provide the post-acute checkups, not only would it be more convenient for the patient (who may be able to be discharged earlier, or may not have to travel back to a hospital/clinic for follow-up checkups), but it would be at a lower cost for Medicare.

## **Behavioral Health**

As we continue to better understand how behavioral health impacts the whole picture of health care, there has been an ongoing effort to increase access to behavioral health. As mentioned earlier, telehealth represents one important opportunity to improve access to outpatient behavioral health care needs. However, there continues to be a need for more intensive, inpatient behavioral and psychiatric care. Unfortunately, these settings face significant funding challenges, particularly in rural areas.

One area of particular concern in Wisconsin is for critical access hospitals (CAH) that have a distinct part unit inpatient psychiatric facility attached to the hospital. These facilities are life-lines, not just to the communities they are located in, but also the broader surrounding communities. For instance, Stoughton Hospital just south of Madison provides essential dementia and other geriatric psychiatric treatment to more than 14 counties in addition to that of Dane which it is located in. While the care provided is essential to the community, it comes at considerable cost to the larger hospital, which heavily subsidizes it to offset under-reimbursements from Medicare and Medicaid. Unlike the regular hospital, the inpatient psychiatric facility does not receive cost-based reimbursement.

The CAH designation was created years ago to stave off the closure of rural hospitals due to the lagging reimbursements by governmental payors. With the current recognition of the need for intensive behavioral health care, WHA recommends Congress explore extending a similar designation and reimbursement level to distinct part units that are attached to CAHs. Without this, those facilities will face the same crisis that CAHs faced years ago, potentially forcing them to close in rural underserved areas where behavioral health care is most needed.

## **Unnecessary Regulations**

The regulatory burden on hospitals continues to be one of the main challenges in providing better patient care. According to the American Hospital Association, the average hospital dedicates 59 FTE staff toward regulatory compliance, with nearly a quarter being physicians and nurses. One example of unnecessary regulations pertains to the ability of hospitals to share space with other non-hospital providers.

CMS missed an opportunity earlier this year when it proposed draft guidance for hospitals co-locating with other hospitals or health care providers. WHA and others have long asked for clarity on how hospitals might share space with other providers without needing to operate such space under the same regulatory requirements as a hospital, or as a hospital-based outpatient department. WHA and its members even had CMS visit rural Wisconsin years ago and was assured this would be a priority issue by CMS field staff. While we were excited to see new draft guidance come out earlier this year, we were disheartened to see CMS clarify that this draft guidance permitting the sharing of space would not apply to critical access hospitals. In the odd logic of CMS, the guidance was only intended to make it easier for hospitals to share space with other hospitals, which CAHs cannot do as it would go against the rule that no CAHs be within 35 miles of another hospital. Unfortunately, this missed the entire point that some CAHs only wanted to share space with other providers in a way that would improve patient care and lower costs for patients and the federal government.

For instance, one rural critical access hospital in Wisconsin has been trying for years to share space with visiting primary care providers that would like to staff an after-hours urgent care clinic. This would help save health care costs for Medicaid and Medicare as patients currently must go to the hospital emergency room after normal hours of business. Since CAHs are reimbursed based on costs, and ER costs are higher than urgent

care, this would be a win-win for the community and the federal government. Unfortunately, previous CMS guidance has hampered this hospital's ability to enter into this agreement and CMS missed the opportunity to fix it with the recent draft guidance. WHA and others would welcome support from Congress in fixing this long-standing issue.

WHA appreciates the opportunity to provide comment on these important issues.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric Borgerding". The signature is fluid and cursive, with a distinct loop at the end.

Eric Borgerding  
President & CEO