

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
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:

On behalf of the more than 130 hospitals in Michigan, the Michigan Health & Hospital Association (MHA) greatly appreciates the opportunity to submit its comments and ideas regarding health care for rural and underserved communities. Depending on the definition of rural, half of the MHA members may be considered rural. Our rural hospitals have physician residency programs, doing post-medical school teaching in Michigan's farm, forest and mining areas. We have full-service community hospitals in underserved urban and rural parts of Michigan, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We extend our thanks to the Ways and Means Committee's Rural and Underserved Communities Health Task Force (Task Force) for its attention to the needs of these communities.

Addressing the issue of health care in underserved areas is complex. Earlier this year, the MHA convened a conversation of more than 40 rural hospital CEOs and CFOs. As part of the content for that discussion, we considered the demographics of Michigan's rural counties. As expected, Michigan's rural areas are older and aging. Michigan's rural areas have small populations, and are decreasing. It was surprising to learn the degree to which Michigan's rural counties trail in education attainment (high school diploma only or less), and struggle with low income (households with income at or below \$25,000/annually). Sustaining our rural hospitals is a serious challenge in rural areas. Hospitals are good employers, but need a workforce with access to post-secondary education. Many of our rural counties have no community college to offer their residents. Without a workforce to grow into pharmacy and lab techs, nursing assistants and those who are prepared to attend four-year institutions, staffing is a major issue. Hospitals in urban areas also struggle with workforce preparedness, including exceptional rates of adults with lack of functional literacy.

Government payers also dominate Michigan hospitals' payer mix. Medicare covers nearly 20% of Michigan's citizens, and Medicare covers 25% on average. Assuming 5% (a favorable assumption) are uninsured, this means only 50% of those in Michigan have third-party commercial coverage. We need more employers who provide a meaningful health insurance benefit. Attracting employers to regions with small populations. 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.

Brian Peters, Chief Executive Officer

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?

Health is a product of environment, genetics, economics, personal situations and habits, and health care. Health care can make a huge difference in an outcome for a person screened and found to have the earliest stage of a treatable cancer. Health care can do little to help a patient who has a genetic disposition to hypertension which is untreated and results in chronic kidney disease, early end-stage renal disease and dramatically shortened life expectancy. 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.

Improving the health status of underserved communities must involve each sector of the community, including education, economic development, social services, and health systems. This [series of articles](#) in the Detroit Free Press illustrates the education issues which compound the health care situation in rural Michigan.

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 timelier access to providers. As the use of telehealth continues to grow, it 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.

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.

Declining populations are a central cause of financial distress for rural hospitals' financial distress. Smaller hospitals are already stressed with fixed costs related to the overhead of operating emergency departments, and other on-call services and required staffing and equipment. Coping with fixed, overhead costs becomes more difficult as the patient population shrinks in response to overall population decline. Poverty is also a contributing factor as those with low incomes are typically covered through Medicaid which does little to cover fixed costs. While this group is unlikely to have commercial insurance coverage, those that do have few resources to pay high deductibles and copays. In addition, many remain uninsured even after coverage expansion. Several special Medicare reimbursement mechanisms are available to small and rural hospitals, but all are ultimately based on the number of patients served rather than addressing fixed costs.

To address the needs of rural communities and preserve the availability of hospital care, the Congress should create a program to provide certain small, rural hospitals fixed Medicare funding in the form of monthly periodic interim payments. The MHA is working on a proposal to do this in cooperation with the American Hospital Association and other state hospital associations.

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?

Primary care providers often become the de facto “specialist” for providing services in rural areas. Michigan uses MC3, the Michigan Child Care Collaborative, which provides psychiatry support to primary care providers in Michigan who are managing patients with behavioral health problems. This includes children, adolescents, and young adults through age 26, and women who are contemplating pregnancy, pregnant or postpartum with children up to a year. Psychiatrists are available to offer guidance on diagnoses, medications and psychotherapy interventions so that primary care providers can better manage patients in their practices. The funding for this program is not secure. The Congress should create specific funding for these types of teleconsultation practices, including incentives for states and commercial insurers to expand the areas of specialty consulting such as managing patients with diabetes, congestive heart failure and chronic kidney disease.

As policymakers consider opportunities to improve the delivery of services via telehealth, the MHA concurs with the Federal of American Hospitals in recommending 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?

In addition to the comments above regarding access to education in rural areas, the passage of H.R. 728, Title VIII Nursing Workforce Reauthorization Act of 2019, extending critical nursing workforce development programs that invest in the education and training of our nation’s nurses is a positive action by the House and needs action in the Senate. 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.

On behalf of the number of investor-owned hospitals both in our rural and urban areas, the MHA supports 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.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Substance use disorder (SUD) treatment for opioid addiction generally requires a daily trip to a treatment location to consume the opioid alternative. SUD is an illness which frequently requires a long-term or even permanent medication regimen. In rural areas, where medication assisted treatment (MAT) may be miles or even more than an hour away, this daily requirement borders on cruelty for someone who is in addiction treatment.

The MHA is working with the Michigan Health Endowment Fund and the Blue Cross Blue Shield of Michigan Foundation to increase the availability of MAT in the primary care setting. The requirements for physicians, the assessments of patients, the level of reimbursement, and the stigma of providing this care are all deterrents to making this type of SUD more readily available. In every area of Michigan we need better access to SUD and better design of treatment protocols, accepting that SUD is medical care to be regulated and reimbursed as such.

The MHA 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 and other underserved areas. If you have any questions regarding these comments, please do not hesitate to contact me (517) 285-2962.

Sincerely,

Laura Appel
Senior Vice President
Chief Innovation Officer

cc: Congressman Dan Kildee