

**Statement
of the
American Hospital Association
for the
Committee on Finance
U.S. Senate**

“Rural Health Care in America: Challenges and Opportunities”

May 24, 2018

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input regarding action Congress can take to maintain access to health care in rural communities.

Nearly 60 million Americans live in rural areas and depend on their hospital as an important – and often only – source of care in their communities. Rural hospitals face multiple instabilities due to the unique circumstances of providing care in rural areas, including remote geographic location, low-patient volumes, workforce shortages, and a population that is often older and sicker and more dependent upon federal programs, such as Medicare and Medicaid, which reimburse below the cost of care.

During the 1990s, Congress created the critical access hospital (CAH) program and other special payment programs to help address the financial distress facing many rural providers, as well as an increase in the number of rural hospital closures.

Over time, as health care delivery has shifted from volume to value, and as more services are provided in the outpatient setting, many of these special rural programs have become outdated and fail to provide the intended financial stability. Over this same period, federal payment changes and the cost of meeting increasing regulatory requirements (e.g., Medicare’s 96-hour rule and “direct supervision” policy, Meaningful Use, etc.) have further exacerbated the financial instability of many rural providers. According to the North Carolina Rural Health Research Program, 83 rural hospitals have closed since 2010 due to “likely multiple contributing factors, including failure to recover from the

recession, population demographic trends, market trends, decreased demand for inpatient services, and new models of care.”

Recognizing these challenges and the need for new integrated and comprehensive health care delivery and payment strategies, the AHA Board of Trustees created in 2015 the Task Force on Ensuring Access in Vulnerable Communities. The following year, the task force issued a report outlining nine emerging strategies that can help preserve access to health care services in vulnerable communities. These strategies will not apply to or work for every community, and each community has the option to choose one or more that are compatible with its needs. The AHA is pleased to include those recommendations in this statement, along with additional policy recommendations from the AHA Rural Advocacy Agenda and the 2018 AHA Advocacy Agenda (attached).

Our statement provides an overview of the unique circumstances and challenges facing rural communities and hospitals, as well as recommendations for action. We appreciate the opportunity to submit this statement for the record.

UNIQUE CIRCUMSTANCES AND CHALLENGES FACING RURAL COMMUNITIES AND HOSPITALS

DECLINING POPULATION, INABILITY TO ATTRACT NEW BUSINESSES AND BUSINESS CLOSURES

Rural communities are challenged by declining populations because population growth from natural change (births minus deaths) is no longer sufficient to counter migration losses when they occur. According to the U.S. Department of Agriculture (USDA), from April 2010 to July 2012, the estimated population of non-metro counties as a whole fell by close to 44,000 people.¹ Although this may seem like a small decline, the USDA indicates that it is a sizeable downward shift from the 1.3 percent growth these counties experienced during 2004 - 2006.² From July 2012 to July 2013, the population in non-metro areas continued this three-year downward trend.³ Such declines may have a ripple effect, leading to other negative impacts, such as business closures. They may change the health or needs of the community, which may in turn affect the viability of certain businesses. When businesses close or a community is unable to attract new businesses, it becomes more difficult for it to retain existing health care services and recruit new providers. As a result, these communities tend to have fewer active doctors and specialists, and face difficulties in accessing care, which can complicate early detection and regular treatment of chronic illnesses.

¹ United States Department of Agriculture Economic Research Service. Rural America at a Glance, 2013 Edition. Last accessed 1/19/16 at: http://www.ers.usda.gov/media/1216457/eb-24_single-pages.pdf.

² Id.

³ United States Department of Agriculture Economic Research Service. Rural America at a Glance, 2014 Edition. Last accessed 1/19/16 at: <http://www.ers.usda.gov/media/1697681/eb26.pdf>.

POOR ECONOMY, HIGH UNEMPLOYMENT AND LIMITED ECONOMIC RESOURCES

The presence of a poor economy typically leads to high levels of unemployment and a limited amount of economic resources. These factors are linked to poor health outcomes. For example, poverty may result in individuals purchasing processed food instead of fresh produce, which over time could lead to hypertension, obesity and diabetes. This also may affect individuals' mental health and result in other health conditions, such as high blood pressure, high cholesterol, diabetes and obesity.⁴ Rural and inner city areas more often show the effects of a poor economy. For example, overall, rural areas have seen moderate growth in employment, but certain areas face losses in jobs (including much of the South, Appalachia, Northwest and the Mountain West).⁵

AGING POPULATION

America's rural areas have a high proportion of Medicare patients, which means changes and cuts to federal reimbursement programs have a disproportionate effect on rural providers. U.S. Census data indicate that close to 18 percent of rural counties' total population is aged 65 or older.⁶ This is in contrast to the general average of 14.3 percent in large metropolitan statistical areas (MSAs) and 14.8 percent in other MSAs.⁷ Given that older individuals are more likely to have one or more chronic diseases, these communities may face poorer health outcomes. This challenge can be exacerbated if access to health care services in the community is already limited.

LOWER VOLUME AND LOWER PROVIDER SUPPLY

Rural hospitals' low-patient volumes make it difficult for these organizations to manage the high fixed costs associated with operating a hospital. This in turn makes them particularly vulnerable to policy and market changes, and to Medicare and Medicaid payment cuts. Many rural hospitals operate with modest balance sheets and have more difficulty than larger organizations accessing capital to investment in modern equipment or renovating or "right-sizing" aging facilities.

Rural hospitals also have a difficult time attracting and retaining highly skilled personnel, such as doctors and nurses.

GEOGRAPHIC ISOLATION

Rural communities are often self-contained and located away from population centers and other health care facilities. Public transportation is rare and, if it does exist, it is sporadic. In addition, for many rural communities, inclement weather or other forces of nature can make transportation impossible or, at the very least, hazardous. Challenges with transportation for many rural residents means that preventive and post-acute care,

⁴ Think Progress. Four Ways That Poverty Hurts Americans' Long-Term Health. Last accessed 10/24/16 at: <http://thinkprogress.org/health/2013/07/30/2381471/four-ways-poverty-impacts-americans-health/>.

⁵ United States Department of Agriculture Economic Research Service. Rural America at a Glance, 2014 Edition. Last accessed 1/19/16 at: <http://www.ers.usda.gov/media/1697681/eb26.pdf>.

⁶ U.S. Census Bureau. 2009-2013 American Community Survey 5-Year Estimates. Note: Urban/Rural status is assigned to counties based on FY 2015 CBSA designations.

⁷ Id. Note: Large MSAs have a population of 1 million or more; other MSAs have a population of less than 1 million.

pharmaceutical and other services are delayed, or, forgone entirely, which can increase the overall cost of care once services are delivered.

LACK OF ACCESS TO PRIMARY CARE SERVICES

High-quality primary care involves health care providers offering a range of medical care (preventive, diagnostic, palliative, therapeutic, behavioral, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated.⁸ A meaningful and sustained relationship between patients and their primary care health care providers can lead to greater patient trust in the provider, good patient-provider communication, and the increased likelihood that patients will receive, and comply with, appropriate care.⁹ Unfortunately, access to primary care services is unavailable for many Americans. Today, nearly 20 percent of Americans live in areas with an insufficient number of primary care physicians. These health professional shortage areas for primary care face clear recruitment and retention issues and have less than one physician for every 3,500 residents.¹⁰ They also tend to be more common in remote rural towns. Lack of access makes it difficult for millions of Americans to access preventive health care services, leaving them and their communities susceptible to fragmented, episodic care and poorer health outcomes.

The AHA's Task Force on Ensuring Access in Vulnerable Communities identified additional challenges facing rural communities in its report. In addition, the task force identified the essential health care services that should be provided in all communities, including emergency services, primary care services, transportation and a robust referral structure. (The task force's full report is attached.)

RECOMMENDATIONS

ALTERNATIVE PAYMENT MODELS

Rural Emergency Medical Center Designation. The AHA's Task Force on Ensuring Access in Vulnerable Communities considered a number of integrated, comprehensive strategies to reform health care delivery and payment. The ultimate goal was to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential services they should strive to maintain locally, and the delivery system options that will allow them to do so.

One such option is the 24/7 Emergency Medical Center (EMC) model. The EMC would allow existing facilities to meet a community's need for emergency and outpatient

⁸ American Medical Association. Health and Ethics Policies of the AMA House of Delegates. Last accessed 10/24/16 at: <http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf>.

⁹ Office of Disease Prevention and Health Promotion. Healthy People 2020 Access to Health Care. Last accessed 10/24/16 at: <http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.

¹⁰ Health Resources and Services Administration Data Warehouse. Last accessed 10/24/16 at: <http://datawarehouse.hrsa.gov/Topics/ShortageAreas.aspx>.

services, without having to provide inpatient acute care services. EMCs would provide emergency services (24 hours a day, 365 days a year) as well as transportation services. They also would provide outpatient services and post-acute care services, depending on a community's needs.

The AHA urges Congress to consider the Rural Emergency Acute Care Hospital (REACH) Act (S. 1130), which would establish a 24/7 rural emergency medical designation under the Medicare program to allow small rural hospitals to continue providing necessary emergency and observation services (at enhanced reimbursement rates), but cease inpatient services.

Additionally, the AHA strongly supports the Rural Emergency Medical Center (REMC) Act (H.R. 5678), which would allow exiting CAHs and those with 50 or fewer beds to convert to a new designation (REMC) under the Medicare program. REMCs would provide 24/7 emergency services and the type of services a hospital provides on an outpatient basis to Medicare beneficiaries, including observation, diagnostic and telehealth services. REMCs also could provide post-acute care in a separately licensed skilled nursing facility unit. Payment for REMCs would be a fixed facility fee and the outpatient prospective payment system (OPPS) rate for services. REMCs would be required to provide transportation services to higher acuity facilities as needed. (The Medicare Payment Advisory Commission recently expressed support for isolated, rural stand-alone emergency departments that would bill at the OPPS rate and provide annual payments that would assist with fixed costs.)

Rural Community Hospital Demonstration Program. Special hospital designations and demonstration programs have the potential to enable rural hospitals to maintain access to critical health care services. The Rural Community Hospital (RCH) Demonstration is a program Congress created in the Medicare Modernization Act of 2003, extended and expanded in the Patient Protection and Affordable Care Act, and extended again in the 2016 as part of the 21st Century Cures Act. The RCH program allows hospitals with 26-50 beds to test the feasibility of cost-based reimbursement. These hospitals are too large to qualify for the CAH program, but too small to benefit from economies of scale. **The AHA urges Congress to expand the RCH program and make it permanent.**

In addition to the EMC model and RCH Demonstration program, the AHA recommends the establishment of additional alternative payment models, including global budgets, a frontier health strategy and urgent care centers. These are discussed in detail in the attached report.

WORKFORCE

Recruiting and retaining health professionals in rural areas remains challenging and expensive. Telehealth offers a promising solution to some of the challenges related to physician shortages in rural areas and limited access to certain services including behavioral health and addiction treatment. However, coverage and payment for telehealth services must be expanded in order to better address the issue (see additional information

below regarding improving access to telehealth). Additionally, Congress should expand existing programs that make it easier for physicians to practice in rural areas and expand scope of practice laws to allow nurses and other allied professionals to practice at the top of their license.

The AHA urges Congress to pass the Conrad State 30 and Physician Access Act (S. 898/H.R. 2141) to extend and expand the Conrad State 30 J-1 visa waiver program, which allows physicians holding J-1 visas to stay in the U.S. without having to return home if they agree to practice in a federally designated underserved area for three years; and the Resident Physician Shortage Reduction Act (S. 1301/H.R. 2267) to increase the number of Medicare-funded residency positions.

REIMBURSEMENT

Medicare reimburses hospitals below the cost of care for the services they provide and does not account for the high fixed costs associated with operating a hospital. Medicare sequestration cuts of 2 percent of reimbursement have further destabilized many small, rural hospitals. The AHA urges Congress to end Medicare sequestration and ensure providers are appropriately reimbursed for the care they provide.

REGULATORY RELIEF

A recent AHA report on the regulatory burden faced by hospitals indicates that the burden is substantial and unsustainable. Hospital and health systems spend nearly \$39 billion a year solely on administrative activities related to regulatory compliance from four federal agencies, such as quality reporting, Medicare conditions of participation, and audits of various kinds.

Meeting regulatory requirements requires an investment of both staff and resources, which can be more challenging for rural providers who must meet many or all of the same requirements as other hospitals. Federal regulation is largely intended to ensure that health care patients receive safe, high-quality care. In recent years, however, clinical staff find themselves devoting more time to regulatory compliance, taking them away from patient care. An overall reduction in regulatory burden would enable providers to focus on patients, not paperwork, and reinvest resources in innovative approaches to improve care, improve health, and reduce costs.

Additionally, certain federal regulations are unnecessary; do not positively impact patient care; and have the potential to limit access to services. Some examples are provided below.

Direct Supervision. The Centers for Medicare and Medicaid Services' (CMS) "direct supervision" rule requires that CAHs and hospitals with 100 or fewer beds provide outpatient therapeutic services under the "direct supervision" of a physician. These services have always been provided by licensed, skilled professionals under the overall supervision of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician. While hospitals recognize the need for "direct supervision" for certain outpatient services that pose a high risk or are very complex, the

agency's policy generally applies to even the lowest risk services. **The AHA urges Congress to pass the Rural Hospital Regulatory Relief Act (S. 243/H.R. 741) to make permanent the enforcement moratorium on CMS's "direct supervision" policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.**

96-hour Physician Certification. Medicare currently requires physicians to certify that patients admitted to a CAH will be discharged or transferred to another hospital within 96 hours in order for the CAH to receive payment under Medicare Part A. While CAHs must maintain an annual average length of stay of 96 hours, they may offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these "96-hour-plus" services. **The AHA urges Congress to pass the Critical Access Hospital Relief Act (H.R. 5507) to remove permanently the 96-hour physician certification requirement as a condition of payment for CAHs, thus recognizing that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services to rural America.** These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

Electronic Health Records (EHRs) and Interoperability. America's hospitals are strongly committed to the adoption of EHRs, and the transition to an EHR-enabled health system is well underway. We are pleased that CMS proposed some significant changes to the newly renamed Promoting Interoperability program to increase flexibility in 2019. This includes moving to a performance-based scoring system and removing several measures that unfairly hold hospitals accountable for the actions of others. In addition, the agency proposes a 90-day reporting period in 2019 and 2020. Unfortunately, CMS proposes to require the use of the 2015 Edition certified EHR in 2019 and to retain the requirement to connect "apps" to a hospital's system without the ability to vet them for security. **The AHA urges Congress to pass the EHR Regulatory Relief Act (S. 2059), which would eliminate the "all or nothing" approach, establish a 90-day reporting period, and expand hardship exemptions.**

Co-location. Hospitals in rural communities often create arrangements with other hospitals or providers of care in order to offer a broader range of medical services and better meet the needs of patients. For example, a rural hospital may lease space once a month to medical specialists from out of town, such as a cardiologist, behavioral health professional or oncologist. These kinds of arrangements can improve access to care and care coordination, while also increasing convenience for patients.

However, in 2015, a CMS presentation created concern among hospitals that longstanding co-location arrangements would be declared "non-compliant with CMS's rules." Since then, hospitals have heard mixed messages related to co-location. Hospital staffs have spent significant amounts of time trying to ascertain the rules and determine how to sustain the most effective patient care for their community while considering whether re-construction would be required in some circumstances. Out of an abundance of concern and in the absence of clear direction, some hospitals have begun to unwind

their co-location or shared service arrangements. Unfortunately, these changes can result in patients having difficulty accessing needed care.

If CMS does not clearly and appropriately define how hospitals can share space, services and staff with other providers in rural areas, Congress should statutorily define such arrangements in order to protect access to specialists in rural communities.

Stark and Anti-Kickback. Hospitals and other providers are adapting to the changing health care landscape and new value-based models of care by eliminating silos and replacing them with a continuum of care to improve the quality of care delivered, the health of their communities and overall affordability. Standing in the way of their success is an outdated regulatory system predicated on enforcing laws no longer compatible with the new realities of health care delivery. Chief among these outdated barriers are portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the “Stark Law”) and certain civil monetary penalties. These laws make it difficult for providers to enter into clinical integration agreements that would allow them to collaborate to improve care in ways envisioned by new care models. Providers also need additional opportunities and support to participate in new models of care, especially in rural areas where there may be limited funds available for the significant infrastructure investments that many of the existing models require.

The AHA urges Congress to create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements so that physicians and hospitals can collaborate to improve care, and eliminate compensation from the Stark Law to return its focus to governing ownership arrangements.

EXPAND ACCESS TO TELEHEALTH SERVICES

Telehealth is changing health care delivery. Through videoconferencing, remote monitoring, electronic consultations and wireless communications, telehealth expands patient access to care while improving patient outcomes and satisfaction.

Telehealth offers a wide-range of benefits, such as:

- Immediate, around-the-clock access to physicians, specialists, and other health care providers that otherwise would not be available in many communities;
- The ability to perform remote monitoring without requiring patients to leave their homes;
- Less expensive and more convenient care options for patients; and
- Improved care outcomes.

Medicare Coverage of Services. Coverage for telehealth services by public and private payers varies significantly and whether payers cover and adequately reimburse providers for telehealth services is a complex and evolving issue. However, without adequate reimbursement and revenue streams, providers may face obstacles to investing in these technologies. This may be especially detrimental to hospitals that serve vulnerable rural

and urban communities – where the need for these services may be the greatest. For Medicare specifically, more comprehensive coverage and payment policies for telehealth services that increase patient access to services in more convenient and efficient ways would likely be necessary to make these strategies work for vulnerable communities. This would include elimination of geographic and setting location requirements and expansion of the types of covered services.

As the use of telehealth has grown in recent years, well over half of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology. However, there are several barriers to wide use of telehealth, including statutory restrictions on how Medicare covers and pays for telehealth. While the AHA was pleased that the Bipartisan Budget Act (BiBA) of 2018 expanded Medicare coverage for telestroke and provided waivers in some alternative payment models, more fundamental change is needed. In addition, many hospitals and health systems find that the infrastructure costs for telehealth are significant. Establishing telehealth capacity requires expensive videoconferencing equipment, adequate and reliable connectivity to other providers, and staff training, among other things. The fiscal year (FY) 2018 omnibus appropriations bill included more than \$50 million for rural telehealth programs, but greater support is needed.

The AHA urges Congress to further expand telehealth capacity by establishing a grant program to fund telehealth start-up costs. Congress also should remove Medicare’s limitations on telehealth by:

- eliminating geographic and setting requirements so patients outside of rural areas can benefit from telehealth;
- expanding the types of technology that can be used, including remote monitoring;
- covering all services that are safe to provide, rather than a small list of approved services; and
- including telehealth in new payment models.

Access to Broadband. Adequate broadband infrastructure is necessary to improve access to telehealth services and facilitate health care operations, such as widespread use of EHRs and imaging tools. Many innovative approaches to care delivery require a strong telecommunications infrastructure. However, according to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband. Lack of affordable, adequate broadband infrastructure impedes routine health care operations, such as widespread use of EHRs and imaging tools, and limits the ability to use telehealth in both rural and urban areas. Congress took steps to address this challenge in the FY 2018 omnibus appropriations bill, which included \$600 million to the Department of Agriculture for a new pilot program offering grants and loans for broadband projects in rural areas with insufficient broadband. The FCC also has a Rural Health Care Program, which supports broadband adoption for non-profit rural health care providers. Unfortunately, the \$400 million annual cap has been unchanged for over 20 years, and

was exceeded in both 2016 and 2017, leading to significant cuts for rural health care providers that have limited budgets. These cuts not only affect the ability of these rural health care providers to maintain strong broadband connections but also could force tough decisions affecting funding for essential health care services. In a Feb. 2 [letter](#), we asked the FCC to restore this funding and supported an FCC proposal to adjust the funding cap annually for inflation, including a “catch up” increase for FY 2017 to account for inflation since the program began. We also urged the Commission to assess future demand for broadband-enabled health care services to set a more accurate cap.

The AHA appreciates Congress’ focus in this area and urges continued support for funding to help improve rural broadband access for health care providers.

CONCLUSION

The AHA applauds this Committee’s focus on issues facing rural hospitals and the patients and communities they serve. The AHA looks forward to working with you and the Congress to take meaningful action to ensure access to health care services in vulnerable communities and to support rural hospitals and the patients they serve.

Attachments:

[AHA Task Force on Ensuring Access in Vulnerable Communities Report](#)

[AHA Rural Advocacy Agenda](#)

[AHA 2018 Advocacy Agenda](#)