American Hospital Association™

Advancing Health in America

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Statement of the

American Hospital Association

for the

Health, Education, Labor and Pensions Subcommittee on

Primary Health and Retirement Security

of the

U.S. Senate

"Health Care in Rural America: Examining Experiences and Costs"

September 25, 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 quality, affordable 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 and a population that is often older and sicker and more dependent upon federal programs, which reimburse below the cost of care. In fact, Medicare pays 87 cents and Medicaid pays 88 cents for every dollar spent caring for patients, according to a 2017 AHA survey of community hospitals. In addition, workforce shortages is an ongoing challenge. While almost 20 percent of the U.S. population live in rural areas, less than 10 percent of physicians practice in these communities.

During the 1990s, Congress created the critical access hospital (CAH) program and other special designations and payment programs under the Medicare

Program to help account for the unique set of circumstances of providing care in rural areas, and to help address 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to value, and as more services are provided in the outpatient setting, many of these special rural programs have become outdated and no longer provide the intended financial stability. Over this same period, federal payment changes and the cost of recent challenges, such as meeting increasing regulatory requirements (e.g., physician certification part of Medicare's 96-hour rule and "direct supervision" policy for outpatient therapeutic services, Meaningful Use, etc.), have further exacerbated the financial instability of many rural providers.

According to the North Carolina Rural Health Research Program, 87 rural hospitals have closed since 2010 (25 have closed since 2016), 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 emerging strategies and new models of care (e.g., rural emergency medical center designation) 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.

We appreciate the opportunity to submit this statement to the Committee.

2018
Rural Advocacy Agenda

America's rural hospitals are committed to serving their communities and ensuring local access to high-quality, affordable health care. The AHA is working to ensure federal policies and regulations are updated for 21st century innovation and care delivery, and new resources are invested in rural communities to protect access.

Fair & Adequate Reimbursement

Medicare pays 87 cents and Medicaid pays 88 cents for every dollar spent caring for patients, according to a 2017 AHA survey of community hospitals. Additionally, these programs do not cover the range of services needed in many communities, such as certain behavioral health and addiction treatment services. **Given the persistent, recent, and emergent challenges of providing care in rural areas, Medicare and Medicaid payment rates need to be updated to cover the cost of providing care.**

Sequestration. Congress should end Medicare sequestration, which bluntly cuts all payments to hospitals and critical access hospitals (CAHs) by 2 percent.

Site-neutral. Site-neutral policies seek to reduce reimbursement for non-emergency services delivered in provider-based departments (PBDs). These policies fail to recognize that patients treated in PBDs – relative to those seen in physician offices – are more likely to be on Medicare, Medicaid, have medically complex conditions, and live in high-poverty areas. PBDs also must comply with more comprehensive licensing and regulatory requirements. **Any expansion of site-neutral policies should be opposed.**

Originating Site. Rural hospitals often are the "originating site" for telehealth services, meaning that the hospital is the local site where patients physically go to receive a service provided from a health professional located at a distant site. However, even in cases where the originating site is eligible to bill Medicare for a telehealth facility fee payment, the reimbursement rates are marginal compared to the overall costs. **Federal payers should provide payment parity with services delivered in-person and cover the cost of providing telehealth at the originating site.**

Behavioral Health. Barriers to treatment such as the Medicare 190-day lifetime limit on inpatient psychiatric treatment should be eliminated and information sharing laws related to a patient's substance use history should be updated. Congress also should fully fund authorized programs to increase access to treatment; enhance access to medication-assisted treatment; enforce mental health payment parity laws; and strengthen prescription drug monitoring programs and prescriber education.

New Models of Care

As the health field moves toward value-based care, hospitals are participating in alternative payment and care delivery models that have different incentives than the traditional fee-for-service system, and often connect patients to services beyond the walls of the hospital. **New rural models need to be developed and those currently being tested by the Centers for Medicare & Medicaid Services (CMS) need to be evaluated for success, and if appropriate, expanded and extended.**

Rural Emergency Medical Center (REMC) Model. Congress should pass the REMC Act (H.R. 5678) and the Rural Emergency Acute Care Hospital (REACH) Act (S. 1130). These bills would establish a new 24/7 rural emergency medical designation under the Medicare Program to allow existing small, rural hospitals to continue providing necessary emergency and observation services (at enhanced reimbursement rates), but cease inpatient services.

Global Budgets. Global budgets prospectively set an annual budget for a defined set of health care services, such as all hospital inpatient and outpatient services. They provide financial predictability for rural hospitals and is currently being tested in Pennsylvania; a similar model has been implemented in Maryland. **These models should be explored further.**

2018 Rural Advocacy Agenda

Bundled Payments. Bundled payment arrangements generally provide a single, comprehensive payment that involves all of the services involved in a patient's episode of care. Most of the existing bundled payment models are beyond the reach of rural hospitals due to their low volume and other unique circumstances. **Voluntary bundled payment models for rural providers should be tested to determine their feasibility and success in improving quality and affordability.**

Rural Community Hospital (RCH) Demonstration Program. Congress has twice extended the RCH demonstration program to allow hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement. These hospitals are too large to be CAHs, but too small to benefit from economies of scale. **The RCH Demonstration Program should be expanded and made permanent.**

Frontier Community Health Integration Project Demonstration. This three-year demonstration, which started in 2016, is testing several care delivery innovations, including cost-based reimbursement for telehealth services and certain CAH-owned ambulance services. Ten hospitals located in Montana, Nevada, and North Dakota are participating. **New models of care that address the varying circumstances of rural hospitals should continue to be tested and evaluated for effectiveness and cost.**

Regulatory Relief

Hospitals and health systems must comply with 341 mandatory regulatory requirements and an additional 288 requirements for post-acute care. They spend $39 billion each year – $7.6 million for an average-sized community hospital – on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, their lower patient volumes mean that, on a per-patient basis, the cost of compliance is often higher. **Policymakers should provide relief from outdated or unnecessary regulations that do not improve patient care.**

Direct Supervision. Congress should 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. Congress should pass the Critical Access Hospital Relief Act (H.R. 5507) to permanently remove the 96-hour physician certification requirement as a condition of payment for CAHs. These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

Co-location. CMS should clarify its rules related to shared space or "co-location" arrangements between hospitals and/or health care professionals to continue to allow rural hospitals to partner with other providers to offer a broader range of services, such as leasing space once a month to medical specialists such as behavioral health specialists and dermatologists.

Care Coordination. Congress should create a safe harbor under the Anti-Kickback Statute to protect clinical integration arrangements that work to improve care through collaboration; and eliminate compensation from the Stark Law to return its focus to government ownership. While not intended by the laws, the potential for violating these statutes may be higher for rural hospitals in light of their unique conditions. For example, low patient volume may necessitate the need to share specialists with non-affiliated hospitals, as a result, ongoing patient referrals to these facilities could implicate the AKS.

Health Information Technology (HIT)

Rural hospitals are committed to the improved care made possible through health information technology, including electronic health records (EHRs) and telehealth. However, they continue to face barriers, such as regulatory burden, lack of adequate broadband and skilled personnel, and the high costs of purchasing, maintaining and updating equipment and software systems to collect and transmit health information.

Promoting Interoperability Program (PIP). The use of EHRs and other health IT to meet increased requirements for information exchange through programs like the PIP result in significant investment to purchase, upgrade, and maintain equipment and software. Many of these costs are ongoing, including expensive system upgrades required by regulation and the recruitment and retention of trained staff to use and service the technology. **Additional flexibility is needed in the PIP, including the elimination of the "all-or-nothing" approach to meeting program requirements**

and the availability of a timeline that supports the safe and effective implementation and optimization of the 2015 edition certified EHR technology.

Telehealth. **Medicare policies should be updated to cover telehealth delivery for all services that are safe to provide, eliminate geographic and setting requirements, and expand the types of technology which may be used (e.g., remote patient monitoring). Congress should pass the Telehealth Innovation and Improvement Act (S. 787), to allow eligible hospitals to test offering telehealth** services to Medicare patients and evaluate these services for cost, effectiveness, and quality of care.

Broadband. Federal investment should continue to be expanded to ensure access to adequate broadband infrastructure for telehealth services and to facilitate health care operations, such as widespread use of EHRs and imaging tools. **Funding should be maintained for the Federal Communications Commission Rural Health Care Program and Healthcare Connect Fund.**

Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. While almost 20 percent of the U.S. population live in rural areas, less than 10 percent of U.S. physicians practice in these communities. **Targeted programs that help address workforce shortages should be supported and expanded.**

Conrad State 30 Program. **Congress should 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 waives the requirement to return home for a period of time if physicians holding J-1 visas agree to stay in the U.S. to practice in a federally designated underserved area for three years.

Graduate Medical Education. **Congress should pass the Resident Physician Shortage Reduction Act (S. 1301/H.R. 2267) to increase the number of Medicare-funded residency slots, which would expand training opportunities in rural setting and help address health professional shortages.**

Prescription Drug Prices

The increased cost of prescription drugs is straining providers' ability to access the drug therapies they need to care for their patients and the ability of patients to pay for their medicines. **Action is needed to reduce the cost of prescription drugs and to prevent erosion of the 340B drug pricing program, which helps hospitals serving vulnerable populations stretch scarce resources.**

High Price of Prescription Drugs. **Policymakers need to make prescription drugs more affordable.** Possible actions include fast-track generic medicines to market; prevent drug manufacturers from making small adjustments to older drugs in order to reap the financial benefits and protections reserved for new drugs; and prohibit payments to generic manufacturers to delay the release of a cheaper version of a prescription drug.

340B Program. In 2015, 340B hospitals provided $50 billion in total benefits to their communities. Hospitals were able to provide these benefits despite significant fiscal pressures. That same year, one out of every four 340B hospitals had a negative operating margin, and one in three 340B CAHs had a negative operating margin. **Any focus on the 340B program as part of a plan to lower drug prices is misplaced. Efforts to scale back the program would have devastating consequences for the patients and communities served.**

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To learn more and view the full 2018 Advocacy Agenda, visit www.aha.org.

Task Force on Ensuring Access in Vulnerable Communities

Millions of Americans living in vulnerable rural and urban communities depend upon their hospital as an important, and often only, source of care. However, these communities and their hospitals face many challenges. As the hospital field engages in its most significant transformation to date, some communities may be at risk for losing access to health care services. It will be necessary for payers and health care providers to work together to develop strategies that support the preservation of health care services for all Americans.

Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, created a task force to address these challenges and examine ways in which hospitals can help ensure access to health care services in vulnerable communities. The task force considered a number of integrated, comprehensive strategies to reform health care delivery and payment. Their report sets forth a menu of options from which communities may select based on their unique needs, support structures and preferences. The ultimate goal is 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. While the task force's focus was on vulnerable communities, these strategies may have broader applicability for all communities as hospitals redefine how they provide better, more integrated care.

November 29, 2016

Characteristics and Parameters of Vulnerable Communities

The task force defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. While the reasons a population may be deemed vulnerable vary widely, the task force found there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. However, they created a list of characteristics and parameters, of which one or more may be necessary and sufficient to identify a vulnerable rural or urban community.

Characteristics and Parameters of Vulnerable Rural Communities

- Declining population, inability to attract new businesses and business closures
- Aging population

Characteristics and Parameters of Vulnerable Communities

- Lack of access to primary care services
- Poor economy, high unemployment rates and limited economic resources
- High rates of uninsurance or underinsurance
- Cultural differences
- Low education or health literacy levels
- Environmental challenges

Characteristics and Parameters of Vulnerable Urban Communities

- Lack of access to basic "life needs," such as food, shelter and clothing
- High disease burden

Essential Health Care Services

The range of health care services needed and the ability of individuals to obtain access to health care services varies widely in each community. The task force determined, however, that access to a baseline of high-quality, safe and effective services must be preserved. Table 1 below highlights the essential health care services identified by the task force and illustrates those which may be maintained or enhanced by each emerging strategy.

Essential Health Care Service

Table 1 (Emerging Strategy)	Primary care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
Addressing the Social Determinants of Health					x				x
Global Budget Payments	x	x	x	x	x	x	x		x
Inpatient/Outpatient Transformation Strategy	x	x	x	x		x			x
Emergency Medical Center	x		x		x	x			x
Urgent Care Center	x					x			x
Virtual Care Strategies	x	x	x						x
Frontier Health System	x	x	x	x	x	x	x		x
Rural Hospital-Health Clinic Strategy	x	x	x	x		x		x	x
Indian Health Services Strategies	x	x	x	x	x	x	x		x

Emerging Strategies to Ensure Access to Health Care Service

Addressing the Social Determinants of Health

Social challenges often prevent individuals from accessing health care or achieving health goals. This strategy includes screening patients to identify unmet social needs; providing navigation services to assist patients in accessing community services; and encouraging alignment between clinical and community services to ensure they are available and responsive to patient needs.

Global Budgets

Global budgets provide a fixed amount of reimbursement for a specified population over a designated period of time. They may be designed in a way that allows each provider to create a unique plan to meet mandated budgets, thereby allowing vulnerable communities autonomy and flexibility to create solutions that work best for them.

Inpatient/Outpatient Transformation Strategy

This strategy involves a hospital reducing inpatient capacity to a level that closely reflects the needs of the community. The hospital would then enhance the outpatient and primary care services they offer.

Emergency Medical Center (EMC)

The EMC allows existing facilities to meet a community's need for emergency and outpatient services, without having to provide inpatient acute care services. EMCs provide emergency services (24 hours a day, 365 days a year) and transportation services. They also would provide outpatient services and post-acute care services, depending on a community's needs.

Urgent Care Center (UCC)

UCCs allow existing facilities to maintain an access point for urgent medical conditions that can be treated on an outpatient basis. They are able to assist patients with an illness or injury that does not appear to be life-threatening, but requires care within 24 hours.

Virtual Care Strategies

Virtual care strategies may be used to maintain or supplement access to health care services. These strategies could offer benefits such as immediate, 24/7 access to physicians and other health care providers, the ability to perform high-tech monitoring and less expensive and more convenient care options for patients.

Frontier Health System

This strategy addresses challenges faced by frontier communities, including extreme geographic isolation and low population density. It provides a framework for coordinated health care as individuals move through primary and specialized segments of the medical system.

Rural Hospital-Health Clinic Strategy

This strategy allows for integration between rural hospitals and various types of health centers in their communities (e.g., Federally Qualified Health Centers and Rural Health Clinics). These partnerships also could facilitate integration of primary, behavioral and oral health and allow for economies of scale between both organizations.

Indian Health Services (IHS) Strategies

This strategy includes development of partnerships between IHS and non-IHS health care providers aimed at increasing access to health care services for Native American and Alaska Native Tribes and improving the quality of care available and promoting care coordination.

To learn more about these strategies and explore case examples, please see the full report at *www.aha.org/ensuringaccess*.

The task force identified four types of barriers that could impede transitioning to or implementing these emerging strategies:

Federal Barriers

Many federal policies serve as barriers to successful implementation of these strategies. These include, but are not limited to, fraud and abuse laws and Medicare payment rules.

State Barriers

State laws also present barriers to implementation of these strategies. For example, issues related to clinician licensure across state lines must be addressed for broad implementation of virtual care strategies.

Community Barriers

At the community level, the ability to attract or retain health care providers will remain a challenge, regardless of which of these strategies are selected. Community input, buy-in and acceptance will be critical for success as hospitals transition to these new strategies.

Provider Barriers

Transitioning to these new strategies also may be challenging. For example, it may take longer or require significant investments of time, effort and finances for providers to implement these strategies.

Advocacy Agenda and Assistance Strategy

Successful implementation of these emerging strategies by vulnerable communities is dependent on numerous public policy changes. The task force recommends that AHA develop an advocacy strategy to facilitate adoption of these emerging strategies. This includes advocating for:

- Creation of new Medicare payment methodologies and transitional payments, as appropriate, that would allow for successful implementation of the strategies identified above;
- Creation of new and expansion of existing federal demonstration projects;
- Modification of existing Medicare Conditions of Participation to allow for the formation of the strategies identified above, where necessary;
- Modification of laws that prevent integration of health care providers and the provision of health services;
- Modification of the existing Medicare payment rules that stymie health care providers' ability to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals; and
- Expansion of Medicare coverage and payment for telehealth.

Even with public policy changes, vulnerable communities and the hospitals that serve them may not have the resources they need to successfully adopt these emerging strategies. AHA will explore providing operational tools and resources to assist our member hospitals and health systems, including toolkits, data analyses, information on grant opportunities, and convening learning networks for information and idea sharing.

To learn more about the work of the AHA Task Force on Ensuring Access in Vulnerable Communities, please visit www.aha.org/ensuringaccess.

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