



Charles N. Kahn III
President and CEO

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The Honorable Benjamin Cardin
509 Hart Senate Office Building
United States Senate
Washington, D.C. 20510

The Honorable Steve Daines
320 Hart Senate Office Building
United States Senate
Washington, D.C. 20510

Delivery via email to: Statementsfortherecord@finance.senate.gov

Dear Chairman Cardin and Ranking Member Daines,

The Federation of American Hospitals (FAH) is pleased to provide this Statement for the Record in advance of the Senate Finance Subcommittee on Health Care's hearing entitled *Improving Health Care Access in Rural Communities: Obstacles and Opportunities*. We also commend the Subcommittee for its leadership in improving rural access to health care.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH and our member hospitals share the Subcommittee's goal of improving access to care in rural communities. More than 60 million Americans live in rural areas across the country¹ and rely on their local hospital as their main access point for receiving the care they need. These rural hospitals face major stresses and challenges including growing inflation, a unique patient mix, low patient volume, a growing workforce crisis, and funding shortfalls. These factors have contributed to the shuttering of 136 rural hospitals since 2010, including a record 19 closures in 2020 alone.²

¹ FAH Blog: <https://www.fah.org/fah-celebrates-rural-hospital-week-2022/>

² AHA Report: <https://www.aha.org/news/headline/2022-09-08-aha-report-rural-hospital-closures-threaten-patient-access-care>

Fortunately, there are several legislative solutions Congress can enact to support rural hospitals and their patients. To help further the Subcommittee's goal of improving health care access in rural communities, this Statement for the Record addresses: preventing Medicaid DSH cuts; making permanent Low Volume and Medicare-dependent Hospital payment programs (LVH/MDH); a rural Medicare Disproportionate Share Hospital (DSH) equity legislative concept; health care workforce solutions; maintaining the current ban on self-referral to physician-owned hospitals; and opposition to site neutral policies.

We look forward to working with the Senate Finance Committee and appreciate the opportunity to provide input on several key policy platforms.

Prevent Medicaid DSH Cuts

The FAH strongly supports *H.R. 2665, The Supporting Safety Net Hospitals Act*, which eliminates the scheduled Medicaid DSH cuts for 2024 and 2025.

We appreciate the inclusion of the legislation in recent House Energy and Commerce Committee hearings, and we urge the Senate to similarly consider the legislation to protect these payments which are critical for hospitals that provide care to millions of Americans in rural communities, where they serve a disproportionate number of low-income and uninsured patients. DSH allotments are scheduled to be reduced by \$8 billion in FY 2024, starting October 1, 2023. If Congress fails to provide relief from scheduled DSH cuts, the financial viability of our rural and safety-net hospitals would be further compromised.

Medicaid patients need to know hospitals will be there when they need care. This legislation is vital for ensuring access to quality care for our most vulnerable patients and safeguarding the essential hospitals that serve them.

Make Permanent the MDH and LVH Adjustment Payment Programs

The FAH strongly supports *S. 1110, The Rural Hospital Support Act*, which would make permanent two crucial rural hospital payment programs, the MDH and LVH Adjustment payment programs.

These programs are essential for small rural providers and are an important part of ensuring rural facilities remain open for the communities and patients they serve. We thank the Senate for reauthorizing the LVH and MDH programs in the *Consolidated Appropriations Act, 2023*, which extended the programs for two years (until the end of 2024).

Making these important programs permanent would build on recent success and provide the financial stability, security, and certainty needed to help prevent closures and disruptions to care in rural communities.

Advance Rural Health Equity by Enacting Rural DSH Parity

The pressures of inflation on top of recovering from the COVID-19 pandemic exposed the need to address equity in many parts of American society, including health care. We applaud Congress' enhanced focus on health equity measures across the care continuum and urge lawmakers not to overlook the significant health disparities found in rural communities.

One step Congress can take to solve the inequities between rural and urban care is to pass legislation to remove the current, and arbitrary, 12% Medicare DSH Payment Adjustment Cap that applies to rural (with some exceptions) and urban hospitals under 100 beds. This policy unjustly impacts rural hospitals by creating an unlevel playing field of payment policies for treating low-income, rural Americans.

By passing rural DSH payment parity legislation, Congress can ensure equity among rural and urban providers and set us on a path toward a healthier rural America.

Investment in Health Care Workforce in Rural America

Perhaps the greatest challenge facing rural hospitals today is maintaining an adequate workforce. Rural hospitals are experiencing a combination of provider burnout, physician and staffing shortages, and difficulty attracting workers to rural areas – all factors causing significant strain on hospital operations.

Hospitals have been doing our part to recruit, train, and upskill employees. Investments in schools of nursing, such as HCA Healthcare's Galen College of Nursing, are contributing to private sector solutions by making high quality programs available to those seeking to enter the profession. However, ensuring that barriers to learning are addressed as well as creating incentives for nursing students to both attend school and retain employment, or return from retirement, could be significant for the nursing workforce of tomorrow.

Hospitals are also investing heavily in both training and patient care management innovation to improve the bandwidth of registered nurses and reduce nurse workload burden. Allowing nurses to reduce paperwork and non-clinical responsibilities through technology and process enhancements would have the added benefit of reducing burnout.

Another pathway for new workers in the health care sector is legal immigration from foreign countries. The downstream impact of reduced net legal immigration in recent years due to both policy and pandemic factors has created enormous gaps in "unskilled" employment areas, pushing up the wages for those roles due to worker demand and shortages. There are an estimated two million fewer working-age immigrants in the US than there would have been if pre-pandemic levels were maintained.³ Hospitals are seeing entry-level candidates for non-licensed positions shift to sectors with higher wages in a less demanding work environment. The result of this is fewer health care workers staying in the industry at the entry level, which compounds the demands on nurses and other licensed staff – ultimately leading to their burnout.

³ <https://www.governing.com/work/where-are-the-workers-labor-market-millions-short-post-pandemic>

Federal legislative action is essential to help rural hospitals maintain a strong workforce, including:

- *The Conrad State 30 and Physician Access Reauthorization Act* to improve and extend the existing program that allows international physicians trained in America to remain in the country if they practice in underserved areas.
- *The Healthcare Workforce Resilience Act* to recapture 25,000 unused immigrant visas for nurses and 15,000 unused immigrant visas for physicians that Congress has previously authorized, and allocate those visas to international physicians and nurses.
- Enhancing investment in provider loan repayment programs, including the Nurse Corps, to incentivize providing care in rural and underserved communities without limits to the clinician's choice to serve in a tax-paying health facility.
- Address visa backlogs and "visa retrogression." There are currently thousands of fully qualified foreign trained doctors and nurses who have been approved for US green cards but who are not in the US because of "visa retrogression," causing applicants to wait for a visa to become available due to the EB-3 visa category being oversubscribed. In addition to immigration reform solutions, other actions include eliminating State Department bureaucratic delays and inefficiencies in immigration to allow foreign-trained qualified physicians and nurses to come to the US to fill vacancies unfilled by US workers.

Enact Bipartisan Senate Rural Health Agenda

A recent study found that more than 600 rural hospitals – nearly 30% of all rural hospitals in the country – are at risk of closing in the near future.⁴ We applaud the robust group of bipartisan Senators who are working to support their rural hospitals by introducing a package of rural health bills aimed at addressing health care challenges in rural America.

We urge the Senate to enact the following legislation:

- *The Rural Health Innovation Act* to establish a competitive grant program to increase staffing resources, extend hours of operation, acquire additional technology and equipment, and pay for construction costs at Federally Qualified Health Centers and Rural Health Clinics.
- *The Rural America Health Corps Act* which creates a sliding scale loan repayment program based on the severity of provider shortages in the area to incentivize health professionals to serve in rural communities.
- *The Save Rural Hospitals Act* to establish a non-budget neutral national minimum of 0.85 to the Medicare hospital area wage index, ensuring that rural hospitals receive fair payment for the care they provide and allow them to compete for and retain high-quality staff.

These policies would help rural hospitals adapt to the unique headwinds they face and allow them to remain viable within their communities.

⁴ Center for Healthcare Quality & Payment Reform:
https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

Maintain the Current Ban on Self-Referral to Physician-Owned Hospitals (POH)

To help achieve the important goal of preserving health care access in rural communities, it is important that Congress continue to reject efforts to weaken the existing ban on self-referral to POHs. Such arrangements are mired in conflicts of interest, and years of independent data show such arrangements result in over-utilization of Medicare services at significant cost to patients and the Medicare program. It is for this reason the FAH strongly opposes *S. 470, The Patient Access to Higher Quality Health Care Act of 2023*.

There is a substantial history of Congressional policy development and underlying research on the impact of self-referral to POHs. The empirical record is clear that these conflicts of interest arrangements of hospital ownership and self-referral by owner physicians promote unfair competition and result in cherry-picking of the healthiest and wealthiest patients, excessive utilization of care, and patient safety concerns. The standing policy includes more than a decade of work by Congress, involving numerous hearings, as well as analyses by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC).

In 2010, Congress acted to protect the Medicare and Medicaid programs and the taxpayers that fund them by imposing a prospective ban on self-referral to new POHs. The FAH strongly believes that the foundation for the current law must not be weakened.

The law helps ensure that full-service community hospitals, especially those in rural communities, can continue to meet their mission to provide quality care to patients. Data from the health care consulting firm Dobson | DaVanzo, released last month⁵, shows that POHs, when compared to other hospitals, treat less medically complex and more financially lucrative patients, provide fewer emergency services, and treat fewer COVID-19 cases. Specifically, the new study shows that POHs:

- Cherry-pick patients by avoiding Medicaid beneficiaries and uninsured patients;
- Treat fewer medically complex cases;
- Enjoy patient care margins 15 times those of community hospitals;
- Provide fewer emergency services—an essential community benefit; and
- Despite POH claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.

The new data reinforces many of the findings of earlier studies, discussed above, by the HHS OIG, GAO, and MedPAC, among others, documenting the conflicts of interest inherent with POHs that led to the Congressional ban in 2010.

CMS itself recently proposed to reimpose “program integrity restrictions” on POH expansion criteria to guard against “a significant risk of program or patient abuse,” and to

⁵ Dobson | DaVanzo Study: https://www.fah.org/wp-content/uploads/2023/03/2023-FactSheet_20230323_wAppendixandCharts_POH-vs.-NonPOH-Only.pdf.

“protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking.”⁶

While POHs create unfair competition across all communities in which they operate, opening the door to POHs in rural communities specifically would undermine the delicate health care infrastructure and patient mix that rural hospitals rely on to keep their doors open.

Thus, maintaining current law is key to ensuring that rural community hospitals can continue to provide quality care to all patients in their communities. Weakening or unwinding the current ban opens the door to expanding the very behaviors that Congress successfully has deterred for more than a decade.⁷

Oppose Cutting Medicare Through Site-Neutral Payment Cuts

The FAH strongly opposes site-neutral payment policy proposals under consideration by the House Energy and Commerce Committee that would reduce hospital-based outpatient department (HOPD) payments in a non-budget-neutral manner.

If site-neutral payment cuts were to be enacted, rural hospitals would be the first facilities to feel the financial strain, forcing difficult decisions regarding the viability of operations in rural areas. Rural hospitals are the hub of health care services in their communities, and site-neutral reductions would put the entire rural health care infrastructure at risk.

Site-neutral payments do not consider one simple fact: hospitals and doctors' offices are not the same. Hospitals provide critical services to entire communities, including 24/7 access to emergency care and disaster relief. They need to maintain the ability to treat high acuity patients who require more intense care, and therefore require a different payment structure. Hospital-affiliated sites offer patients more integrated care across health care settings, services for which hospitals need to be properly reimbursed to maintain coordinated, high-quality care for patients.⁸

Increasingly, care is shifting from the inpatient to outpatient settings, meaning that patients now seen in HOPDs may require a higher level of care than traditionally offered – or even available – in a physician's office. A recently released study from the American Hospital Association backs up this fact.⁹ Researchers found that HOPDs treat more underserved populations and sicker, more complex patients than other ambulatory care sites. The study indicates that relative to patients seen in independent physician offices and ambulatory surgical centers, Medicare patients seen in HOPDs tend to be:

- Lower-income;

⁶ FAH Blog on POH. April 24, 2023: <https://www.fah.org/blog/physician-owned-hospitals-are-bad-for-patients-andcommunities/>.

⁷ FAH Blog on POH: March 28, 2023. <https://www.fah.org/blog/new-analysis-reaffirms-need-to-maintain-currentlaw-banning-self-referral-to-physician-owned-hospitals/?swcfpc=1>.

⁸ FAH Blog on Site Neutral: April 23, 2023. <https://www.fah.org/blog/stronguwhats-in-a-name-because-there-isnothing-neutral-about-site-neutral-policyustrong/>.

⁹ AHA Report: <https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristicsreport>

- Non-white;
- Eligible for Medicare based on disability and/or end-stage renal disease;
- More severe comorbidities or complications;
- Dually-eligible for Medicare and Medicaid; and
- Previously seen in an emergency department or hospital setting.

It is vital that payment for outpatient services provided in a HOPD reflects the higher overhead costs associated with providing care in that setting.

Additionally, regulatory requirements such as the Emergency Medical Treatment and Labor Act (EMTALA), hospital Conditions of Participation, hospital state licensure, and complex cost reports impose substantial resource and cost burdens that physician offices and ambulatory surgical centers do not have and therefore are not reflected in their payments.

Telehealth

One of the silver linings to emerge from the COVID-19 pandemic is the increase in health care services provided via telehealth. Telehealth allows timely access to patient-centered care, enhances patient choice, and most importantly improves access to care in rural areas where many patients travel over an hour for a routine doctor’s appointment, and often much further to seek specialty care. Telemedicine eliminates this geographic barrier and greatly lowers the bar for accessing quality care. Telehealth enables hospitals to meet patients literally where they are, allowing for more tailored treatment.

We thank Congress for extending the pandemic era telehealth provisions through 2024 in the *Consolidated Appropriations Act, 2023*. We urge lawmakers to build on this progress and make permanent pandemic era Medicare telehealth provisions to improve the health of rural residents by giving them better access to the care they need.

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The FAH is committed to working with Congress to ensure the availability of affordable, accessible health care for all Americans including those who live in rural areas. If you have any questions or would like to discuss these policies further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

