Charles N. Kahn III
President and CEO

October 5, 2023

The Honorable Jason Smith
1139 Longworth House Office Building
United States House of Representatives
Washington, D.C. 20515

Submitted via email to: WMAccessRFI@mail.house.gov

Dear Chairman Smith,

On behalf of the Federation of American Hospitals (FAH), we appreciate the Committee's focus on increasing access to health care in rural and underserved communities and we share the Committee's goal of addressing chronic barriers to patient care. We are pleased to provide the following comments in response to your request for information and we look forward to working with the Committee on solutions to reshape and improve our nation's health care delivery system for future generations.

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.

Every day across our nation, millions of Americans in small communities depend on rural hospitals for vital and lifesaving care. Rural hospitals are pillars of the communities in which they operate and are often the largest economic drivers in rural towns. As employers, rural hospitals provide vital jobs in communities, and their tax dollars support local public schools, firehouses, police stations, and other critical infrastructure. Rural hospitals support one in 12 rural jobs in the U.S. and generate $220 billion in economic activity in rural communities.[1]

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[1] rural-hospital-closures-threaten-access-report.pdf (aha.org)

Rural hospitals have overcome constant economic challenges to deliver care to an estimated 60 million people,[2] while facing financial and operational challenges including growing inflation, a unique patient mix, low patient volume, a growing workforce crisis, and funding shortfalls, all of which were exacerbated by the unprecedented COVID-19 pandemic. These factors have contributed to the shuttering of 136 rural hospitals since 2010, including a record 19 closures in 2020 alone.[3]

Fortunately, there are several legislative solutions Congress can enact to support rural hospitals and their patients. To help further the Committee's goal of improving health care access in rural communities, the Federation of American Hospitals offers the following recommendations:

<u>Aligning Sites of Service</u>

Oppose Cutting Medicare Through Site-Neutral Payment Cuts

The FAH strongly opposes site-neutral payment policy proposals such as the site neutral Medicare payment policy for physician-administered drugs in off-campus hospital-based outpatient departments (HOPDs) contained in H.R. 5378, the *Lower Cost More Transparency Act.*

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. The Committee has acknowledged the strain rural hospitals will feel by providing a one-year delay of site-neutral payment cuts in H.R. 5378 to allow rural hospitals extra time to manage finances before the policy is fully phased in. Regardless of when the payment cuts begin, rural hospitals will be hurt.

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, and 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.[4]

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.[5] Researchers found that HOPDs treat more underserved populations and sicker, more complex patients than other ambulatory care sites. The study

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[2] https://www.fah.org/fah-celebrates-rural-hospital-week-2022/
[3] https://www.aha.org/news/headline/2022-09-08-aha-report-rural-hospital-closures-threaten-patient-access-care
[4] 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/.
[5] AHA Report: https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristicsreport

indicates that relative to patients seen in independent physician offices and ambulatory surgical centers, Medicare patients seen in HOPDs tend to be:

- Lower-income;
- 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.

Geographic Payment Differences

Make Permanent the Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH) Adjustment Payment Programs

The FAH strongly supports legislation that would make permanent two crucial rural hospital payment programs, the LVH and MDH 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 lawmakers for reauthorizing the LVH and MDH programs in the *Consolidated Appropriations Act of 2023*, which extended the programs for two years (until the end of FY 2024).

The FAH is proud to support legislation championed by Senators Chuck Grassley and Bob Casey, *S. 1110 - The Rural Hospital Support Act,* which would permanently extend these designations. Additionally, we thank Carol Miller and Terri Sewell for introducing H.R. 8747 - *Assistance for Rural Community Hospitals (ARCH) Act* in the 117th Congress which would have provided a five-year program extension and look forward to again supporting their bill this Congress.

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.

Enact a 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.[6] 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 House to follow suit and enact the following legislation:

- *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.
- *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. This grant program, and those similar, should apply to all providers regardless of tax status.
- *The Rural America Health Corps Act* to create 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.

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

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 *H.R. 977- 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 the conflicts of interest created inherent in these hospital ownership arrangements 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), Government Accountability Office (GAO), and Medicare Payment Advisory Commission (MedPAC).

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

In 2010, Congress acted to protect the Medicare and Medicaid programs and taxpayers that fund them by imposing a prospective ban on self-referral to new POHs. The FAH strongly believes that the foundation for current POH 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. Recently released data from the health care consulting firm Dobson | DaVanzo[7] 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 reimposed "program integrity restrictions" on POH expansion criteria to guard against "a significant risk of program or patient abuse," and to "protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking."[8]

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, patient mix, and patient volume 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.[9]

<u>Sustainable Provider and Facility Financing</u>

Providing care in rural communities is a difficult endeavor as rural hospitals operate on thin margins with delicate payment hydraulics and a fragile patient mix. Because FAH member hospitals rely on integration to centralize overhead costs and support rural operations, a cut to

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[7] Dobson | DaVanzo Study: https://www.fah.org/wp-content/uploads/2023/03/2023-FactSheet_20230323_wAppendixandCharts_POH-vs.-NonPOH-Only.pdf.
[8] FAH Blog on POH. April 24, 2023: https://www.fah.org/blog/physician-owned-hospitals-are-bad-for-patients-andcommunities/.
[9] 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.

any hospital (whether rural facilities or the urban hubs they may refer patients to) would impact their ability to maintain operations in rural areas.

To encourage investments and improve access in rural areas, there are a limited number of options Congress can pursue, including the Rural Emergency Hospital (REH) designation and encouraging the development of Free-Standing Emergency Departments (FSEDs), both important parts of the care delivery ecosystem. However, it is important for Congress to keep in mind as it evaluates policies to lower costs and improve access that a proper balance needs to be struck to sustain all points of access. If Congress pursues policies that reduce Medicare payments, such as proposed site-neutral cuts, this would only weaken the ability of hospital systems to maintain operations in rural and underserved areas.

Understanding the Positive Effects of Hospital Integration

The nation's health care landscape is, by necessity, shifting towards integrated systems and coordinated care. Mergers and acquisitions create sustainable market conditions for hospital care and services, particularly in rural areas with lower patient volumes. This shift has naturally occurred within the health care industry and has been further fueled by health care policies that promote a more patient-centered, value-based health care delivery and payment system. Additionally, increasingly complex health care regulatory and administrative requirements such as those regarding electronic health records, cybersecurity, quality programs, and, increasingly, payer administrative hurdles, are extremely resource intensive and difficult for an individual hospital or an individual physician or small group practice to navigate.

Hospital integration is also a response to inadequate, below the cost-of-care, public sector funding for hospitals, forcing hospitals to adapt to real-world economic and financial factors. The priority of any integration is to keep hospitals open, preserve or expand patients' access to care and continue to provide consistent, quality care around the clock to every patient treated in a hospital. By pursuing mergers and other integration efforts, hospitals are able to maintain their presence in the community, share and scale up best practices, and protect patients' access to essential and affordable quality care, especially in rural communities.

There have been multiple studies that point to the positive effect on quality as well as reduction in mortality associated with hospital mergers. For example, a 2021 study published in JAMA Network Open concluded that hospital mergers improve health outcomes in rural hospitals.[10] The researchers, who are affiliated with IBM Watson Health and the Agency for Healthcare Research and Quality, compared data from 172 merged rural hospitals and 266 comparison hospitals and found that in-hospital mortality rates were lower after the rural hospitals completed the mergers. Researchers noted that "Mergers may enable rural hospitals to improve quality of care through access to needed financial, clinical, and technological resources, which is important to enhancing rural health and reducing urban-rural disparities in quality."

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[10] Jiang HJ, Fingar KR, Liang L, Henke RM, Gibson TP. Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals. JAMA Netw Open. 2021;4(9):e2124662. doi:10.1001/jamanetworkopen.2021.24662.

In addition, the American Hospital Association (AHA) has released numerous studies indicating that hospital integration benefits patients by providing higher quality care at a lower cost. A 2021 study reinforced the conclusions of previous reports: hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost.[11] Specifically, a previous 2018 study found that mergers of hospitals within 30 miles of each other generated savings of more than $6.6 million in annual operating expenses at acquired hospitals.[12] The studies also determined that hospital acquisitions lead to improvements on key indicators of quality. Empirical analysis continues to show a statistically significant reduction in inpatient readmission rates and a composite readmission/mortality outcome measure.[13] Further, the Center for Healthcare Economics and Policy released a comprehensive analysis of hospital integration studies, including 75 studies spanning the years 1996-2013, as well as 36 primary sources. The Center's analysis outlines improvements in health care for communities that result from mergers, including:

- Significant benefits to communities and patients in markets where hospitals remain open.
- Preserved and expanded access to essential medical care.
- Improved service offerings and quality of care.
- Sustained and necessary investment in technology, facilities and health IT.
- Sensible reduction in excess capacity.
- More competitive health care markets.

As the health care landscape continues to evolve and providers accelerate efforts to improve patient outcomes and lower costs through coordinated care, the FAH will continue its efforts to inform Congress about health care competition and hospital integration. It is imperative that this issue is put in proper context, and focus is placed more holistically on the total landscape.

Stop Insurer and Medicare Advantage Unfair Practices

The FAH is increasingly concerned by the alarming practices of Medicare Advantage (MA) and other insurance plans that harm rural patients by eroding access to and affordability of medically necessary care, and also require hospitals and caregivers to divert precious resources and time to respond to these tactics. In some states, small rural hospitals are realizing greater financial losses on services provided to MA patients than those with original Medicare.[14]

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[11] Hospital Merger Benefits: An Econometric Analysis Revisited, conducted by economists at Charles River Associates, Sean May, Monica Noether and Ben Stearns, August 2021, and sponsored by the American Hospital Association.

[12] In Hospital Mergers: Foundation for a Modern, Efficient and High-Performing Health Care System of the Future, conducted by Charles River Associates, 2018, and sponsored by the American Hospital Association

[13] See footnote 10.

[14] https://ruralhospitals.chqpr.org/Problems.html#profits-and-losses-based-on-type-of-private-insurance-in-california

Some of these concerns were included in a recent HHS OIG Report[15] showing that MA organizations (MAOs) systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees. The OIG Report also identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from MA enrollees, as previously discussed. Specifically:

- *Improper prior authorization denials.* The OIG found that 13 percent of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation*. The OIG found that in many cases beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that 18% of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries.

CMS recently acknowledged many of these concerns in a December 2022 proposed rule and April 2023 final regulation[16] that would constrain some of the bad behaviors MA plans employ related to prior authorization and non-coverage of items and services that would be covered for beneficiaries covered under the traditional Medicare fee-for-service program.

As the Committee explores ways to improve access in rural areas, we urge you to investigate these practices and, at a minimum, exercise oversight authority to help ensure MA behaviors that protect patients through, for example, prior authorization reforms, and comprehensive provider networks.

Increase Affordable Health Care Coverage

Hospitals require a balanced payer mix, the share of patients covered by Medicare, Medicaid, and private payers, to ensure the sustainability of hospital finances. Particularly for rural hospitals facing a multitude of financial pressures, expanding comprehensive coverage to patients who are uninsured or underinsured patients can provide the stability needed to keep a hospital's doors open to the entire community. There are several steps that policymakers can take to build on our market-based approach to health coverage:

- The extension of the Advanced Premium Tax Credits (APTCs) in the *Inflation Reduction Act* was an important step to ensuring millions of low-and middle-income families have access to affordable coverage. The FAH urges Congress to consider bipartisan legislation

[15] 8 Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General ("OIG"), OEI09-18-00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18- 00260.pdf

[16] https://www.cms.gov/newsroom/press-releases/cms-proposes-rule-expand-access-health-information-and-improve-prior-authorization-process; https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.

to make APTCs permanent and provide continued support for access to coverage and care for patients in rural areas.

- Medicaid Expansion enables providers to better meet the needs of vulnerable populations who would otherwise seek medical care as a last resort in the emergency room. According to analysis published in 2019 by Flex Monitoring, Medicaid expansion was associated with a change in payer mix at Critical Access Hospitals such that after Medicaid expansion, they treated more Medicaid patients and fewer uninsured patients when compared to their non-expansion counterparts.[17] The FAH strongly supports Medicaid expansion to provide coverage to eligible Americans and encourages policymakers at the federal level to work with states that have yet to expand so that their residents will have access to affordable health care coverage.

Health Care Workforce

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 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, increasing labor costs for struggling rural hospitals. There are an estimated two million fewer working-age legal immigrants in the US than there would have been if pre-pandemic levels were maintained.[18] 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.

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[17] CAH Medicaid Payer Mix in Expansion vs. Non-Expansion States

[18] 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.

Innovative Models and Technology

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. This is especially important, given that labor often accounts for hospitals largest cost center. In many cases, particularly in rural areas where it is difficult to recruit physicians and other highly trained staff, telehealth and other remote technologies can help make up for any staffing shortfalls or staff burnout.

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.

Conclusion

Thank you for taking our comments into consideration as you look for solutions to improve access to health care in rural and underserved areas. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,