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RURAL HEALTH CARE: SUPPORTING LIVES AND IMPROVING COMMUNITIES

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RURAL HEALTH CARE: SUPPORTING LIVES AND IMPROVING COMMUNITIES

THURSDAY, MAY 16, 2024

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Carper, Cardin, Bennet, Casey, Warner, Whitehouse, Hassan, Cortez Masto, Warren, Grassley, Thune, Cassidy, Lankford, Daines, Barrasso, Johnson, and Blackburn.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Marielle Kress, Senior Health Advisor; Joshua Sheinkman, Staff Director; and Kripa Sreepada, Senior Health Advisor. Republican staff: Erin Dempsey, Republican Deputy Health Policy Director; Kellie McConnell, Health Policy Director; and Gregg Richard, Staff Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order. This morning, the committee gathers to discuss the challenges and opportunities in rural communities when it comes to health care, and I am going to be blunt. Without rural health care, you cannot have rural life. It is just that simple.

And yet across the country, rural health providers are struggling to keep their doors open. Too many hospitals, doctors, pharmacies, and other providers in our rural communities are now operating on a knife's edge. They are forced to choose between balancing the books and continuing to provide high-quality care to their communities. Half of all rural hospitals across the country operate in the red. There is no better example of this than what Oregonians in our Baker County experienced over the past year.

In 1897, St. Elizabeth's Hospital opened in Baker City and began to deliver babies. One hundred twenty-six years later, after being acquired by Trinity Health, the sixth largest hospital chain in the country, they closed their labor and delivery unit with less than 60 days' notice. Trinity basically said that delivering babies at St. Alphonsus was just a money-loser.

Nobody saw it coming. The people of Baker City thought their hospital could have a brighter future by joining Trinity Health. When I arrived at a town hall in Baker City last year, there were

hundreds of outraged families, including a number of expectant mothers who had planned to give birth at St. Alphonsus.

The next closest hospital in that part of eastern Oregon is 45 miles away, along a freeway that can be closed during the winter because of icy conditions, and there are also truck crashes. In fact, that hospital, the Grande Ronde Hospital in La Grande, OR is here today, and we are so glad that Mr. Davis made the trek. I know a modest amount about most subjects, but what I really know something about is airline schedules. And for Mr. Davis to get across the country to be with all of us today—it is a long trek, and we appreciate him coming.

Despite efforts at the Federal, State, and local levels, St. Alphonsus in Baker City closed its labor and delivery unit completely last August. The community battled St. Alphonsus to keep basic labor and delivery equipment in Baker City, in the event that the community can find their own solution in the near future. Rather than find ways to keep their obstetrics open, the hospital offered essentially a modest sum of money, given their overall operations as part of the sixth largest chain: $240,000. This lump sum amounts to less than $2,000 for each year the hospital has been in the community.

What happened at St. Alphonsus is a textbook example of what is happening in rural communities across the land. Our view is, these communities deserve better. These Americans deserve better. Between 2011 and 2021, one out of every four rural hospitals in America stopped providing obstetric services. That is 267 communities across the country where giving birth locally is no longer an option. So, make no mistake: if it is not practical to give birth within a reasonable distance of your home, your community is facing the prospect of becoming a maternity desert. In these areas, aspiring parents are going to be forced to make tough decisions about where they live and where they start a family.

Now, everybody knows that it is tough to get nurses, let alone labor and delivery nurses, in rural areas. These hospitals often see a low number of births each year and face high costs to keep their services available. So today, I am going to begin discussing a fresh approach with colleagues on this committee that combines steps that can address the economic realities in these communities with extra financial support, as long as large hospital chains do not take the money and run. My sense is that this is the kind of approach we can come together on to deal with the times.

Let me mention two other areas briefly: telehealth and workforce. Telehealth is vital to health care in rural communities. It is a game changer for seniors to contact their doctor through telehealth service instead of spending half the day or more driving to the health clinic and back home. It is enormously important for young families, who no longer have to take the day off work to help their grandparent. I would just mention—and I think Senator Stabenow remembers it from working closely with me, Senator Lankford as well—when Chairman Hatch and I came together to deal with the CHRONIC bill, the biggest single piece was telemedicine.

And after we got it enacted, it essentially was sitting for a while, and one afternoon I got a call from the Trump administration. They said, "How would you feel about using your telemedicine pro-

visions for the COVID challenge?" And I said, "You are calling from the Trump administration? You want to know how we feel that you would like to use our telehealth provisions?" I said, "This is one of the coolest moments I can remember. I am going to go off and have a hot fudge sundae to celebrate. Thank you very much; we are in." Those were provisions that came from the Senate Finance Committee that were written in a bipartisan way. Telehealth is part of chronic medicine, and we are the law of the land.

So, there is still more to do. I think it is just defying common sense that clinicians in Idaho or Nevada have to jump through extra hoops and pay for multiple licenses, just to provide care via telehealth to a family in eastern Oregon. My friend Senator Cantwell, who has been doing such good work on aviation and a host of issues, I think is aware that a senior in Vancouver, WA cannot receive care via telehealth from a doctor across the Columbia River.

I heard that we have this new thing called the Internet, you know—brand new. We ought to be able to figure this out. With Senator Cantwell's leadership, we will be able to and without mountains of bureaucracy.

The last point that I want to mention is the workforce issue. Health-care jobs are so important. They are an economic engine for rural Oregon. It is becoming more and more difficult to attract qualified health-care workers to rural communities. One of the things we have got to do is update the graduate medical education program in Medicare, to make sure rural areas and high-need urban areas are not given short shrift, and we have to boost primary care. That is the backbone of the front line of American health care. Senator Stabenow has done particularly important work in this area.

And also, as a committee, we have begun to do this, looking at innovative approaches like public-private partnerships, to get into the high schools and start getting students interested earlier in health care. We have always talked about the community colleges. Every member here knows about that. I am committed to getting more high school students, particularly juniors and seniors, into these slots and bringing them into the field.

So, lots to do here, and every member of this committee has an interest in rural and underserved areas.

We have a great panel of witnesses, and Senator Lankford is sitting in for Senator Crapo. We hope his health is good, and Senator Lankford has been a leader on this committee on a host of issues, including health care, but is also known as one of our leaders with respect to charity care, which has been very important to all of us.

Senator Lankford?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. JAMES LANKFORD, A U.S. SENATOR FROM OKLAHOMA

Senator LANKFORD. Thank you. Mr. Chairman, thank you. I do want to submit for the record Ranking Member Crapo's opening statement.

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Senator Crapo appears in the appendix.]

Senator LANKFORD. Thank you. He would definitely be here to be able to address that if he was feeling a little bit better to be able to take that on. So let me say "thank you" to you as well for hosting an event dealing with rural health care.

This is a very significant issue for Oklahoma, just like it is for your State, and my State has 4 million people. Two million of those live in urban areas, and 2 million of those live in rural areas. So I understand well what it means to have the critical needs hospitals in rural areas there. We have 40 rural access hospitals. We have three rural emergency hospitals. We have seen several rural facilities close over the last few years. In fact, one of the reports done by Chartis, one of our witnesses here, shows that about a third of Oklahoma's hospitals are at risk of closure, which ranks Oklahoma as the State with the fourth highest number of potential closures in the United States. So this particular hearing is incredibly important to us in Oklahoma.

Rural health care, though, I do want to remind everyone, is not just hospitals. It encompasses the entirety of the health ecosystem from access to healthy foods, local pharmacies, the independent family physician practices, emergency room access, ambulances or air ambulance, insurance coverage, and insurance networks. All of them are part of that ecosystem, and all are vital access that we have spent some time talking about.

I would argue several things. Some of the issues that we face in rural health care deal with things like physician practices and hospitals and the administrative burdens that they face. Rural providers and hospitals have fewer resources to be able to maintain those practices, and they drown in some of the administrative paperwork. So, whatever we can do to be able to help them actually put more people taking care of patients and fewer people back-office is helpful to them.

Nursing homes have a very difficult time caring for patients, but rural nursing homes have some of the most difficult times, where they are dominantly funded by Medicaid in their community, and they treat a higher level of acuity. So, there are some very real challenges for rural nursing homes.

The pharmacies and the reimbursements—they have some reimbursements that are a lower reimbursement than the actual purchase of the drugs that they stock. But the rural pharmacies, especially independent pharmacies, are often the only health-care provider in the community that they have immediate access to. So, allowing that rural pharmacist to be able to thrive is incredibly important in rural America.

Most importantly, we deal with the issue of patients. Rural patients have an even harder time finding in-network providers, especially as more and more rural hospitals stop accepting Medicare Advantage—which we have had some of our rural providers do in the area—or when there is a requirement for prior authorization for certain testing, and you already drove 45 minutes to be able to get there. When you meet with your doctor, and he says, "We need to do a test, but you have got to come back again before we can get authorization," that just discourages them from ever getting

that test again. It works out well for the insurer; it does not work out well for the patient in rural America.

So these are the issues that we have got to be able to deal with: proper oversight of Medicare Advantage and the networks in rural America; the long-term solutions to the Physician Fee Schedule that we continue to be able to talk about; the PBM reform legislation that this committee has passed overwhelmingly we need to be able to move, because that is an issue for rural independent pharmacies that is very significant, that we have got out of this committee. We need to be able to get it across the floor and be able to get that resolved, as well as dealing with some of the CMS rules that are out there, which I believe are a threat to rural nursing homes with some of the staff requirements that are there, that are going to actually pull RNs away from hospitals that are already struggling to be able to maintain their RNs. To maintain some of the new rules from CMS may make for an even greater challenge for survival for some of those rural nursing homes.

Senator Durbin and I have worked on a bill, the Rural Hospital Closure Relief Act. That is one that we want to be able to work through in trying to deal with the Critical Access Hospitals. We have a lot of issues around the community health centers. Those FQHCs have been a real solution for us in Oklahoma and a lot of rural areas, and we will be able to continue to be able to deal with that.

So, I would just say patients who are in rural Oklahoma should not be punished for living in rural Oklahoma. They should have access there that is consistent, and also be able to face the unique issues that they have in rural America, to be able to both live and thrive there. And for all of us who like to eat food and wear clothes, we really need folks in rural America who are in agriculture, and if we cut off access to health care to them, then we are also going to lose access to a lot of the rest of our economy. So, I look forward to this conversation.

The CHAIRMAN. Thank you, Senator Lankford. I appreciate your making it clear that food does not just fly out of the sky and land up here on the dais, and I also appreciate your comments about the pharmacy benefit manager legislation. It has been bipartisan. You played a key role. It also speaks to this middleman issue. We spend more than $4 trillion a year on health care. We have got to get at this middleman question, and we are looking at some of the work that Senator Lankford and others did in terms of trying to make sure that we could really get good value for the consumers on another bill that Senator Crapo and I have to deal with drug shortages. So, I appreciate this.

Okay. Michael Topchik is going to be our first witness, executive director of the Chartis Center for Rural Health. He has been a specialist in these rural networks. We appreciate him.

Jeremy Davis I have already tried to give a send-off once to, but you know we always like Oregon to get a little bit more attention since we are 3,000 miles away. He is the CEO of Grande Ronde Hospital, where I have been often, an independent Critical Access Hospital in La Grande. He has led the hospital in recruiting more clinicians and the first urgent care facility. They are doing very important work there.

Lori Rodefeld serves as the director of GME development at the Wisconsin Collaborative for Rural Graduate Medical Education—a very experienced advocate in the field.

And Dr. Keith Mueller is director of rural policy research, and he is at the Rural Policy Research Institute as well as the Center for Rural Health Policy Analysis. That is a lot of hats to wear; I do not know when you sleep, but thank you all for being here.

We will begin with you, Mr. Topchik.

STATEMENT OF MICHAEL TOPCHIK, EXECUTIVE DIRECTOR, CHARTIS CENTER FOR RURAL HEALTH, CHICAGO, IL

Mr. TOPCHIK. Thank you very much, Chairman Wyden, Ranking Member Crapo, Senator Lankford—I appreciate your remarks—and members of the committee. Good morning, and thank you for the opportunity to discuss the state of rural health and the implications for the 46 million Americans who call rural communities home. My name is Michael Topchik, and I am the executive director of the Chartis Center for Rural Health. Chartis is a Chicago-based advisory firm dedicated to helping clients create and embrace solutions that make U.S. health care more affordable, accessible, and safe, and my work with the Center is exclusively focused on rural health care.

America's rural communities are older. They are less affluent, and they are less healthy than their urban counterparts. Rural Americans are more vulnerable than nonrural Americans across nearly all of the population health metrics we measure at the Center. Rates of the leading causes of death are all higher in rural America, and the so-called "deaths of despair"—with suicides, the opioid epidemic, alcohol-related deaths—are all much higher in rural America.

With that backdrop, recent history has been difficult for the safety net serving these Americans, particularly hospitals. Since 2010, we have lost 170 of these rural hospitals. Half—half—of rural hospitals are now operating in the red. In States that have yet to expand Medicaid, that number goes up to 55 percent. Even when hospitals do remain open, access to care—access is such an important word in this hearing today—access to care is constrained as facilities are challenged to keep programs open. For example, we have lost 25 percent of the Nation's rural obstetrics in the last decade.

The journey for labor and delivery for these expectant mothers now means an additional 30, 45, or even 60 minutes for that important life milestone. As tough as all of that sounds, our research indicates that the future might be tougher still. Using our data and analytic capabilities, we find 418 additional rural hospitals vulnerable to closure. Senator Lankford, you mentioned some of those in Oklahoma that we are worried about.

This is a national threat that will send shock waves through communities if it is unchecked. When rural hospitals close, accessing care becomes harder if not impossible, and jobs in those communities—and jobs at the hospitals and related jobs—they disappear.

There are really three key factors threatening rural hospitals today. First, rural hospitals have high operating costs, and they have low reimbursements. The unintended consequences are re-

lated to things like sequestration. And bad debt reimbursements, for example, continue to chip away at rural hospitals' reimbursements. To counter operational and financial pressure, nearly 60 percent of rural hospitals are now affiliated with a health system. And while affiliation with a health system is shown to bring services to communities and to improve the bottom line—in our analysis it also is protective against closure—it is not a panacea.

Second, rural hospitals treat a low volume of patients. There are too few patients and even fewer medical professionals to deliver care, meaning that for many hospitals, the math just does not work.

Finally, rural hospitals are plagued by staffing challenges. While rural hospital staffing shortages are not new, the pandemic accelerated this crisis. These shortages impact patient care today, and they threaten the introduction and delivery of new services that communities will need tomorrow.

I would like to share a quick anecdote that I think is on all of our minds, which comes from Walmart. Within the last month, it announced it is leaving the health-care delivery space after just 5 years in this business. They cited staffing and reimbursement challenges as amongst the chief reasons they got out of this space. And so my question is, if Walmart cannot figure this out with their scale and their capacity, how can we expect rural hospitals and their communities that are struggling to see a future in which their situation improves?

Let me finish by just saying that today's hearing is important and timely. I have dedicated approximately the last 20 years of my career to advancing rural health care in America, and I am deeply invested in helping rural hospitals deliver quality, affordable care to some of our most vulnerable communities.

I would like to express my sincere thanks to the Chartis leadership team—including my colleague Anneliese Gerland, who is with me today—who have stood by us in this important mission-driven work, and also my colleagues at home: William Balfour, Troy Brown, Melanie Pinette, and Ana Wiesse of the Charter Center for Rural Health, whose research is fundamental for the testimony today.

I would like to thank all of the members of the Finance Committee and their staffs for the time and opportunity to speak here today. I look forward to your questions. Thank you.

[The prepared statement of Mr. Topchik appears in the appendix.]

The CHAIRMAN. Thanks very much; a great way to start.

Mr. Davis, welcome, and I so appreciate your being here to tell the Oregon story.

STATEMENT OF JEREMY P. DAVIS, MHA, PRESIDENT AND CEO, GRANDE RONDE HOSPITAL, LA GRANDE, OR

Mr. DAVIS. Chairman Wyden, Senator Lankford, and members of the committee, thank you for the opportunity to speak today. My name is Jeremy Davis, and I am the president and CEO of Grande Ronde Hospital, a 25-bed not-for-profit independent Critical Access Hospital in La Grande, OR. Located in rural eastern Oregon, the hospital was founded in 1907. Grande Ronde Hospital serves a

local population of 26,000 residents and other parts of frontier eastern Oregon and southeast Washington. My community is located 260 miles east of Portland, OR and 170 miles northwest of Boise, ID along an interstate that frequently closes due to weather or accidents.

On a personal note, I grew up 45 miles from this community, so rural life, and now rural health care, is dear to me. Union County is a mountainous area with a local economy based on natural resources including farming, ranching, and timber. About 15 percent of our population lives in poverty. In a most recent needs assessment, we identified chronic disease prevention, social determinants of health, and behavioral health services as top priorities. Of the patients we see, over 60 percent are covered by government payers, with 41 percent covered by Medicare and 23 percent covered by Medicaid. For rural hospitals, a substantial portion of patients covered by Medicare and Medicaid underscores the importance of adequate reimbursement for these programs.

But reimbursement is only part of our challenge. The aftershocks of the COVID–19 pandemic shifted the ground beneath hospitals like mine, forcing us to make difficult decisions about the services we provide. While many of the challenges we face today were on the horizon, the pandemic exposed the fragility of hospitals' financial foundations, particularly for rural hospitals. Rising expenses, workforce shortages, stalled revenue, and cratered hospital finances have put hospitals like Grande Ronde in one of the worst overall financial positions seen since 1993. Rural hospital administrators like me have an interconnected list of worries that keep us up at night, including workforce safety and shortages, financial stability, and more recently worries about cybersecurity. And the next emergency, whether natural, public health, or man-made, is always just around the corner.

As wonderful as our rural lifestyle is, it can be a trial for many rural residents, particularly those living in communities surrounding La Grande, with no access to public transportation. Patients often miss, reschedule, or even cancel appointments, delaying needed care. Since 2007, we made an early and significant investment in telemedicine, allowing us to meet the challenges of delivering care in a rural setting, which has resulted in a nationally recognized program. Telemedicine provides access to specialists not available locally, by tapping into specialty expertise typically only available in larger cities. This includes using Telehospalist for nightly call coverage, specialty physician teams when patients present to our emergency department, and pediatric specialists for our youngest patients. Investing in additional equipment as well as configuring exam rooms' workspaces to pivot quickly was the right thing to do. By extending telehealth flexibilities permanently, we can create certainty for Medicare beneficiaries, and certainty for providers like Grande Ronde that cannot always afford to invest in these tools without a reimbursement pathway.

Similar to our telemedicine commitments, our workforce investments have been promising. We have reached out to candidates across the spectrum of both primary and specialty care, and through our recruitment efforts we have expanded services and significantly improved access to care. In 2021, our efforts to grow a

behavioral health services program attracted additional providers and meant better care for Union County residents. Eight years ago, Grande Ronde Hospital established a nurse residency program to attract, train, and retain nurses. We are firm believers in growing our own, and our model has attracted nurses from across Oregon. In 2019, we created a nurse residency educator position to oversee the program, which has enhanced its success. We also collaborate with our local high school, and we are also a partner with the Northeast Oregon Area Health Education Center, which hosts an annual health career exploration camp for high school students.

Any Federal support that provides incentives and supports for these types of programs should be a priority. Growing and supporting our workforce and protecting and expanding services are two sides of the same coin when it comes to rural health care. Neither can be achieved without the other, and both require adequate reimbursement and constant reinvestment.

Rural hospitals have to be especially creative to foster and protect needed services, as we have done with our Children and Recovering Mothers program, CHARM. CHARM is a confidential healthcare program for pregnant women struggling with alcohol or drug addiction. It collaborates with local providers and public health department officials to provide a program that improves care and support for mothers and their infants.

Our maternal care investment helped us respond when our neighboring hospital 45 miles away closed its obstetrical unit in 2023. In preparation, we quickly added two FTEs and four RN positions, which proved to be necessary as we have seen a 65-percent increase in patients from the neighboring county since the closure occurred. While we are committed to meeting this need, decisions like this are a constant juggling of limited financial resources and a balancing of larger workforce needs.

Let me close by commenting, in addition to extending telehealth flexibilities, the following proposals will specifically help us meet the substantial discharge challenges we face in Oregon. One, permanently remove the 96-hour rule for Critical Access Hospitals to allow us to serve patients longer than 96 hours. Two, reestablish the swing bed flexibilities allowed during the pandemic that expanded the ability of hospitals to offer long-term care services to patients who do not require acute care. Three, permanently waive the outdated 3-day hospital stay rule for patients requiring discharge to skilled nursing facilities.

It is an honor and privilege to serve my rural community, and thank you for this opportunity to be here today.

[The prepared statement of Mr. Davis appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Davis, and thank you for your good work at home. And I particularly appreciate this effort to try some fresh approaches to attract nurses, and your focus on starting at home and in nearby communities is clearly an area that has been underutilized. So good on you. I look forward to asking some questions of you.

Ms. Rodefeld?

STATEMENT OF LORI RODEFELD, MS, DIRECTOR OF GME DEVELOPMENT, WISCONSIN COLLABORATIVE FOR RURAL GRADUATE MEDICAL EDUCATION (WCRGME), RURAL WISCONSIN HEALTH COOPERATIVE, SAUK CITY, WI

Ms. RODEFELD. Great. Chairman Wyden, Senator Lankford, and members of the committee, my name is Lori Rodefeld, and I serve as director of GME development for the Wisconsin Collaborative for Rural GME. I also serve as the director of GME development for the Rural Residency Planning and Development, and Teaching Health Center Planning and Development Technical Assistance Centers.

Rural health care has long faced challenges in recruiting and retaining a qualified workforce. This is not just an inconvenience; it threatens the fabric of the health care in rural communities. Rural hospitals and health-care facilities are already stretched thin, serving patients around the clock to meet their community's needs. Unlike other industries, their hours cannot be scaled back. Emergency rooms and patient services, labor and delivery units are all critical services that rely on a strong, stable workforce to keep the doors open.

My testimony will include examples from Wisconsin and across the country, as we look to address rural workforce shortages. I will highlight some innovative approaches that help support rural physician training and the training of other health professionals.

To address the doctor shortage in rural areas, the answer is clear: invest in reality-based residency training. It is a proven strategy that has been in place for decades. Unfortunately, the growth of rural training has not kept pace with the growth of GME as a whole. It is estimated that only 2 percent of residency training takes place in rural communities, despite nearly 20 percent of our population living in rural areas.

A common misconception is that rural hospitals cannot participate in GME programs due to lack of interest, infrastructure, volume, or experience, which simply is not true. Efforts to grow training are emerging, with a number of hospitals—ranging from larger full community hospitals with multiple programs to Critical Access Hospitals to even health centers—stepping up to become involved in rural GME.

In 2013, Wisconsin launched a GME development grant program to help fund the launch of new residency programs. One of the first hospitals to take advantage of this opportunity was the SSM Memorial Hospital, which launched the first family medicine program in the State in nearly 20 years. The program has seen amazing success, retaining 50 percent of its graduates within the health-care system. A majority are practicing in rural areas, and 90 percent of graduates remain in the State of Wisconsin. Since launching our State strategy, the total number of rural GME positions has increased. We now have 27 programs, up from 6 programs just a little over 12 years ago.

The success of RRPD is another example of growing interest in the creation of rural GME programs. The program offers startup funding and technical assistance to support residency development. Forty-six new programs have achieved accreditation by ACGME,

translating into 575 additional positions when all the programs reach their full capacity.

With the demonstrated success of expanding GME as a workforce strategy, there is an opportunity to apply these learnings to other health professions. There are countless examples of rural facilities that have recognized this need and worked to grow their own workforce. I will highlight a few initiatives from Wisconsin and Minnesota. A Wisconsin grant program was developed which mirrors our GME grant program that I described earlier. Funding supports site development, and to date over 50 new educational partnerships have been formed, expanding training primarily in rural areas. This approach has also been used in Minnesota. With the Medical Education and Research Costs program, the State uses Medicaid funding to help support the training of not just physicians, but other crucial health professionals. The program supports training of social workers, community health workers, paramedics, dental therapists, and psychologists.

There is also an initiative focused on the training of medical assistants in the State of Wisconsin, looking at ways that we can better meet our underserved workforce needs. Since this type of training can be offered through an apprenticeship model, our health centers statewide have collaborated to develop programs that will share virtual instruction and offer hands-on training at local centers. MA positions are unique, as they provide an entry point to other health careers.

Despite efforts to develop our workforce in rural communities, significant challenges remain. As these issues are complex, I will focus on only a couple of these challenges. First, Medicare funding complexities do create a barrier to expanding GME in rural areas. An example of this is GME funding models for community hospitals and for sole Medicare-Dependent Hospitals, which do not receive full support from Medicare to cover the cost of training. Financial projections estimate that their indirect medical education payments will be reduced for most of these hospitals. Allowing full payments with IME for these hospitals or treating them as nonhospital provider sites in a manner similar to Critical Access Hospitals could be a potential policy solution.

THCGME supports 81 residency programs, including 30 percent of programs that train in rural communities. THCPD is supporting the startup of 93 new programs, expanding its reach even further. One program making an impact is the Marshall University Consortium residency program, which will begin training psychiatry residents later this year. The program will provide services to a rural county in West Virginia without any psychiatrists. There is not a current THCGME funding opportunity for these grantees like Marshall, which is committed to training doctors in rural areas.

Finally, the support of State-level technical assistance and clinical training infrastructure, and Federal grants, should be explored, to help rural facilities expand their training. Assistance and support are needed for rural hospitals.

Thank you for the opportunity to testify today. The future of rural health care depends on our ability to cultivate a strong workforce.

[The prepared statement of Ms. Rodefeld appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Rodefeld.

Welcome to our final guest, Dr. Mueller.

STATEMENT OF KEITH J. MUELLER, Ph.D., GERHARD HARTMAN PROFESSOR OF HEALTH MANAGEMENT AND POLICY; DIRECTOR, RURAL POLICY RESEARCH INSTITUTE (RUPRI); CHAIR, RUPRI HEALTH PANEL; AND DIRECTOR, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, COLLEGE OF PUBLIC HEALTH, UNIVERSITY OF IOWA, IOWA CITY, IA

Dr. MUELLER. Chairman Wyden, Ranking Member Crapo, members of the Finance Committee, thank you for holding this hearing on rural health. Since I last spoke to this committee in 2018, intractable challenges in hospital finance, meeting workforce needs, and addressing leading causes of death in rural communities remain. Yet we have seen the resilience of health providers and organizations, as they rose to meet the challenges of the COVID–19 pandemic, and now keep their focus on improving health for members of their communities.

In my brief formal comments, I will focus on rural hospitals, Medicare Advantage, and Accountable Care Organizations. Rural hospitals are now comprehensive care centers, with a much higher percentage of total activities and revenues tied to outpatient services. Transitioning to institutions that best serve rural residents may require modernizing facilities, investing in new information systems and technologies, and collaborating with community-based organizations to address living conditions related to chronic health problems.

Additional capital investments in information systems, including cybersecurity and in new technology, can stretch capabilities of small hospitals which have operated on very thin total margins and therefore lack reserves for large investments. In a payment environment shifting to the importance of addressing health, rural hospitals and primary care clinics can be advantaged. However, rural hospital administrators and their limited senior staff may lack the experience and data analytics to leverage their position as primary care providers in negotiations. Programs providing technical assistance make a difference for those institutions.

Shifting to Medicare Advantage, the RUPRI Center for Rural Health Policy Analysis, with funding from HRSA's Federal Office of Rural Health Policy, has tracked rural enrollment since October 2000, when a little over 200,000 beneficiaries were enrolled in Medicare+Choice plans. As of March of this year, there are nearly 4.8 million rural beneficiaries enrolled in MA plans, which is 45 percent of all rural beneficiaries. Growth in rural enrollment in many States has been dramatic since 2019, when nationally it was at 29 percent.

What are the consequences of growth in MA plan enrollment? Well, it is a two-sided coin. On one side, as RUPRI has shown in annual reports and periodic policy briefs, there are many more choices now for rural beneficiaries. This includes more widespread availability of additional health benefits, including vision, hearing, fitness, and dental. As of 2022, all are available in more than 90

percent of rural counties. On the other side of the coin, MA plan payment to rural providers is set through contracts, not the pricing system of traditional Medicare. Consequently, strategies private insurance companies use to control spending will apply: claims denial—which can be appealed—prior approval, and variable deductibles and copayments.

This coin metaphor brings to mind the term "managed competition," that in health care there is value to competition, but given compelling objectives of access and equity, some public policy management may be needed.

The number of ACOs grew to 480 in 2024, including 276 low-revenue ACOs. The number of beneficiaries is holding somewhat steady at 10.8 million nationally. There are more than 2,500 participating Rural Health Clinics in ACOs, and 513 Critical Access Hospitals. Rule changes allowing up to 7 years in an upside risk-only model and an advanced investment payment are likely to result in more rural participation. RUPRI has followed ACO development in rural places, and impacts on rural providers, including finding a somewhat positive impact on rural hospital revenues.

The RUPRI Health Panel, supported by the Helmsley Charitable Trust, has written extensively on policy choices since 1993. Based on our products and discussions with my colleagues, I will close with what I characterize as sharp-point concerns in rural health that demand attention.

The first is securing the workforce needed to sustain rural services. A modern patient health team includes community health workers, lay health navigators, behavioral health providers, and of course, medical care providers. All are in short supply and high demand. We need a multipronged approach to meet these needs, from pipeline training programs, to better pay and benefits, to improving workplace environments.

A second sharp point is maintaining essential services in rural communities. As already discussed, this includes OB/GYN. Perinatal and postnatal women must have equitable access to high-quality care. Other essential services include emergency care, primary care, and public health.

Thanks again for this opportunity to discuss critical issues and policy considerations that would strengthen and sustain essential health services in the Nation's rural communities.

[The prepared statement of Dr. Mueller appears in the appendix.]

The CHAIRMAN. Dr. Mueller, thanks very much. Excellent panel.

Let me start with you, Mr. Topchik, and I know that you have spent 20 years in the field, so you have really gotten a sense of now how tough the math is in rural communities. You have to maintain labor and delivery services; you have a low number of births each year, yet you have high costs. And as people sometimes say, you know, the babies do not always decide to arrive between 9 and 5. You have to show up and be there around the clock.

So, what we are trying to do is look at a better way to invest in rural maternal health, without letting hospitals take the money only to leave a maternity desert behind. What is your sense about the direction that we are looking at now, where we could have a fresh approach that really zeroes in on the economic challenges in

these rural communities that I mentioned, and ensures that there would be a bit of extra financial support for the big hospital chains, as long as they do not take the money and run? Is that something that we can work around?

Mr. TOPCHIK. I think there is a robust discussion there, Senator. The tension I see is access, access, access, versus reimbursements and the dollars required. In the case of labor and delivery, I think everybody here is for motherhood and apple pie, and we absolutely need to invest more in motherhood if we are going to sustain it in rural America.

The math is not adding up. We are losing it. The proof is right before our very eyes, so it's very concerning. Health systems play a role in investing in rural communities when very difficult decisions, like the example you gave in Oregon, arise. They are not taken lightly, and it is tough. It is tough for the mothers. It is tough for the community. It is tough for the doctors and hospitals that want to deliver those services.

What they are asking for in return is, can you help us with the reimbursements to maintain this particular vital service, but others as well? It could be chemotherapy; it could be others.

The CHAIRMAN. We will want your input as we go on. You know, the challenge is, it is not as if the rural hospitals and providers are just left to go off and make the sensible decisions that you are talking about. So many of the shots are being called from thousands of miles away in these big chains. And that is why we are going to want your good counsel as we go forward, so that we can take the economic realities of these rural communities and connect them to the fact that often these judgments about whether, particularly these big hospitals, are going to stay there and going to stay there for a significant period of time—those decisions are being made thousands of miles away from the rural communities where you are doing such good work.

And I very much appreciate your leadership. We are going to want to call on you.

Mr. TOPCHIK. Thank you.

The CHAIRMAN. Let me go to you, Mr. Davis. Beyond the fact that I know the community so well and they are doing such good work with nurses, I think people would kind of like to hear the Oregon secret sauce here. How did you manage to stay independent all these years, when everybody, even as we have been talking about, in the neighborhood is getting gobbled up?

You stayed independent in the face of increasing consolidation and ownership by these big corporations. How did you do it?

Mr. DAVIS. You know, that is a great question. It is one I get asked a lot, and honestly, I ask myself that question often as well. You know, when you look at us, it should not be the case. We are one of five independent nongovernmental hospitals left in the State of Oregon; there used to be six. And when you look at the geography that we serve—very isolated frontier in eastern Oregon—we have a lot of things stacked against us.

And there are a couple of things that I think add to the secret sauce. One is, the hospital in La Grande was started in 1907 by four local physicians, and I think whatever they did back in 1907, that culture and that vision that they set forward has carried us

through today. I think there is a grit in eastern Oregon that ties back to the Oregon pioneers. We have just had to figure out ways to solve our own problems.

And typically, when we are asking for help, we are looking for a hand up, not a handout. I think the fact that we are independent—one of the reasons I think we have remained independent is, we have really good governance. We have a local board of trustees that is dedicated, committed to the success of the organization. Our board actually leaves LaGrande once a year and goes to a conference together to learn about emerging trends, emerging innovations, so we can figure out ways to try to bring those back into our local community, so we can, again, take care of our local community.

We are a rare breed in the fact that it is local decisions and local money, and there are some things that have helped us. Strong leadership—we have had two CEOs now in the last 40 years, and my predecessor was there for 35, so I cannot take credit for a lot of that.

But I cannot think—I betcha there are not many large or small hospitals in this country that can say they have had two hospital CEOs in the last 40 years. So, stable leadership certainly matters. Not to say that we are perfect; we make mistakes. But there has been a commitment in leadership to stay and see the vision and see the care through. We have a great team of physicians and staff.

Dr. Hunsaker told me when I first arrived in La Grande that we fight above our weight class here, and to me that is a testament to our medical staff, that they too are committed to drive decisions and challenge administration and find creative ways to provide as much care locally as we can, and that has carried us through.

And then I would say, when you are doing good things, good things happen, and then there is a little bit of luck. But Oregon certainly being a State that was an earlier expansion State for Medicaid certainly helped. And we know the data bears out that the States that did not expand Medicaid—the majority of rural hospitals that are vulnerable to closure in this country are in those States.

So, I think there are a lot of things that Oregon has done right, and then there are a lot of great people in La Grande who have gotten us to where we are today.

The CHAIRMAN. You really are a poster child for the kind of nuts and bolts work we have ahead of us, and we are throwing bouquets to everybody in eastern Oregon. We want to throw some your way, because leadership starts at the top. Good work, and we are going to be calling on you, sir.

Senator Lankford is next.

Senator LANKFORD. Thank you. Thanks to all of our witnesses. I appreciate the work very much.

Mr. Topchik, I want to be able to drill down with you a little bit. You have been at this for 2 decades and getting a chance to be able to research rural hospitals. We were not dealing with the number of rural hospital closures 3 decades ago that we are now. So, what has shifted in those 3 decades, that 3 decades ago we were opening rural hospitals, and now we are closing rural hospitals? What has shifted?

Mr. TOPCHIK. Rural hospitals predominantly rely upon Medicare and Medicaid reimbursements, and as rural hospitals' expenses have continued to climb—especially recently with the inflationary pressures—staffing challenges have continued to grow. New technologies are required to do business today that did not exist 3 decades ago. All of this is very expensive, and the reimbursements have not kept up. I think that is the simple answer. We see declining reimbursements relative to the fixed costs of operations.

Senator LANKFORD. What do those reimbursements need to be for a rural hospital, as far as a percentage increase, to be able to make the math work for them? And I know it is going to be different for different hospitals. I understand the administrative structure, so it is not one-size-fits-all, but what are we talking about?

Mr. TOPCHIK. Right. I think it was this committee, under Senator Baucus's leadership, that recognized this low-volume problem, and we created a cost-based reimbursement system, cost-based plus. And over time—if my consulting peers would suggest that even at the beginning of that program it was probably in the high 90th percentile of the actual costs of running a hospital, today, what we hear is, it is probably more like 90 percent. So, what that difference is and how to make up for that, I think, is something that we would need to look at more carefully. But your question is spot-on. There is a lack of reimbursement, and that gap, it continues to widen, as we have seen.

You know, 10 years ago, Senator, when I was looking at this data, a third of rural hospitals were in the red, and today it is 50 percent.

Senator LANKFORD. Right. So the challenge has been staffing for rural hospitals. That has been significant. There is a new CMS rule that is out right now dealing with staffing for nursing homes, which I think, disproportionately, will hit rural nursing homes as well in staffing. Their solution to increase the quality in nursing homes is just increase the staffing; just hire more people, and to be able to add into it. The challenge that I have is, obviously, if they are going to hire more nurses there at rural nursing homes, they are going to come take them from rural hospitals to be able to get there, to be able to maintain this.

There are a limited number of people who are already there to be able to do it. How do we deal with the staffing issues in rural America, knowing that the DC solution is just, if there is not enough staff, just hire more people. How do we deal with that?

Mr. TOPCHIK. Senator, I appreciate the question. The entire panel was having a discussion in the antechamber just before this about threading that needle and how challenging it is. I think all of us can get behind additional staffing and higher quality of care for our seniors in long-term care.

I am comforted when I look at the final rule, that there were recognitions of rural challenges around being in a health-care professional shortage area to begin with. How can we, if we are in a shortage area, meet these challenges? But I saw then provisions to give a timeline that was extended, as well as waivers in those cases where it is not possible. So, on the one hand, threading the needle, Senator—I like the idea of increased quality of care for my dad, for

example, but I totally understand that the hospitals that I serve, they are now facing an additional burden, and that is the challenge.

Senator LANKFORD. Yes. It is a challenge. When I went through the rule as well, you have 3 years to get there for an urban and 5 years to be able to get there for a rural. I think the challenge is going to be that the urban is going to basically hire as many people as they possibly can, and it puts the rural behind them, even farther behind, because the urban has a faster deadline to be able to get there.

The other challenge is going to be waivers, as you mentioned before. If you request a waiver and get it, you have to publicly display that you have a waiver, that you are operating under a waiver. You have to tell every future family that is considering you, you are operating under a waiver. So, while you could request a waiver, it seems like the first step toward closure, to announce that you have a waiver. Because now you are not going to have families take you up on it, because they are going to go, okay, you are a problem facility, you are operating under a waiver. So it puts a stigma on you right at the beginning, which I think would decline even faster there. So, there are some real challenges on the waiver process that, I think, actually will lead to more rural closures than actually more opportunities there. Time will tell on that, but that is one I am hopeful that CMS will actually take up, and be able to take a harder look at that same issue on this.

For all of you, I would love to be able to sit and visit with you for hours, because we have lots of questions on it. But obviously, there are a lot of us who want to be able to drill down on these issues. Thanks for your testimony and for the time you have been able to put into this. Thank you.

The CHAIRMAN. Important questions, Senator Lankford.

Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman. And first let me say to our acting ranking member, my mom grew up in—was born and raised in Oklahoma and came to Michigan when she married my dad and worked at a rural hospital. She was director of nursing at the hospital where I grew up, and so——

Senator LANKFORD. You are welcome to retire and come to Oklahoma. [Laughter.]

Senator STABENOW. Yes. I keep telling her now, though she is 97 years old, that with 42 years in nursing, she could probably get whatever salary she wanted. So, I grew up around the hospital and around rural health care, and I really appreciate all of your work and what you are doing.

I do want to say, there are so many different fronts we need to work on. Reimbursement is critical, and staffing, and so on. I mean, there is some good news around high-speed Internet access. We are pushing to do that so that everywhere telehealth is available—and there are other things. We had a lot of recent success on creating certified behavioral health centers fully funded under Medicaid, getting those into rural areas. That is positive.

But we have a lot of work to do around what you were talking about today, and in addition to hospitals, I just also want to lift up another area that I have been working a lot on, and that is our

home health care sector, where disproportionately we have seen cuts and cuts, and they fall on small home health agencies.

We have lost more than 1,000 home health agencies so far, despite huge demand for home health. So I am very concerned about what is happening in rural communities for home health as well.

In my position as chair of the Agriculture, Nutrition, and Forestry Committee, I recently introduced a version of the 5-year farm bill, the Rural Prosperity and Food Security Act. I mention this because, important to this hearing, it makes critical investments in rural health by expanding access to capital for rural health-care facilities through the Community Facilities Programs—supporting access to distance learning and telemedicine grants for projects, for behavioral health as well—and we reauthorize something called the Farm and Ranch Stress Assistance Network program related to mental health.

And so, Dr. Mueller, I wanted to ask you. You mentioned the role of USDA's Community Facilities Programs in your testimony in helping rural hospitals invest in meeting the needs of patients. I wonder if you might speak at all to our efforts to extend the loan and grant flexibilities in the Community Facilities Programs, to allow awards to be used more broadly for medical supplies, increasing telehealth capabilities, and meeting staff needs. And could you speak to the impact on rural hospitals and why we need an, I think, all-hands-on-deck approach—not just the Finance Committee, but in every committee that touches on rural health?

Dr. MUELLER. Thank you for the question, Senator Stabenow. As Mr. Davis pointed out, it takes a lot of investment in new technologies to maintain the role of the hospital in the community, and the USDA is vital in doing that with the community programs, as you mentioned.

I think expanding that into different realms of utilization that help with telehealth, in particular, in making that readily available, is important. I think associated with that, USDA, about 2 or 3 years ago now, started up a technical assistance program to help those hospitals that have, as I mentioned in my testimony, very little administrative core staffing and analytic capability, to come in with some technical assistance to help them deal with the new technologies and information systems, with the new technologies in telehealth, and with utilizing their information in negotiation and payment contracting.

I think all of that is important, and it is good to see that USDA in the new farm bill would continue that investment as well.

Senator STABENOW. Thank you.

Just quickly, Mr. Davis, in looking at all the work you are doing in nursing and all of the behavioral health and all of the important areas, in the Affordable Care Act, I authored a demonstration for a graduate nursing education program. We found that it led to a 54-percent increase in advanced practice registered nursing enrollment, and a 67-percent increase in graduation, and we would like to make that permanent. There is a group of us who have put in legislation to make a national graduate nursing education program permanent. I wonder if you might speak to that as a possibility.

Mr. DAVIS. Sure. Yes, I think anything that you can do to stabilize the workforce and create a pathway—instead of extending

some of these avenues—would certainly be advantageous for rural hospitals, because we are constantly—it seems like there is always a cliff. There is something that is being extended, and you are wondering, is it going to be extended, is it going to be extended?

And so, I think making those things permanent would certainly free up some of our time to focus on some of the more mission-critical work that we have in front of us.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague. And so our panel knows, Senator Stabenow has been our leader on these behavioral health issues. So, as we go forward, we are going to have some opportunities. I am not just talking about the lame duck session. We have a lot of health-care work to do. So your testimony, your presence here today, is very timely.

Next is Senator Grassley.

Senator GRASSLEY. Dr. Mueller, we welcome you back to the committee again. We appreciate your insight on rural health care and keeping in touch with us.

Mr. Chairman, I want to say, I share your interest in improving maternal and child health. When I was chairman of this committee, we sought stakeholder feedback to improve maternal health.

I have also introduced the Healthy Moms and Babies Act with Senator Hassan. Our bill seeks to improve the economics of rural labor and delivery units through a health home model, to make sure that we are using modern technology in maternity care and reducing the unacceptable rise of maternal mortality rates. I hope this committee can work in a bipartisan way to advance this common-sense idea.

Now I go to Dr. Mueller. Over 600 rural hospitals benefit from the Casey-Grassley Rural Hospital Support Act. The bill permanently extends the Medicare-Dependent Hospital and Low-Volume Hospital programs. Congress has reauthorized these programs more than seven times. We have other rural hospital Medicare programs that offer flexibility and support for rural hospitals, but those programs have not been made permanent. Why is it important for there to be flexible and targeted rural hospital programs under Medicare, and why should they be made permanent?

Dr. MUELLER. I think it is important to have those programs, as you have heard today in the testimony, particularly from Mr. Davis and Mr. Topchik. The current financial situation for a lot of hospitals across the country, including the 85 Critical Access Hospitals in Iowa, is precarious.

I think the reason to make those programs permanent—again, Mr. Davis's comments were spot-on just a couple of minutes ago when he talked about how you get to a cliff of, oh, what is going to happen now that the program is going to run out in 2 months, and do I need to start preparing for that? You spend valuable, precious management time trying to work through scenarios that you should not have to. You should be able to rely on what the reimbursement rate will be going forward.

I think we also need to continue to work on increased flexibility of how the dollars are used by rural hospitals, so that you can take some revenue streams and convert the revenue from direct patient

care, get that funded appropriately, and have a revenue stream for some of the new administrative tasks and the task of meeting health-care needs in the community through collaborations with community-based organizations.

Senator GRASSLEY. Yes; thank you, Dr. Mueller.

Ms. Rodefeld, CMS is currently distributing 1,200 additional graduate medical education slots. With the 400 slots already distributed, I am very concerned CMS is not meeting the rural and underserved thresholds as required in the 2020 law that I helped pass when I was chairman of this committee.

When I wrote CMS last year, they responded that they are meeting the rural threshold by counting urban hospitals that are reclassified as rural. The agency also cited a lack of rural hospital applications. So my question is, are rural hospitals getting a fair look for additional residency slots, and what can CMS be doing to help rural hospitals apply and be competitive?

Ms. RODEFELD. Thank you for the question. I was part of a team that did an analysis of the round 2 slot distribution, and we are seeing that rural hospitals are not being prioritized for slots because of the issue you mentioned with rural referral centers. The legislation used the language "treated as rural," which does include those nongeographically rural hospitals in the distribution of slots. There are a number of barriers to getting rural hospitals to apply. We have a relatively low number of rural residency programs. I think it was around 150 in 2022. So, when you add in factors like having to have a HPSA designation, then that narrows the pool even further of hospitals that are going to apply.

But I would like to note that we have one geographically rural hospital in Wisconsin, Marshfield Clinic, that has applied in the first two rounds of slot distributions and has not received slots, because CMS prioritizes based on HPSA designation. Other hospitals that do not have a HPSA designation have not applied. I know I had a program director in one of our Wisconsin hospitals with a CMS MEARIS application open just a couple of months ago. He was eager to apply, expand his program, and I had to break it to him that because he was not located in a HPSA, he cannot apply for those slots.

So I think that any future slot distributions should pay attention to whether there is a HPSA designation requirement in order to apply. You know, I think gatekeeping programs that are successful out of this process is kind of unfair. They are still rural hospitals, they are still doing a great job in recruiting residents and retaining them in their communities.

Senator GRASSLEY. I will submit some questions for the record.

The CHAIRMAN. Thank you, Senator Grassley. And I just want to note for our guests and the members, you and I have taken on some big health-care giants over the years. And I think part of this—and I think you had to be out of the room at the time—is how can we respond to the changes, particularly in rural communities, as it relates to health care. And Mr. Topchik and all of our guests have done it, and at the same time say, okay, if you are going to make a commitment to stay and to work with the community, you are not just taking the money and running. And we may be able

to give them some extra help. So, very good to have you here, and I look forward to working with you.

Senator Cassidy?

Senator CASSIDY. Mr. Davis, everybody is familiar with the Change—the UnitedHealth issue, where there was a hack. And speaking to Andrew Witty, the CEO of United, he said that they will update software if any software is more than two generations old. So, if Windows 15 is the latest version, anything older than Windows 13 is replaced.

And exploring this with him, it is my impression though that a lot of rural hospitals would have Windows 5, and I am not blaming them. I am saying when you have thin margins with a lousy payer mix, there is a limit to how much you can put into reinvestment.

So frankly, there may not be the people. If you need somebody onsite to service, then you need to have people living in a rural community to service, or driving there from someplace else. Any thoughts about this? I mean, I was pursuing if this is a point of vulnerability for Change, that we have people billing from places where cybersecurity may not be strong. He assured me that their software would attempt to intercept that, but the point is—you see where I am going with this?

Mr. DAVIS. Yes. It is a great question. You know, I think the reality is that the industry is heavily reliant on technology. And so, we have to keep up, and we really cannot defer upgrading some of our basic infrastructure in terms of computing power, whether it is Windows ME or Windows 1 or Windows 11. Obviously, there is a grace period there when you update and replace. But there is so much technology, whether it is imaging, whether it is nuclear medicine, whether it is cardiac, and we would not be able to render care if we do not have adequate infrastructure——

Senator CASSIDY. So, I understand the infrastructure is necessary.

Mr. DAVIS. Yes.

Senator CASSIDY. Obviously, if you do not have an MRI, you cannot do an MRI.

Mr. DAVIS. Right.

Senator CASSIDY. But you are going to have to bill it no matter what, and now everything is billed electronically.

Mr. DAVIS. Right, right.

Senator CASSIDY. And so, what is the general state, do you know—or perhaps this is a question for Dr. Mueller. What is the general state, do you know, of rural hospital cyber infrastructure? You know, is it like, somebody just resident and all in the thing, or are they in the cloud? Do you see where I am going with this?

Mr. DAVIS. Sure. Yes, well a couple of points. One is, I can tell you that since 2019, our cyber insurance premiums have gone up by 608 percent.

Senator CASSIDY. Okay, but I have limited time. Do you have a sense of—or maybe I will just go to Dr. Mueller. Dr. Mueller, do you have a sense of what is the kind of general state of what we have been speaking of at the average rural hospital?

Dr. MUELLER. Frankly, no. That is something that I will follow up on.

Senator CASSIDY. Okay; thanks.

Now the next thing: Obamacare—and we are going to be revisiting Obamacare next year—expanded Medicaid. But Medicaid, absent of a program like UPL or Disproportionate Share, when I speak to hospitals, frankly it is such a lousy payer they cannot keep the doors open with it. And they use 340B to subsidize. They use other things to subsidize, and I say that because I was just visiting an urban hospital in California, and they were telling me that Medi-Cal pays so poorly that they are worried—and this is an urban hospital system—that Medi-Cal is paying poorly.

So, what advice would you give to us as we look to reauthorizing some of these programs, recognizing that there is the essential nature of an adequate payer mix, and an adequate payment from that mix in order to keep the hospitals open? Mr. Davis?

Mr. DAVIS. Yes. So adequate reimbursement and stable reimbursement are absolutely critical. You know, many rural hospitals have over 60 percent of their payer mix as either Medicare or Medicaid, obviously, with the UPL and Medicaid expansion, 340B, a lot of programs that are meant to help subsidize inadequate reimbursement.

So, anything I think that this committee and Congress can do to pay providers adequate reimbursement for the cost that it takes to render the service——

Senator CASSIDY. Now, the providers and the hospitals do have those subsidies, but the physician typically does not.

Mr. DAVIS. Correct.

Senator CASSIDY. And so, the physician, if she or he is attempting a private practice say, it is going to be sucking wind if you have that kind of payer mix. Mr. Topchik, how would you respond to this?

Mr. TOPCHIK. I would echo Mr. Davis's comments, in that the mix is problematic to begin with. You mentioned two primary government payers that drive rural reimbursements, and they have——

Senator CASSIDY. Medicare and Medicaid drive lower reimbursement?

Mr. TOPCHIK. Yes, and they have eroded, sir——

Senator CASSIDY. Yes, and I think we could add CHIP to that too, because that is usually a Medicaid rate. I am almost out of time. I will yield; thank you.

The CHAIRMAN. Thanks to you.

Senator Johnson is next.

Senator JOHNSON. Thank you, Mr. Chairman.

Ms. Rodefeld, first of all, welcome. It is always nice to have witnesses from our home State. You are familiar with what is happening with the two hospital closures in Chippewa Falls and Eau Claire.

I always like to look back in time. You know, these are hospitals—I met with their representatives—I think they have served the community for over 100 years. I met with these representatives just yesterday, and the description of why they closed is different than what has been provided here. And again, I do not dispute your three main points. But as it was described to me, what happened is, you had private equity-owned hospitals move into the area, pretty well skim off the private-sector patients, leaving these

hospitals with Medicare and Medicaid patients so that, due to low reimbursement, they just simply cannot survive.

Is that an inaccurate assessment in terms of your understanding of what happened there?

Ms. RODEFELD. I think the situation up in the Eau Claire region, it is very tragic, it is very complicated, and I know that there are a lot of ripple effects from that. I know there are private practices that now cannot get privileges at the two health systems that remain in that region. But my understanding is that the hospital that closed in Eau Claire was a safety-net hospital. Reimbursements were a factor in the closure. I do not know that it was the only factor in leading to the closure. Unfortunately, it did lead to the closure of two residency programs, one rural track in Augusta and another in Eau Claire.

So that has been a really significant hit for the workforce in northern Wisconsin as well. So again, really sad to see that hospital closure, because they were meeting a huge need.

Senator JOHNSON. So, there are always multiple factors in just about anything, but again, as the representatives related to me, that was the primary factor right there you know, private-equity hospitals skimming off the private-sector patients and leaving them with government-run health-care reimbursements.

And that is the point. I mean, we need to take a look at this. The model for rural health care/rural hospitals worked for 100 years, up to a point something changed. You know, one thing I have been encouraged by—because this is not just about rural hospitals, this is about rural health care—is the growth in direct primary care operations or clinics. And there are over 2,300 nationally. There are 86 in Wisconsin. I have visited some of them. I will say the health-care providers, the doctors, and nurses, really enjoy it. What happens is, they just opt out of Medicare so they are not subject to all the rules, all the regulations.

They charge really reasonable prices. I think it is somewhere around a $50 to $100 per month subscription fee. I know when I was there a couple of years ago, it was $55 for a half-hour visit. Now, they do not have all the resources. They need hospitals for testing, that type of thing. But some combination of clinics that are kind of outside the system, that are not harmed by the system, are not harmed by all that.

Together let's try and figure out some way to get control of our financing system. But just comment, just in terms of these direct primary care clinics. Are you familiar with them in Wisconsin, and does your hospital system, do they cooperate with these?

Ms. RODEFELD. So, I do not work for a hospital system any longer. But I know—yes, I am familiar with many direct primary care practices, and it does simplify everything, and it is not just Medicare and Medicaid. It is also working with private insurance, the paperwork, preauthorization. There are a lot of things we need to address within health care beyond government payments. You know, the insurance companies also do require a lot of our primary care physicians, whether they are in private practice or not.

Senator JOHNSON. The reason I keep bringing this up is, I want the committee to think outside the box, you know, kind of travel back in time and take a look at, well, it worked then. What has

changed? Maybe the solution is to kind of go back to the way things operated back then, when doctors were independent instead of 80 percent employed, when you did not have all these rules and regulations, where government-run health care did not drive the entire bus in terms of reimbursement rates and just how to practice medicine.

And again, that is where I suggest to the committee members, just take a look at some of these models and think innovatively. Is there some way we can integrate this, because in these hearings we are always hearing that one of the solutions is, we have to increase competition. But then nobody ever talks about how to actually increase competition. It is always about a new government program or a new grant program—and again, I realize free Federal money is great. It just does not solve the problem. I would argue it oftentimes exacerbates the problem.

So anyway, I appreciate you coming here; I appreciate the testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Johnson.

Senator Whitehouse is next.

Senator WHITEHOUSE. Thank you very much, Mr. Chairman. Thank you to the panel for being here.

Dr. Mueller, you talked about ACOs in your testimony, and we are looking at changing the rules for prior authorizations to essentially bar prior authorization requirements with respect to ACOs, as long as the ACOs are operating effectively, unless they go to CMS and get prior authorization to have a prior authorization. Because it strikes me that in the fee-for-service system, there is a danger to the payer of a medical practice trying to run up bills by doing the most expensive treatments and doing additional unnecessary treatments. So one can argue that prior authorization in that fee-for-service environment is a necessary check on the behavior of the provider.

We can argue that, but at least it is a proposition out there. To me, the proposition completely evaporates when you are dealing with an ACO or other value-based care model, where the doctor on the ground making the decisions about the patient's care is just as motivated to not engage in unnecessary and excessive expenditure as the insurer. And I would be interested in your comment on what sense it makes to allow prior authorization requirements for providers operating successfully in the ACO model.

Dr. MUELLER. That is a great point, and I like the way you phrased it in the larger value-based payment arena, in which you are trying to change the incentives for everyone, including the providers, so that they understand if they add an additional procedure that is going to cost more, they will exceed expenditure targets, and they will have to pay back.

So they do have the incentives to keep the utilization down. So I think that is an appropriate way to begin to think about whether we do not need to have prior authorization. That would also create frankly—as a researcher, in my mind I am thinking that would be a great source of data then for us to investigate what happened when you lifted prior authorization as a requirement. Did utiliza-

tion spike up or not, and did appropriate utilization remain in place? I believe it would work.

Senator WHITEHOUSE. Not to mention an inducement and a reward for, particularly primary care practices that go through the ordeal of becoming an ACO and setting up their systems to report that way and change their business model to operate that way. So I hope we can get that done, and I appreciate your thoughts on it.

Mr. Davis, I wanted to ask you about telehealth. We are working on a bill. It is called the TREATS Act, that would extend the ability that we created during the COVID pandemic for patients with opioid disorder to get treatment and prescriptions via telehealth.

It makes perfect sense, seems to have worked very well. It is expiring. Could you comment on whether letting it expire is a good idea, and how the access to telehealth is of particular advantage to patients in rural communities?

Mr. DAVIS. I think anything that we can do to extend the waivers and flexibilities around telehealth would be a godsend, especially, I would say, payment parity. There is a significant pay discrepancy between an in-person visit, versus a telehealth appointment.

I know early on in the pandemic, you probably could have heard a collective sigh of relief when we saw that we were going to be able to get paid the same for a telehealth visit, as well as an in-person visit. And then in terms of behavioral health/substance abuse disorder, absolutely.

There is a shortage of behavioral health specialists across this country. So, leveraging technology—and we have also found that a lot of these patients are more comfortable reaching out and seeking these services when they are able to do it from the comfort of their own home.

Senator WHITEHOUSE. I am really glad to hear you say that, because that is the exact same thing I have heard from the treatment and recovery community in Rhode Island. They did not expect that, Mr. Chairman. They expected that when they got access to telehealth, that would solve the COVID exposure problem and there would perhaps be more utilization of services, which in fact there was, which is a good thing in that environment.

What they did not expect, but what they have told me over and over again they experienced, is that the content of the engagement actually improved, because the patient did not have to drive across town, sit in the stupid waiting room, fill out the stupid clipboard, go into an alien office, and then share what was going on with themselves. They could do it from the comfort and security of their own homes.

So, thank you for bringing that up. Well said.

The CHAIRMAN. Thank you, Senator Whitehouse. And Senator Whitehouse, as usual, is talking about important health-care reforms, and I just want to note—we touched on it a little bit earlier.

When Senator Whitehouse talks about using the COVID model for telemedicine—and Senator Warner knows this—the Senate basically used our model, the Finance Committee's model from the chronic care bill, and plugged it into what we did for COVID.

So, we have a lot of history, and I look forward to hearing more about what you are—you call it TREATS? Great; good name.

Okay. Senator Barrasso is next.

Senator BARRASSO. Thank you, Mr. Chairman.

Dr. Mueller, in Wyoming our medical school works in partnership with the University of Washington, along with Montana, Alaska, Idaho—the WWAMI program. And what we find out is that giving students and residents a rural experience helps them recognize early in their career the benefits of working in rural clinics and hospitals, hopefully then moving there and practicing full-time. I really think it is a great recruitment tool if they have that experience.

So, research shows residents are more than five times more likely to then go on and practice in a rural community if their residencies are in those type of communities. And I see, Ms. Rodefeld, you agreeing completely. I am going to have a question for you soon about OB/GYN in some of these areas.

You know, that is why I have introduced legislation called the Rural Physician Workforce Production Act, to provide additional funds to rural hospitals that train residents. Right now, so much of the funding goes to the large city hospitals, not the rural experience. So, how could a sustainable resident payment model for training in rural areas—and this is political, but it is bipartisan, because whether you are Republican or Democrat, if you are from a State that has a lot of rural areas, you want to get doctors into those areas. So how could a program like this, this model for training in rural areas, actually help training programs be more viable in those locations?

Dr. MUELLER. You hit on it. The answer is part of the question, Senator Barrasso, in that getting that additional funding would put a lot of the rural hospitals sort of over the threshold of being able to implement the program. The next step would be to find a way, through the GME funding streams, to have funds flow directly to those hospitals for those programs, rather than having them flow through a teaching hospital, which then allocates out to the rural hospital. So, the direct expenditure from GME would be very helpful.

Senator BARRASSO. Great.

And, Ms. Rodefeld, could I go next to you? In Wyoming, due to financial strains and workforce shortages, maternity services are closing. You are an expert in this area. Five of our counties have lost maternity services entirely, 7 others have minimal access to care, and this leaves only 11 of our 23 counties with adequate access to OB services.

Now just for reference, every single county in Wyoming is larger than the entire State of Delaware, the entire State of Rhode Island. Some of our counties are larger than Connecticut, larger than the State of New Jersey. So, can you imagine if the entire State of Delaware, or Rhode Island and New Jersey, lost all of their OB services? You know, it would be on the front page of every paper.

So what I would like to talk to you about, as the expert you are, is, how we can address this crisis? It is a matter of health and economic viability for rural America. If you cannot provide opportunities to deliver babies, it is harder to recruit teachers, people in small businesses, all of those things.

You really were successful, I thought, in Wisconsin in crafting that residency program to be a tool to addressing rural access. So,

on the Federal level, can we mirror the access and the success that you have had?

Ms. RODEFELD. Yes. I think maternity care is a huge issue. It is an issue in Wisconsin. I think we have 13 OB units that have closed within the past 11 years. So, we are right up there with you in your State. But I would say that we need to get family medicine residents OB experience and encourage and nurture their interest in performing OB. I will say in smaller hospitals, in smaller settings, it is hard to be a physician of one, providing service to a community. I know how difficult it can be if you want to take a vacation. Who is going to cover? Who is going to deliver your babies for you?

Similarly, there is a dearth of OB/GYN rural residency programs. We have one in Wisconsin. I believe that there are three others across the country. But I think that hope is on the way. I have talked with many hospitals that are looking at creating rural tracks. Section 127 of the Consolidated Appropriations Act does allow for complement increases.

I think it is educating OB programs that this is possible, that you can do a complement increase, have one extra resident and give them 50 percent of training time in a rural area, which we know leads to future rural practice. But again, it is not a one-size-fits-all approach.

We have also launched two OB fellowships in Wisconsin, but that has been a long time in the works, and it is not going to get us exactly where we need. But we need to support those physicians who have an interest in OB and provide some mentorship, because I think one barrier I have seen with new grads from any OB program is that, if they are the only provider in a hospital, that is very scary if you are not as experienced.

Senator BARRASSO. Final question, for Mr. Davis. Good to see you again; welcome to Washington. You went to County, where you were in Evanston. I was there for the health fair many times in Evanston as well. You went to the county health fair in Bridger Valley just 2 weeks ago. So, I am there in the community a lot.

As you know, rural hospitals and clinics across the country are closing at a higher rate than urban hospitals. Patients are forced to travel greater distances. You know, I think that telehealth has helped, but how else can we strengthen rural care so patients are not forced to drive hours for care?

Mr. DAVIS. Yes. So you hit the nail on the head. Obviously, expanding telehealth and making some of the flexibilities we have, making those permanent, would be a huge help. Again, I think recruitment incentives would be very helpful.

Many of these providers have significant student loan debt—and I heard HPSA scores were brought up, having that reevaluated. And then, just adequate reimbursement. We have seen significant increases in wages and compensation to keep up, to attract, and it is a challenge. So reimbursement would be a big help.

Senator BARRASSO. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Barrasso, and you hit the key question, which is, how we can find new ways to create incentives to strengthen these rural communities? We will want to talk with you.

Okay. Senator Bennet is next.

Senator BENNET. Thank you, Mr. Chairman. Thank you all for being here today.

When you get toward the end of the dais, some of your questions have been asked already. But I hope that this one has not. In Colorado and across the country, we are seeing entire swaths of rural counties that have no obstetrics care of any kind, no mental health care of any kind. People coming out of COVID have used telehealth, I think, in ways that have been useful. But it does not replace having people in your community doing this.

Increasingly, Ms. Rodefeld, a barrier in Colorado seems to be housing, places where people just cannot afford to live in rural parts of the State. Providers are becoming housing deliverers, because otherwise there is no housing for them in places like the San Luis Valley in Colorado, which used to be competitive.

Alamosa, CO—it was an advantage that real estate was inexpensive there. Today, they are having a hard time hiring doctors, to say nothing of something like the Roaring Fork Valley between Aspen and Glenwood Springs, where people commonly say to me that no doctor can afford to live there.

So if you could say a word about that, I would really appreciate it.

Ms. RODEFELD. Yes. We are absolutely seeing the issues with housing, and that does not just impact physicians and nurses. It also impacts the ability of rural residencies to train and recruit their graduates.

I will say, the rural hospital that I worked in prior to coming into my position did own several houses and did explore ways that they could build their own housing for their workforce. I think any innovation where you can provide some type of affordable housing, especially for those lower-wage positions like medical assistants and the folks who work in the cafeteria—they need affordable housing as well. And I am impressed when I work with rural hospitals launching residency programs. So, they have been very successful in fundraising. In fact, one of the grantees that I work with has actually been able to secure private funding to be able to purchase houses for the new residents coming to their hospital, and that is a huge relief for those incoming residents when they can know they have a place to live and they do not have to search for a home.

And I think, looking at other creative strategies—I don't know if Dr. Mueller is familiar with anything with USDA, but any infrastructure development that rural hospitals could use to further build housing for their workforce could be helpful.

Senator BENNET. I have a couple of minutes. So, Dr. Mueller, would you like to use some of that? And I think, Mr. Davis, you may have some experience building housing for teachers. So, it would be good for us to hear that too.

Dr. MUELLER. I think that was a great summary. I would just add two things to that.

One is, there has been some creative use of Medicaid waivers around the country to be able to use some of the Federal match in Medicaid to address housing issues, predominantly because when patients are discharged from hospitals, if they are discharged into a homeless status, then they are right back in the hospital later.

So, using some of our payment through the health payment system to address that is useful.

The other comment is, whatever the investment sources might be—and USDA is one, through their programs; Housing and Urban Development is one—State governments and philanthropy are all stepping up to the plate in isolated examples that I am aware of around the country. We can learn from those, try to expand that to more communities.

Mr. DAVIS. You know, when I got into health care administration, I never thought I would be managing houses, and I think we have 10 or more leases. And one of the things that I think is a really neat public-private partnership with the local school district is—they noted there was a shortage of tradespeople who do this type of work, so they developed a CTE program. We had a need for workforce housing, so we agreed to buy those initial sets of townhomes so they have the reassurance that those are going to be sold, and they could use that funding to then perpetuate that program.

So we view it as a community benefit, as we get an intrinsic value out of it for our workforce, but it also is investing in these young kids and hopefully creating a pipeline that helps housing construction accelerate in the community in the future.

Senator BENNET. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague. Next is Senator Carper. We also have a vote on, and I think that we can get to all of the people here today before we see the vote close. We will have to see who else arrives. But that is going to be the goal.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman.

Welcome. I think I had the chance to shake your hands and welcome you here earlier this morning. So we are glad you are sticking around and that we have a chance to ask you some questions.

In 2020, in response to the COVID–19 pandemic, CMS implemented what they called the Acute Hospital Care at Home waiver program. You may be familiar with that. The program permits Medicare beneficiaries to receive hospital-level services in the comfort of their own home, which is really what people prefer to do, as you probably know. For now, patients and providers continue to access the Hospital at Home program. Last Congress, Senator Tim Scott and I championed legislation that extended the Hospital at Home program waiver for 2 years beyond the duration of the COVID–19 public health emergency.

Since then, this health care delivery system has not only benefited patients by making hospital-level care more accessible, it has also been shown to do a number of things that we all should seek, and one of those is reduce cost. Another is to improve patient outcomes, and a third is to provide high patient satisfaction. That is like a hat trick.

Today, hospitals and health-care systems across, I think 36 or 37 States, including my own home State of Delaware, utilize the Hospital at Home program to provide safe, high-quality hospital-level services in patient's homes. Currently, the Hospital at Home program is set to expire in this country at the end of this year.

I just believe, and Senator Scott believes, that we cannot allow this to happen. To ensure that Medicare beneficiaries and their health-care providers have the certainty and stability that they need for this important care delivery option, this week Senator Tim Scott and I introduced the Hospital Inpatient Service Modernization Act of 2024. The bipartisan legislation would further extend the Hospital at Home waiver program for another 5 years. As rural communities face an abundance of access and quality-of-care issues, alternative care delivery models like Hospital at Home hold the potential to improve health-care delivery in rural communities.

Question for Mr. Topchik. I always liked Mr. Topchik; love that name. And could you please share with us how the Hospital at Home program has been beneficial to patients in rural areas, please?

Mr. TOPCHIK. Senator, thanks for that and all your work on the issue of Hospital at Home. I think it is an innovative model, and it is proving out across the country. This movement to provide a relief valve in the provision of high-quality care at lower costs, and keeping patients at home is so, I think, valuable to the patients. And in rural areas that is such a challenge, keeping patients home instead of traveling great distances.

I think the tension here in rural areas is workforce, and it is the volume and the scale. But I know there are experiments going on right now with rural Hospital at Home programs, and I really look forward to seeing how they play out.

Senator CARPER. I am going to ask you another question for the record, and that is: how do we as policymakers address these barriers, including workforce? I think it is important. I will ask you to respond for the record.

Mr. TOPCHIK. I am sorry, how do we directly——

Senator CARPER. No, no. We will ask you to respond for the record in writing, okay?

Mr. TOPCHIK. Okay; thank you.

Senator CARPER. Okay. We will follow up. Yes, there you go.

When I visit health-care facilities up and down Delaware, I ask three questions, and I do it every day. We go home—we will finish up here later today—I will go home tomorrow, be all over the State. I visit businesses large and small, and I ask them three questions: how are you doing, how are we doing—our congressional delegation, the Congress, and so forth—and what can we do to help?

The biggest challenge I hear about consistently now for, not just weeks, months, but for years, has been workforce—you know, having people show up for work who are either trained or trainable, and who are willing and ready to do a day's work.

But the challenge is amplified in the more rural counties. We have two rural counties, and we have three counties in Delaware. The southern-most county is a very rural county. We have that challenge throughout the health-care industry. Two of Delaware's three counties are considered Health Professional Shortage Areas. We simply do not have enough health-care providers choosing to practice in these rural communities. It is critical that our rural communities are able to recruit and retain a qualified workforce to ensure patients have access to high-quality care.

I have one last question, and, Mr. Davis, this would be for you, please. What are you learning from the health-care facilities that are doing well at recruiting and retaining staff? What did you learn from those? I always say, "Find out what works; do more of that."

Mr. DAVIS. I think, in terms of workforce training, doing good onboarding training programs. We do a lot of leadership development. Our strategic plan that we just adopted—we are going to be investing a lot in our middle management to kind of grow our own.

At one point, we had 220 open positions during the pandemic. So we were kind of up against the ropes, and thank goodness for our workforce and our staff. We have clawed back, and now we are back to about 60 open positions, which is kind of pre-pandemic. It is just continuing to create a culture and an organization that people want to be a part of.

The CHAIRMAN. As much as I agree with Senator Carper, we are going to have to move on to get everybody in.

Senator Warner?

Senator CARPER. Thanks to you all.

Senator WARNER. Thank you, Mr. Chairman. I want to echo what Senator Bennet said. Sometimes when you are at the end of the dais, your questions have been asked.

I do want to mention the fact that I thought Senator Whitehouse was doing such a good job on telehealth, in raising the important issue of what telehealth actually did with opioid abuse, and the notion that we can use this tool in a dramatic way, and for things like Suboxone, and there were no abuses. I said, "Boy, how is he so smart?" My staff said, "Well actually, you and he are working together as coleads on that bill." So, I was glad to be informed that we were jointly smart.

In that same context there, Senator Barrasso's comments about the lack of OB/GYNs—I mean, in my State, in the Commonwealth of Virginia, we have the area between Richmond and the North Carolina border, it is called Southside. We have had five OB/GYN practices leave hospitals, and we have a wide swath—maybe not as big as New Jersey—but a wide swath of our State where people literally have to travel hours and hours. That is why, Mr. Chairman, I am glad that you and I and others are going to introduce the labor and delivery support, to try to increase the Medicaid reimbursement issue.

I think one question that maybe has not been asked—and this is for Dr. Mueller—is the question around pharmacy services. Again, one of the things that we saw during COVID was better utilization by pharmacies of things like COVID tests, tests for flu, for strep. And in Virginia, we had been pretty good about trying to look at the evolving nature of pharmaceutical services, and the fact that pharmacists are now providing a lot of services that people used to have to go to either an actual provider or an urgent care center for.

The thing is, we have worked on employer plans. We have worked on Medicaid, but those Virginians on Medicare cannot get the reimbursement through their pharmacy. Dr. Mueller, do you want to make a comment on that?

Dr. MUELLER. I think you are correct that that set of services is critical and available in a lot of rural communities only through the pharmacy, as you point out. And we did some early work during the pandemic to call attention to that, when it came to distribution of vaccines. The only way to get that out across all of rural America was to get it out through the local independent pharmacies.

So, everything that we do in reimbursement policy, including Medicare, the gap that you mentioned, is something that we need to pay attention to, to keep that vital service there and to point out finally that the pharmacy service is part of the health team, and to think of it that way rather than only, well, that it is just dispensing drugs. No; there is a lot more to the local pharmacy services.

Senator WARNER. Yes, I think there is. Again, a lesson learned from COVID that we ought to continue. And if we have employers, if States are using the Medicaid plans, I hope we can work on that reimbursement on Medicare.

I want to raise—we are in a hurry, so I will stick with you, Dr. Mueller, on this. Something that I think has been indirectly talked about a lot is how we make sure we keep rural hospitals alive and vibrant. I was proud that we—in Virginia we were actually, after 6 years, able to reopen one of our most rural hospitals in far southwest Virginia, Lee Hospital.

But working with my colleague Senator Blackburn, we have introduced, for a number of years, what we call the Save America's Rural Hospitals Act, which would try to go ahead and look at the average wage index and bump it up to a base minimum across rural communities.

I think what we have seen, particularly from MedPAC, is that we have carved out some of the exemptions in that formula, and I would just really question whether it is working. From the rural hospital standpoint—and before Senator Blackburn, I worked with Senator Lamar Alexander on this. Our rural hospitals have to have that minimum floor, or they are not going to be able to compete.

But maybe we should just go ahead and look at this whole tool, which frankly, in many ways I think has been so chopped up and carved out that it does not meet basic needs. I know the whole panel would like to weigh in, but I am going to stick with you, Dr. Mueller, to try to make sure that I adhere to the chairman's 5-minute rule.

Dr. MUELLER. Quick answer: yes, we should be looking at the wage index issue with what you have in mind. Are we doing it the right way? And then second, why are we doing it? Why are we saying that there is such variability in that when we are hearing about the cost of workforce recruitment and retention?

Senator WARNER. And, Mr. Chairman, I am more than willing to waive back my remaining 11 seconds so Senator Hassan, who has been so patient, gets her—or whoever is next.

The CHAIRMAN. Collegial as always. Thank you, Senator Warner.

Next is Senator Blackburn, but we are going to get everybody here in, and we will see if anybody comes in and tries to juggle it. But thanks for being so helpful.

Senator Blackburn?

Senator BLACKBURN. Yes: thank you so much. And I am going to pick up right where Senator Warner left off, because several years ago, I developed what is the rural health agenda. It was important for my State of Tennessee—and Senator Durbin and I have worked together on workforce, and have legislation that would beef up that workforce.

As you mentioned earlier, Ms. Rodefeld, getting people to work in a rural area—so, if you do this for a period of 5 years, then your student loans would be forgiven tax-free. And so, Senator Durbin and I are working on that. Senator Hickenlooper and I are working on innovative delivery models, so that you carry that access into the rural areas. And Senator Warner—he and I have worked on this area wage index. You know, having these differentiations made sense in 1968. They do not make sense today. Health-care delivery is technology.

I am reminded of this as I go through my community every day, with health-care innovators that are there in Nashville. I do want to talk—let's see. Mr. Davis, let me talk with you about telehealth, because this is something—when I was in the House, we worked on telehealth.

We have seen tremendous promise with this. I think we have 90 percent of the health-care centers now offering this, and of course we decoupled it from the emergency health order. Permanency is going to be important. Stopping this thing of having to go back and reauthorize is going to be important too.

But the disparity in the reimbursements—our rural centers are getting $95 for a telehealth visit. Urban and in-person visits are $195. Now, we know this is expanding. I recently went through the technology, that is, the doctor is a hologram. It is in the box, it is in the room with the patient. So that is the next evolution of this.

So talk to me about the difference in reimbursement rates from the telehealth to the in-person, the way you get better compliance with adding in the telehealth, and the difference that makes for people in rural areas?

Mr. DAVIS. Sure. That is a great question, and I think you kind of bring up a great point. I think we are at an inflection point in this country where we had been advancing telehealth, and then the pandemic hit, and we really saw a lot of providers and patients who actually learned to love it. Where they were really reluctant to use it prior to that, now they do not want to go back.

They see it as a great tool to improve access, and really for some of those patients who are really hard to get in—they have transportation issues, they have mobility challenges, they are busy; maybe they are working professionals.

So to be able to leverage technology is huge, but there is a misaligned incentive whereby these Rural Health Clinics and FQHCs, we do not get the equal payment. And so, it is to our advantage for those who run these clinics to prioritize and prefer and almost push these patients to come in for a visit.

And so absolutely, anything that we can do to increase that payment parity. You know for us, we have a couple of Rural Health Clinics, and we have to carve out any space in the building that is being used for telemedicine. We cannot recoup those costs. And to me it should not matter whether we are rendering that service

via camera or by microphone, or whether in person. We are taking care of rural Americans, and therefore the payment should be on par.

Senator BLACKBURN. Well, I agree with that. And the area wage index—I want to add just one more thing on this and the work that Senator Warner and I are doing, trying to establish that floor and get it at an 85-percent floor, because technology is where it is now, and we have to make certain that you preserve that access to care in these rural areas. Unless we address this wage index, we are not going to be able to guarantee that.

I will yield back my 19 seconds, Mr. Chairman.

The CHAIRMAN. More collegiality. Thank you, Senator Blackburn.

Senator Hassan, you are next.

Senator HASSAN. Well, thank you very much, Mr. Chair, and to you and the ranking member for this hearing. To the witnesses, thank you for being here, but also for the work you do. And I want to add on to the line of questions about maternity and obstetric care.

I recently toured the birthing unit at Speare Memorial Hospital in Plymouth, NH. It is the only birthing unit left in that area of the State. Eleven maternity wards have closed in New Hampshire in the last 2 decades. The average time now to get to a birthing unit in New Hampshire is about 40 minutes, and when you add bad weather and mountains to that, it can be pretty dicey.

So, the situation in rural New Hampshire is certainly not unique, as we have heard from this dais this morning. Since 2011, around one in four, or more than 260 rural hospitals, have shut down their obstetric services.

Mr. Davis, this is a question for you. We have talked about how we can make sure there are obstetric services available, but what I am concerned about specifically is, how do we make sure that all hospitals are ready to provide urgent obstetric care such as labor and delivery, even if they do not have an obstetrics unit but somebody appears at the emergency room?

Mr. DAVIS. Yes. Well, it is a great question because, when you think about health care, you have pre-hospital, you have acute, and then you have post-discharge and post-acute. And given the maternal crisis we have in the country, we have to think upstream. We have to make sure that EMS, certainly the emergency room, can be a safety net.

But they are not doing deliveries every day, and so adequate training, adequate equipment—I know in the case of Grande Ronde Hospital, when we learned that the nearby hospital in Baker City was closing their maternity program, I was really proud of our emergency department and our OB providers. One of our ER docs serves as the medical director, and so he went out and did some refresher courses with EMS, and then the same with our OB/GYNs.

And your case in point, I actually just learned recently, in the last month and a half, that there was a mother in Baker County who—of course, I think it was late at night, you know, all times of day—did not make it to the hospital, and ended up delivering in her car in a canyon.

Senator HASSAN. Right; yes.

Mr. DAVIS. And luckily it was this time of year instead of December or November or January. And so that pre-hospital preparation for EMS is going to be absolutely critical.

Senator HASSAN. Absolutely. And I just want to make the chair and my colleagues aware that Senator Britt and I have the Rural Obstetrics Readiness Act, with Senator Collins and Senator Smith, that will help rural health-care facilities train their staff, purchase equipment. And then one of the other things we are looking at is a nationwide telehealth service, so that if you are dealing with an obstetric emergency in an emergency room, you can hook in 24–7 to an obstetric expert who can guide you through that particular emergency.

Mr. Topchik, as we have heard today, Medicaid covers nearly half of our rural births across the country. It covers prenatal visits and labor and delivery, but providers often cannot get reimbursement for the time they need to spend coordinating care, such as developing a care plan for a pregnant woman or coordinating with community resources to get her the support that she needs. How can we help doctors and hospitals provide the consistent coordinated services that women need to stay healthy during and following pregnancy?

Mr. TOPCHIK. Right. You know, from prenatal care through birth and post-natal care, we need to support mothers and their children, and the biggest payer of that in this country is Medicaid. This body has done a great deal of work with seniors through the Medicare program. Medicaid of course being a Federal-State partnership, it is a little bit more challenging, but I think similar types of investments are going to be needed to be made in order to sustain what is an eroding aspect of the American health safety net, which is maternal care.

Senator HASSAN. Well, I appreciate that. And, Mr. Chair, I know that this is an area of great interest for you. Senator Grassley and I have the Healthy Moms and Babies Act—and I know Senator Grassley has mentioned it—which would create an option for States to reimburse for highly coordinated maternal health care. So I hope it is something we can consider as we are moving forward on this topic.

The CHAIRMAN. We will. We will definitely be interested in working with you.

Senator HASSAN. Okay. And I will not ask this question, because I think it will elicit a long answer, except I will ask it for the record later on. But I am working on, obviously, site neutrality as an issue in our health-care system. As we work on that, we also have to make sure rural hospitals are appropriately reimbursed.

And so, I will look forward to submitting that question for the record as well. Thank you.

The CHAIRMAN. Great; very good.

Senator Cortez Masto is next.

Senator CORTEZ MASTO. Thank you, Mr. Chairman. Thank you also to the panel for being here.

I have been focused on, in my State of Nevada, expanding opportunities for health-care providers to train there, because we know once they train, they usually remain, and that is a key, I think, for many of us. And that is why I have been part of a bipartisan work-

ing group with my colleagues here on the committee to advance additional Medicare graduate medical education proposals, and you all are very familiar with that.

Congress recently approved Medicare-supported residency positions and specified that these slots should go to hospitals serving Health Professional Shortage Areas, HPSA. I support this policy because in Nevada, all 17 of our counties—all 17 of our counties—are designated shortage areas. However, listening to the testimony today, you have highlighted that some rural hospitals in Wisconsin have not applied for slots because they do not have that designation.

My aim is to make sure that these new slots are allocated to the areas where there is the greatest need. So I guess, Ms. Rodefeld, my question to you is, you talked a little bit about why rural areas in Wisconsin lack HPSA designation, despite experiencing this health-care workforce shortage. Do you believe we need to clarify current law regarding the GME allocation formula to better identify and support our rural communities with those critical health-care needs?

Ms. RODEFELD. Yes, that is a great question. And I think as you look at, again, the relatively small pool of rural hospitals that host GME, and then those that are located in a HPSA area, it is going to be even smaller.

I would say in Wisconsin, we actually have four hospitals that are looking to expand their rural programs that are training not only for their local community, but what I have seen time and time again is, when they are full, they feed the nearby counties that are HPSAs. So again, while you may not have a residency program located in a HPSA, they may be attracting those residents, because all the data shows residents typically stay within 100 miles of where they do their training.

And if they cannot stay in that HPSA, they will go to the neighboring county. I have seen—right now we are at about 70-percent retention of residents in-state. And again, we have done a lot of really great work to partner together to meet our workforce needs in the State. But I think, looking at prioritizing HPSAs in site distribution—absolutely, hospitals with HPSA should get slots first.

But if there are remaining slots, we could look at those residency programs in rural hospitals that are doing great work and allow them to expand as well.

Senator CORTEZ MASTO. Okay. Thank you. That is helpful.

And, Dr. Mueller, sole community hospitals—Nevada has two of them—sole community hospitals and Medicare-Dependent Hospitals are well-positioned to host the residency programs. However, those compensated based on their hospital-specific rate face financial constraints due to a lack of independent medical education adjustment, leading to inadequate financial support for training programs for Medicare.

In contrast, sole community and Medicare-Dependent Hospitals paid under the Federal rate receive both direct medical education and indirect medical education payments when starting teaching programs. So, Dr. Mueller, my question to you is, do you believe that sole community and Medicare-Dependent Hospitals, which ac-

tually represent 80 percent of eligible rural training hospitals, should receive fair incentives for teaching programs?

Dr. MUELLER. Yes. That is a fairly easy answer.

Senator CORTEZ MASTO. And can I ask, would addressing this Medicare payment gap contribute to securing the workforce needed to sustain these rural service areas?

Dr. MUELLER. It would certainly be very helpful. You know, we are always hesitant to say a single lever is going to change a lot of behavior. But it seems like it would be a necessary and, in many cases, sufficient condition, yes, to get them to change.

Senator CORTEZ MASTO. Good. Thank you, because I agree with you 100 percent.

And then finally, let me just say to the panelists, telehealth is a game changer. We all know that, particularly in our rural communities and our frontier communities across this country, including in Nevada.

I am curious though. Which specific Medicare telehealth flexibilities do you believe are most essential for addressing the healthcare needs of rural communities? We talked a little bit about payment parity. Are there other things that we should bring to the attention of this committee, to make sure that we are prioritizing or making permanent, when it comes to telehealth services?

Mr. DAVIS. I can take that one. So, a couple that I wrote down just in case. There should be no geographic restriction from originating site for nonbehavioral health, mental health, or telehealth services. Some nonbehavioral health can be delivered using audio-only communication platforms.

And then the big one is, an in-person visit within 6 months of the initial behavioral health/mental telehealth visit, and annually thereafter, is not required. So there are just some little, I think, tweaks that can be done that would make this much more efficient.

Senator CORTEZ MASTO. Thank you, and I know my time is up. Audio-only—is that something you would support?

Mr. DAVIS. Well, given that many of the rural communities cannot meet the broadband requirements at this point, then, yes—and we want to get to video.

Senator CORTEZ MASTO. Yes; thank you. That is the answer I wanted. Thank you so much.

Thank you, Mr. Chair.

The CHAIRMAN. The Senator from Nevada and I both know when to quit while we are ahead. And well said; thank you.

The chair of the the Health Care Subcommittee, an expert on these issues, is here: Senator Cardin.

Senator CARDIN. Thank you, Mr. Chairman, and thank you for holding the full committee hearing in regards to rural health care. The subcommittee has been actively engaged in this issue, and this hearing very much helps us in filling in some of the additional information for us to adjust policies to deal with the gaps we have in rural America.

I represent the State of Maryland. Most people think the State of Maryland is a pretty urban State. We have rural communities that have challenges with access to health care. In the western part of our State, the eastern part of our State, it can be a challenge to be able to get access to health care.

I know there has been a good deal of discussion on two areas that have been extremely important in our State. Telehealth has been a real game changer. I've been to Pocomoke City on the Eastern Shore of Maryland, seeing the direct benefits of telehealth in being able to get health-care needs met. And we invested a long time ago in broadband, so that most of our communities now have access to high-speed Internet. So we have been able to put in the infrastructure for rural Maryland that has helped us a great deal to deal with these challenges.

But there are at least two areas where we find a real challenge. One more thing about Maryland: Maryland has a Total Cost of Care model, the only one in the country, where we have an all-payer rate structure. So, we can use our rate structure to provide equities to rural hospitals that would otherwise be at a disadvantage because of the volume that is in these facilities, compared to our urban centers.

But there are two areas that we find challenging that I would like to get your comments on. They are both related, and one is preventive health care, which many times requires a person to travel in order to have the follow-up necessary for the preventive health-care services, and that can be a challenge in rural America. The second is oral health care. Oral health care has been an area of particular concern to us in Maryland. I mention this frequently.

When I came to the Senate in 2007, we had the tragic loss of Deamonte Driver because he could not get access to health care. All he needed was a simple extraction. It did not get treated. His mother tried, could not get access. There were no facilities available. In the rural parts of our State, the rural parts of our country, it is not as easy to get access to oral health care. At times, we do not think that is quite as important, and it is critically important for rural health care.

So, can you tell us what strategies have worked in rural America, what we can do better to be able to put a priority on access to oral health care, particularly for our children—which is now a covered service under all of our health-care plans—but also for the adult population, as well as how we can better serve in dealing with the extraordinary technologies that have developed in detecting diseases early, which are not always available as easily to people who live in rural America?

Who wants to take a stab at that? Everybody is volunteering. I appreciate that very much. I will call on you then. Dr. Mueller, you are up first.

Dr. MUELLER. Okay.

Senator CARDIN. You give short answers. That's why I'd like to call you first. [Laughter.]

Dr. MUELLER. The true answer is, I think a comprehensive health team—which I mentioned in my oral testimony—has to include preventive health services and oral health care. Once we establish that as part of the health team, I think we will start dedicating more resources to figuring out how we get that everywhere, where we are saying that we are serving populations.

And the answer for that in rural is some combination of telehealth, where we can use it, but different levels of professional

services with preventive care. What can we utilize? We talked about pharmacy earlier. How can pharmacies play a role in that?

In oral health care, how can we utilize dental hygienists as effectively as possible, and how do we utilize oral health clinics that can be mobile and serve multiple communities, rather than thinking we have to have one in each community?

Senator CARDIN. Ms. Rodefeld, I see you are in the GME issue. One of our areas that we have been able to expand is the qualified health centers to include oral health care, and have them located in rural communities, not just in the urban centers.

A lot of that deals with having the personnel. So how do you incentivize getting the medical personnel in rural communities through the graduate medical programs?

Ms. RODEFELD. Yes. I think that there are a couple of initiatives. One is, the family medicine residency programs have a Smiles for Life curriculum, and trying to get them to approve that and implement that is a big approach, because primary care can make referrals to dental.

I have been involved with efforts with teaching health centers, and we have a number of teaching health center planning and development grantees that are dental. But even if they are located in an urban area, a lot of them have mobile units. And actually I was, just a few weeks ago, at a NAC conference where they were talking about ways that they could get their dental residents out into rural communities with mobile units—so, very similar to what Dr. Mueller just shared. But I think supporting any incentives to get dental residents or even dental students into rural communities is a great strategy to help address some of these issues we are seeing.

Senator CARDIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I would just say, to our friends and people following this, Senator Cardin has been the go-to person in the Senate—using his chairmanship on this Subcommittee on Health Care—for oral health care. I so appreciate it, and we are going to have to find a way to fill his big shoes, and it will not be easy.

Senator Warren?

Senator WARREN. Thank you, Mr. Chairman.

Rural health-care providers face a slew of challenges—low patient volumes, high operating costs, staffing shortages—and this threatens health-care access and quality of care for millions of people in rural communities. In April, CMS took a big step to improve quality of care in nursing homes by putting in place minimum staffing standards, including ensuring that facilities have a registered nurse on duty 24–7.

Mr. Topchik, you are an expert on rural health care needs. So can you tell us, what will this new staffing rule mean for quality of care, particularly at nursing homes in rural communities?

Mr. TOPCHIK. Senator, I appreciate the question. I was just evaluating nursing homes a couple of months ago for my father, and was shocked to learn that there was not a nurse on staff 24 hours a day. So, the idea of elevating staffing requirements to better serve our seniors, to provide higher-quality care, thrills me.

I do note the tension that the committee noted in the final rule by referencing the challenges rural faces and by offering a 5-year ramp-in to meet those challenges, as well as a variety of opportunities for waivers, if they happen to be in a Health Professional Shortage Area. So, I appreciate that.

Senator WARREN. Good; thank you. You know, I think this is a good rule that is going to help millions of nursing home residents, and it is made even stronger by the fact that CMS listened and they addressed the concerns of rural nursing home providers. I think that is an important part of it.

Fortunately, CMS also had the good sense to ignore the biggest nursing home companies' claims that they cannot afford to increase staff. Last week, I wrote to three of the biggest publicly traded nursing homes about a new analysis that my office did, that found that these homes had paid out over $600 million in stock buybacks, dividends, and CEO pay since 2018, which sounds to me like they actually have the resources to implement this rule.

Mr. Chairman, I would like to make those letters part of the hearing record.

The CHAIRMAN. I am looking forward to reading them; so ordered.

[The letters appear in the appendix beginning on p. 97.]

Senator WARREN. Okay; good.

So now I want to talk about another health-care challenge facing rural communities. In just the past decade, over 160 rural hospitals have closed, while over half of all rural hospitals are currently operating in the red. Rural hospital operators have identified the same program as the biggest hospitals have. Their threat to survival is Medicare Advantage, or MA, which allows private health insurance companies to administer Medicare coverage for over 31 million Americans.

Mr. Topchik, do you agree that Medicare Advantage is the biggest threat to rural hospitals?

Mr. TOPCHIK. Senator, I work with hundreds of rural health executives who tell me that it is keeping them up at night. It is one of their single biggest concerns, and I asked them about this. And what they tell me is, they cite a more challenging environment with preauthorizations. They cite differing net reimbursements, especially around the critical swing bed program with Critical Access Hospitals. They cite higher rates of denials and delays in reimbursements, and they tell me they're falling behind.

Senator WARREN. All right. So basically, they delay payments, they deny payments, which boosts profits for Medicare Advantage and leaves our rural hospitals in the red. Private insurers in Medicare Advantage are routinely delaying and denying payment to providers, and they make it increasingly difficult for rural hospitals to get reimbursed.

For example, in 2022, an investigation by the Health and Human Services Inspector General found that nearly one in five payment denials by insurers in Medicare Advantage violated Medicare coverage rules—one in five. And this is particularly devastating for rural hospitals, which rely more on public payers like Medicare.

So that is why I have called on CMS to aggressively increase its audits of private insurers in Medicare Advantage, and to terminate

contracts with those wildly profitable corporations when they are in violation of Medicare law. It is past time that we protect taxpayer dollars and at the same time ensure that rural hospitals can stay open for the millions of seniors who rely on them. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague, and I just want to say, as we have talked about before, I think that the Senator is right, that we need additional audits as it relates to Medicare Advantage. I am very supportive of it.

Okay. To our guests, thank you for giving us this kind of on-the-ground assessment of what is going on in rural health in America. Mr. Davis, I think you really gave us a chance to kick this off. It was the Oregon way especially, but what you said, and I wrote it down exactly, is in rural health, you know, communities are looking for a hand up and not a handout, and that is what we are kind of going to build on.

I think everybody heard us discuss the fact that the committee feels strongly that we have been able to take some steps to be helpful in rural areas. The telehealth model came from the CHRONIC Care Act that was written in this room—in this room.

The late Orrin Hatch led a big group of us. I remember—you know, Medicare, when I was director of the Gray Panthers, was largely about acute care. It was about, you broke your leg and you went to the hospital, that was A; and you had health problems and you went to the doc, and that was B.

Now it is chronic disease, and what we are using is the importance of telemedicine to deal with a lot of those kind of conditions. So, we are going to take what we have done in telehealth so far and extend it, and particularly look to using it across State lines with some of the flexibility we were talking about.

I do think that we have got to zero in on this question I started like 2½ hours ago with Mr. Topchik. We want to help rural communities with their conditions on the ground, and we talked about not very many babies, but you have to have something 24–7 and the like.

I am prepared to help in those kinds of issues, as long as the big guys do not take the money and run. We need all of you to kind of help us get the nuts and bolts right. It is always one thing to say it in a hearing; it is another thing to actually write it in language so you get it right, and we are going to want to do that.

And my colleagues all through the morning had suggestions and ideas they are working on. You can see there is tremendous passion for this cause here in the Finance Committee. And I did not hear a lot of people say, well, there is only a Democratic way and a Republican way, and go back and forth. They were talking about sensible ideas.

And for me, this comes back to the proposition—and Mr. Davis knows this. We have 36 counties in Oregon, and a lot of them are such a far distance from Washington, DC, they think that for all practical purposes in their lives, DC might as well be Mars for all the connection it has to them.

What you do is, you bring us the kind of view on the ground, all four of you. This is what we are dealing with, and these wonderful

people sitting in back of me try to take those ideas and turn them into good and sensible policy.

We talked about maternity deserts. I mean, I think that is really what we are looking at. I just want you to know on my watch, as long as I am chair of this committee and have the tremendous honor of representing Oregon in the U.S. Senate, we are going to fight that kind of concept. We are not going to let rural health care and these communities become sacrifice zones. We can do better than that. And Oregon is mostly rural, and you can hear from my colleagues that many of their States are largely rural.

So you gave us a great kick-off to the cause of taking some significant reforms as it relates to strengthening rural health care in America. We are going to follow up with all of you.

For the Senators who are following the wrap-up, questions for the record are due 1 week from today, at 5 p.m.

Thanks to all of you. We are adjourned.

[Whereupon, at 12:13 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

For more than 46 million Americans, including more than one in every four Idahoans, rural communities offer a vibrant, culturally rich way of life, bolstered by strong social bonds and a shared appreciation for the natural surroundings that make this country so exceptional.

Federal health programs, including Medicare and Medicaid, have an obligation to serve the unique needs of rural communities. This means addressing the challenges facing rural hospitals and providers as they deliver high-quality medical care to families in environments with more limited resources.

The perspectives presented today will help us not only to identify hurdles and barriers, but also to build on meaningful, sustainable solutions aimed at ensuring remote communities can access care as close to home as possible.

This hearing comes at a critical time, as a number of provisions—from telehealth flexibilities to continued financial support for rural hospitals and ambulance providers—expire at the end of this year. The Finance Committee has come together numerous times in recent years to extend these and other must-pass policies, which ensure seniors and working families from all walks of life can continue to access the care they need.

In 2022, nearly one-third of Medicare beneficiaries relied on telehealth services. For rural areas in particular, where clinician shortages continue to rise, cutting off this lifeline is not an option. But, while telehealth can bridge access gaps, particularly for specialty and mental health services, we must also maintain and expand in-person options in rural communities.

Creative workforce growth and retention strategies have the potential to bolster the number and types of providers in rural areas. Evidence shows that doctors, nurses, and other health professionals who train in rural areas are more likely to remain in these regions to practice. It is critical that the programs within our committee's jurisdiction ensure that there are ample training opportunities for these health professionals.

Remote front-line providers often face substantial financial strain once in practice, frequently driven by factors entirely outside their control. In addition to serving patients, rural hospitals are often critical to local economies, employing hundreds of individuals and supporting regional business development. Unfortunately, since 2005, more than 105 rural hospitals have closed, with numerous others forced to fend off constant closure risks.

Medicare's existing strategies to preserve access to health care in rural areas often rely on special reimbursement programs that supplement payment rates to account for the unique geographic and patient needs in rural America. We must prioritize the continuation of these essential designations later this year.

However, even with a wide range of targeted payment adjustments, some rural hospitals still struggle to achieve financial stability. For example, small rural hospitals continue to be more heavily dependent on inpatient volume as part of their total revenues. At the same time, the health-care system is experiencing a steady, nationwide shift away from inpatient care to outpatient services. Although this transition often improves patient outcomes and lowers costs, it can leave hospitals ineli-

gible for certain Federal Government programs and without a reliable revenue stream.

For some communities, Medicare's current payment structures may actually stifle innovations that could pave the way for more sustainable rural health-care delivery systems. Resolving these issues is no easy task. Rural communities need the Federal Government to support data-driven State and local modernizations that have the promise to achieve results—increasing access to medical care, lowering costs, and improving patient outcomes.

Alternative payment models, if well-designed, offer one potential avenue for mitigating rural providers' financial challenges, but bureaucratic barriers and insufficient payment arrangements can complicate efforts to leverage these models to their fullest potential. As our committee continues exploring clinician payment policy reforms, bridging these gaps will remain a priority.

Fortunately, across the country, leaders and innovators from all sectors and backgrounds continue to spearhead partnerships, strategies, and initiatives aimed at driving improved outcomes in rural communities, often building from the ground up. Federal programs should facilitate these efforts and learn from providers and patients on the ground.

Thank you to our witnesses for being here today. I look forward to your testimony. Thank you, Mr. Chairman.

PREPARED STATEMENT OF JEREMY P. DAVIS, MHA,
PRESIDENT AND CEO, GRANDE RONDE HOSPITAL

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to speak with you today.

My name is Jeremy Davis, and I am the president and CEO of Grande Ronde Hospital, a 25-bed, not-for-profit, independent Critical Access Hospital in La Grande, OR. Located in rural eastern Oregon, the hospital was founded in 1907. Grande Ronde Hospital—which also owns and operates 19 outpatient clinics—serves the local population of 26,000 residents and other parts of frontier eastern Oregon and southeast Washington. My community is located 260 miles east of Portland, OR and 170 miles northwest of Boise, ID along an interstate that frequently closes due to weather or accidents. Because the nearest hospitals are an hour's drive away—and are also Critical Access Hospitals—we play a vital role in our community and region, ensuring local access to quality health care. On a personal note, I grew up 45 miles from this community, so rural life and now rural health care are core to who I am.

Covering 2,000 square miles (an area about the size of Delaware), Union County is a mountainous area with a local economy that is based on natural resources including farming, ranching, and timber. As of the 2022 American Community Survey's 5-year estimates, our median household income is approximately $62,000, which is $13,000 less than the median for the rest of the State. About 15 percent of our population lives in poverty.[1]

A recent CDC study highlighted the health-care disparities in rural America, finding that people in rural areas are more likely to die from five leading causes than people in urban communities. Hospitals like ours stand in this gap, working to ensure that our rural residents have access to high-quality health care.[2] Union County has a high prevalence of adults who are overweight or obese, have high cholesterol and high blood pressure, or who chose not to have screening exams. During our most recent community health needs assessment,[3] we identified chronic disease prevention, social determinants of health, and behavioral health services as top priorities.

Of the patients we see, over 60 percent are covered by government payers, with 41 percent covered by Medicare, and 23 percent covered by Medicaid. For rural hos-

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[1] *https://data.census.gov/profile/Union_County,_Oregon?g=050XX00US41061.*
[2] *https://www.cdc.gov/ruralhealth/cause-of-death.html.*
[3] Grande Ronde Hospital, Inc., Community Needs Health Assessment Implementation Strategy, Fiscal Years 2023–2025, *https://res.cloudinary.com/dpmykpsih/image/upload/grande-ronde-site-351/media/1a56a0e071a745d0a7fcb97c2086298d/chna-written-implementation-strategy-final-09-15-22.pdf.*

pitals, the substantial portion of patients covered by Medicare and Medicaid underscores the importance of adequate reimbursement from these programs.

But reimbursement is only part of our challenge. The aftershocks of the COVID–19 pandemic shifted the ground beneath hospitals like mine and those throughout Oregon, forcing us to make difficult decisions about the services we provide to our communities. While many of the challenges we face today were on the horizon, the pandemic exposed the fragility of hospitals' financial foundations, particularly for rural hospitals. In 2022, Oregon hospitals posted their worst financial performance in 30 years. Rising expenses, workforce shortages, and stalled revenue cratered hospital finances throughout the State, putting hospitals in one of the worst overall financial positions seen since 1993. As an example of our increased costs, Grande Ronde saw a 608-percent increase in cyber insurance premiums since 2019. Since then, we have only seen incremental improvements in our finances due to higher costs and needed investments. In 2023, Oregon hospitals collectively posted a −1.3-percent operating margin. Without Federal CARES Act funds propping up hospitals' margins in 2020 and 2021, last year would have marked the fourth straight year hospitals experienced significant financial losses.

Rural hospital administrators like me have an interconnected list of worries that keep us up at night, including workforce safety and shortages, financial stability, and more recently, worries about cybersecurity. And the next emergency whether natural, public health, or man-made is always just around the corner.

Let me touch specifically, but briefly, on some of the important issues that I know the committee has under consideration. I recognize that we must focus on not only what is needed, but also on what is doable.

As rural providers, we find ourselves reacting to the economic challenges of the communities we serve since they can affect our patients' health and their ability to access care. These include struggles with housing insecurity, affordable housing, stable employment, and transportation. Because of these factors, we have focused our broader community investment efforts on positively impacting education, access to care, housing, and transportation, with an emphasis on the underserved populations in our service area. We have always believed in the importance of investing in our local community. We have gone beyond the four walls of the hospital to help build playgrounds, sponsor swimming lessons and sports teams, and build community gardens. One of our most recent community collaborations was the Union County Drug Treatment Court, which provides program support that promotes and provides access to a continuum of alcohol, drug, and other related treatment and rehabilitation services for individuals diagnosed with a substance use disorder.

Living in our area can be a beautiful experience, but sometimes an exhausting challenge. As wonderful as our rural lifestyle is, it can be a trial for many rural residents, particularly those living in communities surrounding La Grande with no access to public transportation. Patients often miss, reschedule, or even cancel appointments, delaying needed care. By developing sustainable partnerships and voucher systems with local transportation services, we helped 79 patients keep their appointments during FY 2023.

Pairing our local transportation services with an early and significant investment in telemedicine allows us to meet the challenges of delivering care in a rural setting. Our vision has always been to seek out and bring the best health care available to the local community. Since 2007, we have done that through our nationally recognized and award-winning telemedicine program. Telemedicine in our outpatient clinics provides access to specialties not available locally including endocrinology, medical oncology, neurology, and post-stroke recovery. As part of our inpatient and emergency services, we also use our telehealth program to tap into specialty expertise typically only available in larger cities. This includes using tele-hospitalists for nightly call coverage, specialty physician teams when stroke, acute myocardial infarction, trauma, or septic shock cases present in our emergency department, and neonatologists and pediatric intensive care specialists for our youngest patients. The telehealth flexibilities provided during the pandemic were a lifeline that allowed for the safe and effective care of COVID-positive patients while also ensuring increased access to primary care and behavioral health visits that decreased demand on our Emergency Department. Purchasing additional equipment as well as configuring exam rooms and workspaces to pivot quickly was the right thing to do for our patients and community.

Current telehealth flexibilities like the ones I described have played a critical role in promoting access to vital health-care services. Our experience shows the impor-

tance of telehealth care for patients in rural and underserved areas, those with mobility issues, and patients with transportation or other limitations that prevent them from accessing in-person care in a timely manner. This is especially important in a State like Oregon, which has limited inpatient bed capacity. Telehealth gives us the opportunity to keep patients in their local community for care, which benefits the rural patient, but also the patient in the urban community who has access to that hospital bed made available by the avoidance of a transfer. By extending telehealth flexibilities permanently, we can create certainty for Medicare beneficiaries, who will otherwise wonder if they will have continued access to clinicians and services they are using virtually; strengthen our health-care workforce by enabling a greater number of clinicians to provide telehealth services; allow for investment in flexible virtual staffing models that address current workforce shortages while maintaining high-quality health care; and ensure continued investment in the technology tools and infrastructure to offer telehealth services. This is particularly critical for smaller providers like Grande Ronde that cannot always afford to invest in these tools without a reimbursement pathway.

Our efforts to improve services, enhance quality of care, and expand access are tied to the workforce, and we feel fortunate that our efforts and programs have seen results. Grande Ronde Hospital added more than 45 providers during the 2020–2023 period. We are recruiting additional primary care providers in family practice, internal medicine, and obstetrics and gynecology.

We have a personal approach to reaching out to candidates across the spectrum of both primary and specialty care, and through our recruitment efforts we have expanded services and significantly improved our patients' access to care. In 2021, our efforts to grow the behavioral health services program attracted additional providers, including Grande Ronde Hospital's first employed psychiatrist. The integration of behavioral health care into our system has meant better care for Union County residents.

Eight years ago, Grande Ronde Hospital established a nurse residency program to attract, train, and retain nurses. Nurse residency programs bridge the gap between school and practice through hands-on professional development opportunities.

As a teaching hospital, the program made sense, and we are firm believers in "growing our own." Our evidence-based practice model, which is tailored to the individual, has attracted nurses from across Oregon. In 2019, we created a nurse residency educator position to oversee the program, which has enhanced its success. We have been successful with this program, graduating on average about six new nurses a year, and often retaining all of them to work for Grande Ronde. Many other rural hospitals do not have a way to integrate and successfully onboard new graduates.

We have also partnered in multiple ways to help high school students gain exposure to the depth and breadth of health-care careers. We collaborate with our local high school on a "Medical Pathway" program, and we are also a partner with the Northeast Oregon Area Health Education Center, which hosts an annual health career exploration camp for high school students. Creating career pathways for our youth helps with recruiting and retention of new health-care workers and strengthens our local economy by keeping our talent in our community. Any Federal support that provides incentives and support for these types of programs should be a priority.

In a unique program, we partnered with our local school district's student construction program to help build four townhouses for the hospital. These townhouses will be used for our workforce when someone is moving to the area or when providing services at the hospital on a short-term basis. The La Grande School District originally received a Federal grant to start the program at the high school.

Growing and supporting our workforce and protecting and expanding services are two sides of the same coin when it comes to rural health care. Neither can be achieved without the other and both require adequate reimbursement and constant reinvestment. For example, Grande Ronde implemented a new program in 2017 to combat the drug problem in our community to bolster mental health services, but it required an investment in our workforce and an expansion of our services.

And importantly for this hearing, I want to comment on our CHARM program implemented in 2018, which is our Children and Recovering Mothers Program. CHARM is a confidential health-care program for pregnant women struggling with alcohol or drug addiction. Our Family Birthing Center nurse manager has collaborated with local providers and public health department officials to develop a pro-

gram that improves care and support for mothers and their infants. This includes early pregnancy visits, rehab and behavioral health counseling, early nurse home visits and parental classes. We have served 192 women and children in the CHARM program and have had fewer neonates needing NICU care.

The investment in our CHARM maternity care program helped us respond when a neighboring hospital 45 miles away closed its obstetrical unit in 2023. In preparation, we quickly added two FTEs and four RN positions, which proved to be necessary as we have seen a 65-percent increase in patients from the neighboring county since the closure occurred. While we were prepared and committed to meeting this need, decisions like this are a constant juggling of limited financial resources and a balancing of our larger workforce and service needs for our community.

To help rural hospitals support and maintain maternity services, policy solutions must consider that most of these patients are covered by Medicaid and many have other health needs, which could include chronic disease and behavioral health. Services can include a combination of acute and outpatient care, in-home and telehealth services, and we need enough flexibility to move between these settings based on the patient's needs. I appreciate Senator Wyden's recognition of many of the challenges to providing obstetrical care in rural communities. I hope I can be helpful as we work toward policy solutions.

Let me close by commenting on several flexibilities that were allowed during the pandemic but were ended with the end of the public health emergency last year. I have already addressed the importance of extending telehealth flexibilities. In addition, the following proposals would specifically help us meet the substantial discharge challenges we face in Oregon. Discharge challenges due to shortages of behavioral health beds and post-acute workers, delays in prior authorization, and network inadequacies are especially challenging for rural hospitals. The following proved successful during the pandemic and should be reestablished:

- Permanently remove the 96-hour condition of payment for critical access hospitals to allow us to serve patients longer than 96 hours and still satisfy Medicare's condition of participation. This requirement is a barrier to meeting the patient's needs and a burden for critical access hospitals like ours that are unable to appropriately discharge their patients and could continue to safely provide their care.
- Reestablish the swing bed flexibilities allowed during the pandemic that expanded the ability of hospitals to offer long-term care services to patients who do not require acute care but meet the skilled nursing facility level of care criteria. If skilled nursing care is not available, then a rural hospital should be allowed the maximum flexibility to swing the bed to continue patient care as needed.
- Permanently waive the three-day hospital stay rule for patients requiring discharge to skilled nursing facilities. This outdated rule fails to recognize what is best for the patient and the cost of keeping patients in acute care settings when a skilled nursing level bed is available.

It is an honor to serve my rural community. Thank you for the opportunity to share my experiences in rural health care, and I welcome your questions.

QUESTIONS SUBMITTED FOR THE RECORD TO JEREMY P. DAVIS, MHA

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. Millions of seniors and Americans with disabilities have come to rely on telehealth as a lifeline, enabling access to a broad range of clinicians and services. For residents of rural communities, this can mean the difference between a 50-mile drive and the click of a few buttons.

That said, without congressional action, Medicare telehealth coverage will all but cease to exist at the end of 2024, creating a dire cliff. Fortunately, data and experience from temporary extensions can offer insights into the best path forward, ensuring seniors and working families can continue to receive the care they need.

From an on-the-ground perspective, how have the current flexibilities helped to provide high-quality care, and what would their expiration mean for patient access moving forward?

Answer. Currently, FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services. Grande Ronde Hospital (GRH) currently

owns/operates three RHCs and the ability to offer primary care patients the flexibility of a telehealth visit has been a patient and provider satisfier, resulting in improved access to preventive health-care services and reducing patients ER visits and fewer hospital admissions. This becomes even more important during periods of inclement weather (snow storms, et cetera) that make transportation difficult in States like Oregon and Idaho. The very nature of a Rural Health Clinic is that the community is likely underserved in terms of the limited number of providers and being able to maximize the skills and training of our workforce is enhanced through available technology. By extending telehealth flexibilities permanently, we can create certainty for Medicare beneficiaries, who will otherwise wonder if they will have continued access to clinicians and services they are using virtually; strengthen our health-care workforce by enabling a greater number of clinicians to provide telehealth services; allow for investment in flexible virtual staffing models that address current workforce shortages while maintaining high-quality health care; and ensure continued investment in the technology tools and infrastructure to offer telehealth services. This is particularly critical for smaller providers like Grande Ronde that cannot always afford to invest in these tools without a reimbursement pathway.

Question. What considerations and lessons learned should Congress bear in mind as we evaluate permanent telehealth legislation?

Answer. My simple answer is to make the remaining COVID flexibilities permanent to provide some relief to rural health-care providers so that we can focus our time on other mission driven priorities related to sustainable health-care access. I would encourage the following given our experience:

(1) ensure Medicare patients can receive telehealth services in their home.

(2) ensure there are no geographic restrictions for originating site for nonbehavioral/mental telehealth services.

(3) allow some nonbehavioral/mental telehealth services to be delivered using audio-only communication platforms;

(4) remove the requirement of an in-person visit within 6 months of an initial behavioral/mental telehealth service and annually thereafter. We have found that many providers and patients will naturally have a face-to-face encounter at some point but the one size fits all approach of requiring an in-person visit is typically problematic for the most difficult of patients and lots of resources are exhausted by clinic staff to try and convince the patient to come in.

(5) make the program permanent so that patients have certainty and providers will know there is a payment pathway if they invest in telehealth.

Question. Are there additional pandemic-era flexibilities or waivers that Congress should consider either restoring or continuing to extend?

Answer. Yes. Here are a couple of significant interest to me.

1. **Swing Bed Program**—*A COVID flexibility which ended with PHE:* The swing bed program was created in 1980 as a way to transition rural patients from acute to skilled nursing level care, especially when there are no post-acute beds/facilities available. According to CMS regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a medically necessary stay of at least 3 consecutive calendar days. During the PHE, CMS waived the eligibility requirements to allow hospitals to apply for swing bed services that were needed to provide skilled nursing facilities (SNF) level care for non-acute care patients, this was often done with just a call to the CMS hotline. These flexibilities ended with the end of the PHE, however, the with the post-acute bed shortage, reestablishing these rural hospital swing bed flexibilities seems especially important as a tool to meet the needs of rural patients and to allow rural hospitals to better manage this care and reassure patients their care will be stable when they transition from acute to post-acute.
2. **CAH 96-hour Rule**—*A COVID flexibility which ended with PHE:* During the PHE, CMS waived the requirements that CAHs have a length of stay limited to 96 hours under the Medicare conditions of participation. The so called "96-hour rule" flexibility ended with the end of the PHE. The combination of post-acute bed shortage and the MA prior authorization delays, make

it especially untenable for CAHs to meet the 96-hour rule. MA plan "ghost" networks for SNF beds add to the challenge of discharging these patients. Many small rural hospitals found they could keep sicker patients than they were previously, by allowing CAH's to better serve their local community unnecessary transfers (often Medicare beneficiaries) would be reduced.

Question. Rural providers and patients can face substantial access barriers to cutting-edge medical devices and treatments, as well as AI-enabled tools and technologies. Many of these innovations offer the potential for cost savings in the long run, along with improved health outcomes, but high up-front costs—coupled with ill-suited reimbursement models and regulations—can pose hurdles.

How have you approached these types of common access gaps, and what steps could Congress or CMS take to help bridge them?

Answer. At GRH we have adopted an AI governance process to help us evaluate and implement AI-enabled tools and technologies to ensure that any such adoption is safe for our patients, staff and providers—and affordable.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. We know that hemorrhages are a major underlying cause of pregnancy-related deaths. Better prenatal care, telehealth, remote monitoring, training for rural emergency rooms, and novel medical devices can all play an important role in preventing maternal deaths.

What community-driven actions are important to ensuring women have access to maternal health care when a local hospital closes its labor and delivery unit?

Answer. Workforce shortages and low reimbursement are the two biggest challenges to providing maternity care in our rural communities. Finding ways to attract and retain OB clinicians is especially hard when the annual volume of deliveries may be low. Add to the mix that most of these rural maternity patients are covered by Medicaid which pays less than the cost of providing the care. For example, Oregon hospitals received 70 cents for every dollar spent caring for Medicaid patients in 2022. And many State Medicaid programs do not cover midwives or doulas which could otherwise help us extend our workforce. At GRH, we are constantly recruiting additional primary care providers in family practice, internal medicine, and obstetrics and gynecology. For our nurses, we have established programs which reflect our firm believers in "growing our own." In 2018 we began our CHARM to better support mothers and infants. By investing in our Family Birthing Center it allowed our nurse manager to collaborate with local providers and public health department officials to develop a program that improves care and support for mothers and their infants. This includes early pregnancy visits, rehab and behavioral health counseling, early nurse home visits and parental classes. We have served 192 women and children in the CHARM program and have had fewer neonates needing NICU care. The investment in our CHARM maternity care program helped us respond when a neighboring hospital 45 miles away closed its obstetrical unit in 2023. In preparation, we quickly added two FTE's and four RN positions, which proved to be necessary as we have seen a 65 percent increase in patients from the neighboring county since the closure occurred. While we were prepared and committed to meeting this need, decisions like this are a constant juggling of limited financial resources and a balancing of our larger workforce and service needs for our community.

Question. Are there Federal regulations or administrative burdens that drive up costs for rural providers? If so, what are they?

Answer. While often framed as transparency, the past few years have resulted in an explosion of new Federal administrative requirements. Even when the goals might be worthy, the hospital price transparency and No Surprises Act requirements have resulted in significantly more administrative burdens. And recent discussions about new cybersecurity mandates and legislative proposals suggesting new 340B requirements will be additional worries which will require a workforce and dollars we don't have.

Question. I frequently hear from Iowans about poor access to health-care services, especially in rural areas. In many States, pharmacists, audiologists, and more are licensed and trained to perform certain medical services that Medicare currently does not pay for. For example, right now, pharmacists cannot get paid under Medi-

care Part B rules for providing wellness screenings, immunizations, or diabetes management. I support modernizing Federal rules.

Should modernizing Federal rules to match licensing and training laws be part of efforts to strengthen and improve health outcomes for patients?

Answer. Yes, yes, and yes! Anything that creates better alignment that would encourage and support allowing any health-care provider to practice to the top of their licensure would be fantastic. Given that there is a shortage of health-care providers in this country we must enlist the help of others like pharmacists, audiologists, etc. if we want to get "upstream" in terms of health promotion and wellness.

Question. The Centers for Medicare and Medicaid Services (CMS) have over 2,000 quality metrics in its inventory that health-care providers submit data for. In 2005, the Finance Committee held a hearing on quality metrics in Medicare. I said at the time, we did not want to overburden providers with reporting requirements and it is important to develop quality measures by consensus.

Should CMS go on a quality metrics diet? What quality measures do patients care about and which ones should be kept to best capture outcomes in health care?

Answer. Quality measures are an important part of national work to improve quality and patient safety. However, when the measures are too numerous or definitions too complex, data collection activities can overwhelm hospital resources and hinder hospital's ability to actually bring about improvement. A careful, focused approach to quality measurement is especially important at a time when hospitals and health systems are grappling with multiple challenges, including workforce shortages, inflationary pressures on drugs, supplies, and labor, and downward pressure on both governmental and private-sector payment.

We can appreciate CMS's efforts over the past several years to streamline and focus the measures in their programs for hospitals and health systems. The agency's "meaningful measures" framework has been helpful for organizing the agency's measurement programs around a more transparent and coherent set of priority topics. However, the volume of measures hospitals are required to report under CMS programs is still substantial, and some of the measures no longer add value because their performance is approaching topped out status, or have substantial methodological flaws. To further advance "measures that matter" the most to patients, communities and hospitals, CMS should:

- Continuously review the measures in their programs to determine whether they align with meaningful measure priority areas and have a meaningful performance gap, removing those that do not;
- Work to better align measures across public and private payers to increase focus and reduce administrative burden and inconsistency;
- Ensure measures are as administratively simple to collect and report as possible;
- Prioritize the use of rigorously risk-adjusted outcome measures that give patients more meaningful information about hospital performance and hospitals greater flexibility in designing their care to meet those outcomes;
- Continue to use pre-rulemaking multistakeholder input on both measure additions and removals in its programs; and
- Phase out measures with low reliability or other known methodological issues that affect their accuracy.

Question. Rural communities and hospitals are facing an ever-growing challenge of staffing ambulances for emergency and transport services. I am aware that CMS is conducting a multiyear data collection of ground ambulance services.

Are there successful rural models to sustain ambulatory services? If so, what makes them sustainable?

Answer. While GRH does not operate an ambulance service, having ambulances for emergency and transportation services is critically important to delivering care in rural communities. It is my understanding that ambulance services are confronting the same challenges as all rural providers, which include workforce shortages, workforce safety, low reimbursement, poor insurance coverage, and high costs (in this instance, high fuel costs). Just discharging a patient from acute care in a hospital to post-acute care in a long-term care facility can be challenging when no transportation is available. It's a costly delay and clearly impacts patient care.

Question. In my 99-county tour of Iowa, I frequently hear about the workforce shortages in health care. Some rural hospitals have established community-led

strategies to address their workforce needs. This includes proactive engagement with middle and high school students, supporting or developing a pipeline of health-care professionals with a local college, professional school training opportunities, and a robust recruitment strategy.

What should a comprehensive workforce strategy look like for a rural hospital? If possible, please provide leading examples of rural hospitals deploying a successful community-led strategy.

Answer. Great examples I have seen and been a part of include the following. In addition, I would be more than happy to spend more time with your staff to further discuss ideas and/or be part of a task force or workgroup on this.

- Early and often exposure to health care by children—positive health-care interactions lead to curiosity, so reinforcing and incentivizing well-child visits, preventive screenings, telemedicine flexibilities, et cetera, can create an early interest for the health-care field.
  - At a previous rural hospital I worked at in Wyoming we brought kindergartners for a tour. It served two purposes: (1) hopefully make the hospital less scary for them, and (2) start recruitment early.
- Shadowing opportunities: We have also partnered in multiple ways to help high school students gain exposure to the depth and breadth of health-care careers. We collaborate with our local high school on a "Medical Pathway" program, and we are also a partner with the Northeast Oregon Area Health Education Center (NEOAHEC), which hosts an annual health career exploration camp for high school students. Creating career pathways for our youth helps with recruiting and retention of new health-care workers and strengthens our local economy by keeping our talent in our community. Any Federal support that provides incentives and support for these types of programs should be a priority.
- Nurse Residency: 8 years ago, Grande Ronde Hospital established a nurse residency program to attract, train, and retain nurses. We have an almost 90 percent retention rate of nurses who went through our program which is quite impressive. The few that have left ended up leaving for family obligations, career advancement, and desires to advance further into a career specialty we don't offer. Nurse residency programs bridge the gap between school and practice through hands-on professional development opportunities. As a teaching hospital, the program made sense, and we are firm believers in "growing our own." Our evidence-based practice model, which is tailored to the individual, has attracted nurses from across Oregon. In 2019, we created a nurse residency educator position to oversee the program, which has enhanced its success. We have been successful with this program, graduating on average about six new nurses a year, and often retaining all of them to work for Grande Ronde. Many other rural hospitals do not have a way to integrate and successfully onboard new graduates.
- Financial Stability: It goes without saying that rural hospitals need stable and consistent reimbursement from programs like Medicare and Medicaid. Without stable finances it is hard for rural health providers to attract a workforce that will want to stay.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. Nationwide, one in four rural hospitals have stopped delivering babies. Washington State has seen multiple labor and delivery ward closures in recent years, including by hospitals in Toppenish and Bremerton.

Those closures are a wake-up call: hospitals in rural and underserved areas need more support to be able to continue their essential labor and delivery services. Many of these closures stem from financial challenges. Programs that must operate 24/7 have fixed, steep costs. For labor and delivery, that includes on-call time for physicians, on-call time for anesthetists, and 24/7 availability of labor and delivery nurses.

The costs of a maternity program do not decrease if there are fewer births—but revenues do. For example, one hospital in Washington State only delivers four babies per month on average, but still must pay for 24/7 coverage for OB–GYNs, c-section providers, anesthetists, and nurses.

That's not financially sustainable. We must find ways to address the root financial causes of labor and delivery ward closures in rural and underserved communities.

Would increasing Medicaid reimbursements for labor and delivery services help rural hospitals keep these services open?

Answer. Yes, this is an important first step. In many cases 40–60+ percent of labor and delivery patients are covered by Medicaid. I think increasing the Medicaid payment rate for labor and delivery services and providing a foundational payment for any rural or CAH that delivers less than 350 deliverers a year would help shore up many of these hospitals in terms of maintaining L&D services. In addition, an increase in the Federal medical assistance percentage (FMAP) for labor and delivery services at eligible hospitals would be helpful as well. In case it helps, we lost about $600,000 on L&D services prior to the closure of maternity services at a nearby hospital. As a result of the closure, we have incurred between $500,000–$750,000 in additional expense (wages, supplies, equipment) in order to be ready for the additional volume. We will get some incremental revenue as a result of additional deliveries but our team estimates we will lose close to $1 million once the dust settles. We aren't looking for a handout but a hand up so we can continue to ensure access to such a critical service. In addition, which folks often don't talk about, access to maternity services could also been seen as an economic growth strategy as businesses are likely to not set up shop in a community that doesn't have maternal services. So I see a lot of synergy with other sectors with a Federal investment in maternal access in rural areas.

Question. In your experience running a Critical Access Hospital, what are the biggest financial obstacles to keeping labor and delivery services sustainable?

Answer. The 24/7/365 nature of the service in which we can go several days without a birth and then have six in one day coupled with the labor and equipment costs given it is a specialized scope of nursing. We have also invested in simulation training given our volumes to maintain proficiency.

Question. Why is it important for rural patients to have access to labor and delivery services in their home community?

Answer. Access to L&D services in a mother's local community is both a health and human services imperative but an economic one as well. Local care is often more affordable for the patient and the insurer. Lack of access leads to delayed visits which in turn leads to disparities that end up being more costly as more specialist have to get involved not to mention that long-term health effects to the child and mother in which those costs are born by employers, communities and society as a whole.

Question. The COVID–19 pandemic revolutionized the use of telehealth in our health-care system and served as a catalyst for its expansion into many different areas of health-care service delivery. Since the expansion, telehealth has proved to be extremely popular.

A recent report published by the Washington State Department of Health shows that telehealth allowed more people in rural and underserved areas to access care, increased prevention visits that reduce more costly care further down the road, and saved money for patients and the government. However, the COVID-era flexibilities for Medicare payments for telehealth services will expire at the end of this year.

Without congressional action, Medicare will not be able to reimburse for a wide range of telehealth visits that have helped so many people from the pandemic up until today.

That is why I cosponsored the CONNECT for Health Act, which would permanently remove all geographic restriction on telehealth services, allow more eligible health-care providers to offer the service, and remove the in-person visit requirement.

These flexibilities are necessary to patients in medically underserved areas for accessing mental health, sexual and reproductive health, and other crucial health care.

Do you agree that telehealth has expanded access to care in underserved areas and legislation such as the CONNECT for Health Act is necessary to maintain this level of access to care?

Answer. Yes, I do agree that telehealth has been a wonderful resource in expanding access to care in underserved areas and any legislation that makes permanent

the COVID-era flexibilities would be critical to ensuring access to cost-effective health-care services in rural and underserved communities. Make the program permanent so that patients have certainty and providers will know there is a payment pathway if they invest in telehealth.

Question. Do you think people in rural areas currently have the technological means, including broadband access and digital literacy, to fully benefit from telehealth services?

Answer. I believe we are at an inflection point in this country where we've been advancing telehealth, and then the pandemic hit, and we really saw a lot of providers and patients who actually learned to love it where they were really reluctant to use it prior to, and now they don't want to go back. They see it as a great tool to improve access, especially for those patients that are really hard to get in, whether it be transportation issues, mobility challenges, working professionals, et cetera. As a result of the pandemic many individuals learned to embrace technology so I do think rural Americans are starting to embrace the technology and the timing is great to support telehealth moving forward.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. Similar to your experience in rural Oregon, South Dakotans have long understood the value of telehealth. While Congress has extended telehealth flexibilities in Medicare until December of this year, we need permanent telehealth policies in Medicare, such as those in bipartisan legislation I have led with my colleagues like the Connect for Health Act and the Telemental Health Care Access Act.

Based on your work as a health-care provider in a rural community, how would the patients you serve be impacted if current telehealth flexibilities were not extended?

Answer. I believe we are at an inflection point in this country where we've been advancing telehealth, and then the pandemic hit, and we really saw a lot of providers and patients who actually learned to love it where they were really reluctant to use it prior to, and now they don't want to go back. They see it as a great tool to improve access, especially for those patients that are really hard to get in, whether it be transportation issues, mobility challenges, working professionals, et cetera. Not extending the current telehealth flexibilities I believe would be a wasted opportunity to continue the shared goal of improving access while reducing costs for beneficiaries. Couple this with workforce shortages across the country that are exacerbated in rural communities and I think the impacts of not extending the telehealth flexibilities will be exponential.

Question. How would permanent telehealth access in Medicare help rural health-care providers better serve their patients?

Answer. Making the telehealth flexibilities permanent would be a tremendous boost for health-care providers, especially those in rural areas as telehealth allows more people in rural and underserved areas to access care, helps increase prevention visits that reduce more costly care further down the road which will save money for patients and the government. Removing this cliff will be well received by patients as well. Make the program permanent so that patients have certainty and providers will know there is a payment pathway if they invest in telehealth.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. Do you think that there should be increased CMS enforcement mechanisms in place to ensure that MA plans are better incentivized to have local providers in their networks in order to maintain access to care in rural communities?

Answer. We have the lowest MA plan penetration of any area of our State, so I feel less able to respond in detail, but all providers and their patients are hurt when health plans, Medicare Advantage or not, have incomplete, inaccurate, or ghost networks.

Question. Please explain the value of ambulance services, both ground and air, to rural communities and rural hospitals? With your partnership with those entities, how can we best move forward with ensuring they are financially viable in order to keep providing their services?

Answer. While GRH does not operate an ambulance service, having ambulances for emergency and transportation services is critically important to delivering care in rural communities. It is my understanding that ambulance services are confronting the same challenges as all rural providers, which include workforce shortages, workforce safety, low reimbursement, poor insurance coverage, and high costs (in this instance, high fuel costs). Just discharging a patient from acute care in a hospital to post-acute care in a long-term care facility can be challenging when not transportation is available. It's a costly delay and clearly impacts patient care.

Question. My bill, the Rural Hospital Closure Relief Act, would allow States to deem a small number of struggling hospitals as "necessary providers," allowing them to gain access to the Critical Access Hospital designation if they do not meet the current arbitrary mileage requirements of CMS.

How has your community benefited from the Critical Access Hospital designation?

Answer. Our hospital has benefited immensely by being a CAH. The mere fact that it has stabilized finances for us by ensuring that we receive relevant reimbursement from Medicare is just a fraction of the benefits. Our hospital is the largest private employer in Union County (approximately 26,000 residents) and so being a stable employer allows other important sectors (education, business/industry, law enforcement, public health, et cetera) to exist as part of a community framework. With over $70 million in wages and benefits we provide some tangible economic and social benefits beyond just the health-care access that a CAH provides.

Question. Hospital consolidation has increased in recent years, which can increase health-care costs for patients and limit patients' choices in rural communities.

When a hospital system buys up all the medical facilities in a community or even across many States, it often increases prices, which can make it even more difficult for families to afford their health care.

At the same time, we need to identify how to better support small rural hospitals that operate on thin margins.

What can Congress do to support the financial viability of rural hospitals? How do we balance support for rural facilities with affordability for patients in those communities?

Answer. While I can understand congressional concerns about the impact of consolidation, often the local hospital is the only option to maintain rural physician practices. Often hospital involvement in the medical practices can expand access and services, since hospitals treat a higher percentage of Medicare and Medicaid patients (than independent practices and ASCs) and can offer more complex patient care. This might also include stabilizing post-acute patients while they wait for behavioral health or SNF care. But the high percent of Medicare and Medicaid patients seen by rural hospitals (often 70 percent or higher) can result in a tenuous financial foundation. Equitable and adequate reimbursement needs to be addressed if rural health care is going to be stabilized.

PREPARED STATEMENT OF KEITH J. MUELLER, PH.D., GERHARD HARTMAN PROFESSOR OF HEALTH MANAGEMENT AND POLICY; DIRECTOR, RURAL POLICY RESEARCH INSTITUTE (RUPRI); CHAIR, RUPRI HEALTH PANEL; AND DIRECTOR, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, COLLEGE OF PUBLIC HEALTH, UNIVERSITY OF IOWA

Chairman Wyden, Ranking Member Crapo, members of the Finance Committee, thank you for holding this hearing on rural health and giving me the opportunity to share my perspective on key issues and related policy considerations. Since I last spoke to this committee in 2018 intractable challenges in hospital finance, meeting workforce needs, and addressing leading causes of death in rural communities remain. Yet we have seen the resilience of rural health providers and organizations as they rose to meet the challenges of the COVID–19 pandemic and now keep their focus on improving health for members of their communities. In my brief formal comments I will focus on rural hospital evolution, rural activities of Medicare Advantage, MA, plans, and Accountable Care Organizations, ACOs. I'll close with observations about sharp points demanding immediate attention.

As we move to the health care delivery system of the future, which takes full advantage of advances in chronic care management and changing sites of acute care, the roles of rural hospitals have evolved. They are now comprehensive care centers,

with a much higher percentage of total activities and revenues tied to outpatient services. Transitioning to institutions that best serve rural residents may require modernizing facilities, investing in new information systems and technologies, and collaborating with community-based organizations to address living conditions related to chronic health problems. An obvious requirement is capital enabling significant investments; and the USDA is a leading source of that capital, within the rural development agency, community facilities program.

Additional capital investments in information systems, including in cybersecurity protecting the information, and new technology, can stretch capabilities of small hospitals who have operated on very thin total margins and therefore lack reserves for large investments. They can find themselves needing to join hospital networks to centralize administrative functions and negotiate payment contracts. The networks can be across rural hospitals, as well as affiliations with urban-based systems. In networks or on their own rural hospitals can be a position of strength in any negotiations because of their primary care base and integration into their communities. In a payment environment shifting to the importance of addressing *health,* rural hospitals and primary care clinics can be advantaged. Rural hospital administrators and their limited senior staff may lack experience and data analytics to leverage their position in negotiations; programs providing technical assistance supported by USDA and HRSA make a difference for those institutions.

Shifting to MA, I'll use work from the RUPRI Center for Rural Health Policy Analysis which was formed in 2000 funded by the Health Resources and Services Administration Federal Office of Rural Health Policy. We have tracked rural enrollment in MA plans since October of that year when 201,655 beneficiaries were enrolled in Medicare+Choice plans. As of March of this year there are 4,734,003 rural beneficiaries enrolled MA plans, 45.1 percent of all rural beneficiaries, see Table 1.

Table 1: Enrollment in Medicare Advantage Plans, 2019 and 2024

	National Enrollment	Percent of Eligibles	Rural Enrollment	Percent of Eligibles
2019	21,912,432	40.3%	2,876,598	29.1%
2024	31,177,866	52.3%	4,734,003	45.1%

SOURCE: RUPRI Center for Rural Health Policy Analysis, preliminary analysis based on Centers for Medicare and Medicaid Services (CMS) data, as of March 2024.
Note: Excludes enrollees in U.S. territories (due to data incompatibilities).

Growth in rural enrollment in many States has been dramatic since 2019; Table 2 shows the percent of beneficiaries enrolled in 2019 and 2024. As evident in the table, enrollment growth is quite dramatic, with only Alaska still having lower than 10 percent total, and nearly all States well above 20 percent to as high as more than 60 percent. More of the story of what is happening may revealed by examining specific counties in States with high numbers of rural Medicare beneficiaries. We have developed some early maps showing the contrast from 2019 to 2024, presented in this document after Table 2. The changes are obvious in observing the increased number of counties in the darkest shade and the near disappearance of the lightest shade in four of the six States illustrated.

Table 2: Enrollment in Medicare Advantage Plans, by State, 2019 and 2024

State	2019 Total		2019 Rural		2024 Total		2024 Rural	
	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled
Alaska	81,415	2.1%	26,240	1.9%	97,413	2.8%	30,891	2.5%
Alabama	962,963	44.8%	259,680	36.3%	1,024,371	64.0%	267,977	62.2%
Arkansas	588,083	28.1%	261,456	25.9%	626,168	48.2%	268,805	47.0%
Arizona	1,200,467	44.0%	67,426	26.6%	1,358,579	54.9%	76,508	47.1%
California	5,510,735	49.0%	195,542	8.3%	6,126,479	56.6%	206,172	16.6%
Colorado	809,098	46.0%	130,909	21.8%	929,919	57.2%	150,275	38.0%
Connecticut	605,051	45.1%	38,160	40.6%	628,847	52.4%	40,135	47.9%
Dist. of Columbia	76,328	22.7%			79,455	39.6%		
Delaware	190,089	17.4%			222,068	34.4%		
Florida	4,220,918	48.8%	147,368	33.8%	4,754,205	59.9%	162,353	52.7%
Georgia	1,565,339	42.9%	357,563	39.5%	1,757,771	59.9%	387,396	60.3%
Hawaii	233,551	53.3%	52,018	41.3%	263,746	61.7%	61,250	54.7%
Iowa	576,499	24.0%	274,989	15.7%	633,761	39.6%	293,193	31.5%
Idaho	306,090	36.4%	106,860	23.6%	360,795	51.9%	123,636	40.7%
Illinois	1,996,966	30.0%	318,054	21.9%	2,161,795	47.3%	332,033	39.5%
Indiana	1,158,322	34.1%	294,909	31.0%	1,266,994	52.9%	316,209	50.9%
Kansas	486,599	20.2%	178,760	7.8%	537,221	36.0%	189,024	22.5%

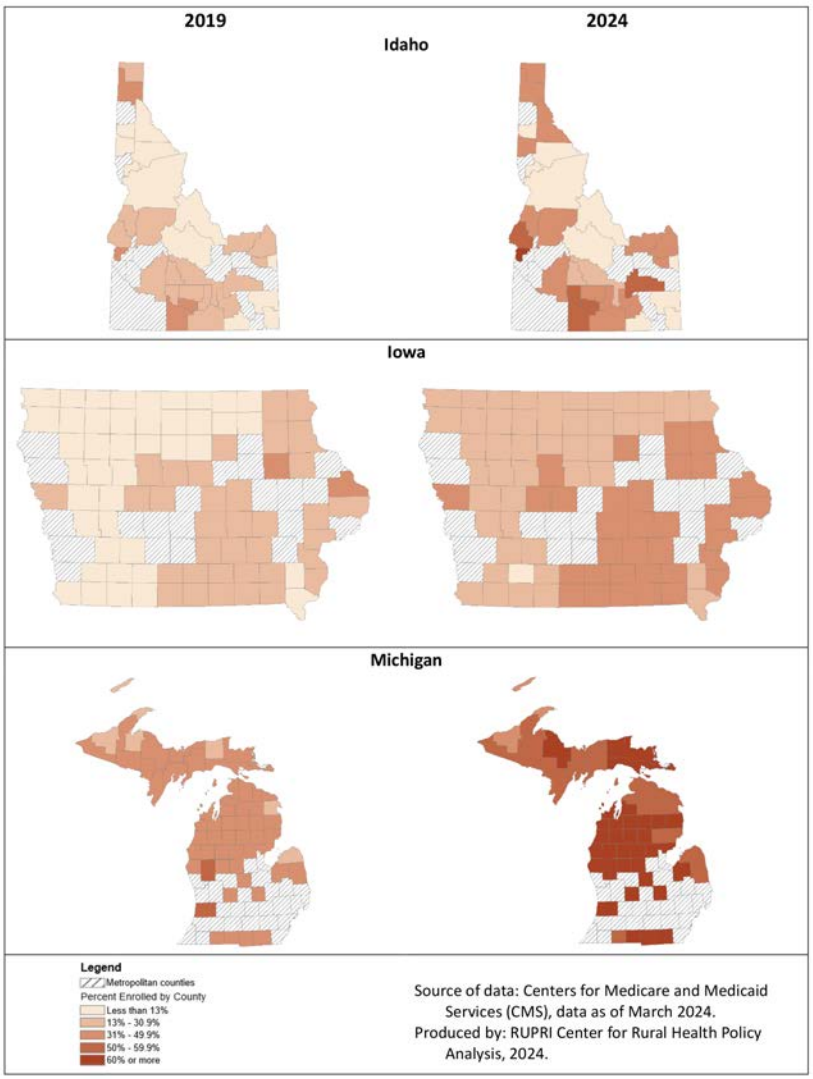
Kentucky	850,777	35.8%	409,180	32.1%	903,748	57.6%	422,097	59.3%
Louisiana	796,623	40.9%	144,855	24.1%	864,806	59.8%	152,244	49.3%
Massachusetts	1,180,663	27.8%	22,809	19.0%	1,294,557	39.4%	25,984	27.9%
Maryland	886,137	14.2%	35,533	6.4%	977,374	27.4%	38,450	19.7%
Maine	309,503	37.7%	139,759	33.9%	345,647	61.5%	154,242	60.6%
Michigan	1,915,848	44.4%	431,580	38.6%	2,087,568	65.6%	472,829	63.1%
Minnesota	931,818	49.4%	275,226	45.4%	1,052,916	63.9%	301,844	58.9%
Missouri	1,124,181	39.9%	337,902	28.4%	1,222,114	57.1%	356,050	49.1%
Mississippi	561,054	21.4%	326,577	16.7%	595,420	45.0%	338,429	43.0%
Montana	209,413	21.1%	141,333	19.0%	239,102	31.8%	161,829	29.8%
North Carolina	1,841,513	39.4%	490,858	32.3%	2,054,364	58.9%	524,956	56.8%
North Dakota	118,630	20.3%	65,155	15.9%	133,809	37.0%	71,564	33.3%
Nebraska	313,805	18.0%	134,159	8.2%	349,046	36.5%	144,642	27.3%
New Hampshire	263,499	20.4%	114,649	19.5%	303,679	38.6%	131,117	38.6%
New Jersey	1,415,809	33.3%			1,548,262	45.4%		
New Mexico	376,869	40.1%	127,411	23.4%	417,414	54.1%	135,919	44.8%
Nevada	467,819	42.2%	61,596	24.9%	534,651	56.4%	69,540	38.5%
New York	3,213,675	45.9%	293,266	41.4%	3,527,243	56.6%	317,176	56.8%
Ohio	2,134,329	46.6%	480,827	35.4%	2,321,531	59.8%	515,972	52.3%
Oklahoma	668,082	23.8%	259,105	13.4%	727,493	44.0%	272,142	35.7%

Table 2: Enrollment in Medicare Advantage Plans, by State, 2019 and 2024—Continued

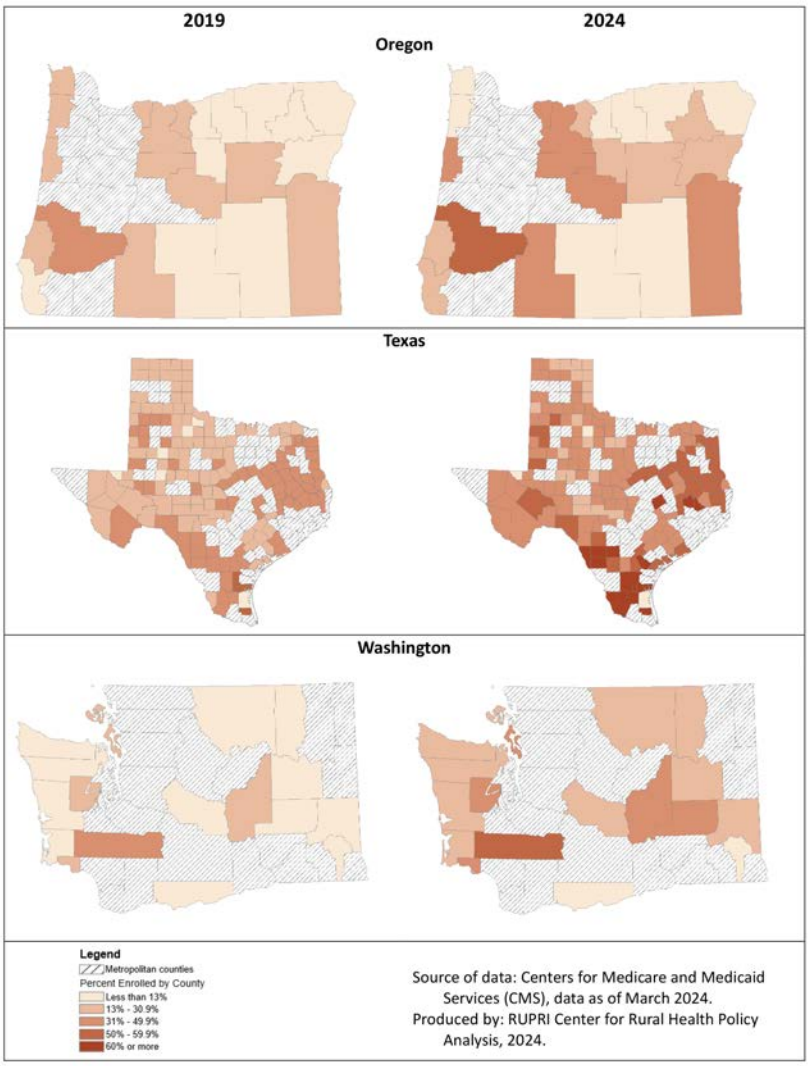
State	2019 Total		2019 Rural		2024 Total		2024 Rural	
	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled	Eligible	Enrolled
Oregon	783,740	49.7%	169,107	22.1%	865,671	59.1%	184,192	32.2%
Pennsylvania	2,477,094	46.6%	336,514	43.7%	2,679,216	57.5%	356,654	59.4%
Rhode Island	192,558	51.8%			215,587	65.8%		
South Carolina	994,370	31.9%	173,617	34.6%	1,130,161	48.5%	186,418	53.6%
South Dakota	158,706	23.4%	82,557	21.3%	179,370	39.0%	91,025	35.4%
Tennessee	1,250,487	42.9%	357,326	37.1%	1,358,749	56.5%	378,039	53.6%
Texas	3,739,559	43.6%	602,788	33.1%	4,277,896	58.5%	647,669	50.6%
Utah	355,224	41.6%	48,758	19.8%	415,102	56.9%	58,418	40.1%
Virginia	1,341,435	24.1%	264,255	25.6%	1,496,450	42.2%	276,702	47.6%
Vermont	132,806	13.0%	95,552	12.7%	150,400	35.0%	107,058	33.1%
Washington	1,220,424	37.2%	178,496	15.6%	1,370,121	53.4%	198,876	32.7%
Wisconsin	1,082,360	46.4%	342,196	41.8%	1,219,762	60.5%	383,009	56.0%
West Virginia	407,206	35.8%	168,723	34.7%	420,214	57.3%	171,386	58.3%
Wyoming	99,394	5.1%	69,107	4.9%	116,022	18.5%	81,593	17.4%

SOURCE: RUPRI Center for Rural Health Policy Analysis, preliminary analysis based on Centers for Medicare and Medicaid Services (CMS) data, as of March 2024.
Note: Excludes enrollees in US territories (due to data incompatibilities). The states of Delaware, New Jersey, and Rhode Island and the District of Columbia contain no rural counties.

Percent of Eligible Rural Medicare Beneficiaries Enrolled in Medicare Advantage, March 2024



Percent of Eligible Rural Medicare Beneficiaries Enrolled in Medicare Advantage, March 2024



What are the consequences of the growth in MA plan enrollment? Well, it is a two-sided coin. On one side, as RUPRI has shown in annual reports and periodic policy briefs, there are many more choices for rural beneficiaries. This includes more widespread availability of additional health benefits including vision, hearing, fitness, and dental—as of 2022 all are available in more than 90 percent of rural counties. There are differences in expanded benefits such as in-home support services (54 percent in remote compared to 82 percent in metropolitan counties) and in special supplemental benefits such as food and produce—available in 91 percent of metropolitan counties and 64 percent of remote counties. On the other side of the coin, MA plan payment to rural provides is set through contracts, not the pricing system of traditional Medicare. Consequently, payment is not cost-based or other special payment as it is traditional Medicare, and strategies private insurance companies use to control spending will apply—claims denial (can be appealed), prior approval, and variable deductibles and copayments. This coin metaphor brings to mind the

term "managed competition"—that in health care there is value to competition, but given compelling objectives of access and equity, some public policy management may be needed.

The number of ACOs grew from 456 in 2023 to 480 in 2024, and included 276 low-revenue ACOs, a jump from 252 in 2023. The number of beneficiaries is holding somewhat steady at 10.8 million. There are more than 2,500 participating Rural Health Clinics and 513 participating CAHs. Rule changes promulgated in 2022 that took effect in 2023 and 2024 may influence more rural participation: up to 7 years in an upside risk only model, and an advanced investment payment—19 started with the advanced payment in 2024. RUPRI has followed ACO development in rural places and impacts on rural providers, including finding a positive impact on rural hospital revenues. The CMS Shared Savings Program Fast Facts show the data regarding participants and assigned lives, including a map showing assigned beneficiaries by county.

The RUPRI Health Panel, supported by the Helmsley Charitable Trust, has commented on proposed rules and requests for information, including from this committee and from the House Committee on Ways and Means. Based on those letters, Panel papers, and discussions with my Panel colleagues, I will close with what I characterize as "sharp point" concerns in rural health that demand attention. The first is longstanding, but with new twists thanks to changes in delivery models: securing the workforce needed to sustain rural services. A modern patient health team now includes community health workers, lay health navigators, behavioral health providers, and of course medical care providers. All are in short supply and high demand. We need a multi-pronged approach to meeting this needs, from pipeline training programs, to better pay and benefits, to improving workplace environments. A second sharp point is maintaining essential services in rural communities. As already discussed today, this includes OB/GYN—perinatal and postnatal women must have equitable access to high-quality care. Other essential services include emergency care, primary care, and public health. Other services could be included, but these are fundamental building blocks in the continuum of care. Finally, providing the range of services needed by an aging population is a critical need in rural communities—recent closures of rural nursing homes is creating a service gap that needs attention.

Thanks again for this opportunity to discuss critical issues and policy considerations that would strengthen and sustain essential health services in the Nation's rural communities.

QUESTIONS SUBMITTED FOR THE RECORD TO KEITH J. MUELLER, PH.D.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. Millions of seniors and Americans with disabilities have come to rely on telehealth as a lifeline, enabling access to a broad range of clinicians and services. For residents of rural communities, this can mean the difference between a 50-mile drive and the click of a few buttons.

That said, without congressional action, Medicare telehealth coverage will all but cease to exist at the end of 2024, creating a dire cliff. Fortunately, data and experience from temporary extensions can offer insights into the best path forward, ensuring seniors and working families can continue to receive the care they need.

From an on-the-ground perspective, how have the current flexibilities helped to provide high-quality care, and what would their expiration mean for patient access moving forward?

What considerations and lessons learned should Congress bear in mind as we evaluate permanent telehealth legislation?

Are there additional pandemic-era flexibilities or waivers that Congress should consider either restoring or continuing to extend?

Answer. A complete termination of the waived provisions for Medicare telehealth coverage would result in declining access to services in those instances where telehealth has provided a means of contact with health-care providers that otherwise would not exist. This is particularly true for behavioral health services, for which utilization increased during the PHE and continues to remain above pre-PHE levels. While research is ongoing, early findings indicate patients who were previously unserved are now under the care of a behavioral health provider. This results from

more convenient access (no travel) and a stronger sense of privacy (not being seen going to a behavioral health clinic). Certain subspecialty services, such as oncology, are also more accessible to rural residents thanks to telehealth. There is limited use of Hospital at Home in rural places, but ending coverage would be premature. Finally, an abrupt end to the waivers could stifle innovation in telehealth that would improve integrated care for rural patients.

Determining and providing adequate payment to providers delivering services through telehealth is a challenge. At a minimum, provider time needs to be compensated. Beyond that we stronger evidence regarding the total cost of delivering services through this mechanism. For example, while the overhead costs of engaging with patients through virtual technology may be less than those associated with office visits, they are nonetheless real and need to be considered. Further, the net benefit of using telehealth needs to include return on investment from early and continuous interactions with patients with chronic conditions, including behavioral health and substance use. Seen through a different lens, guard rails may be needed to prevent telehealth use from totally supplanting in-person patient care, especially rural and underserved populations. We need to be confident we will not exacerbate issues of equity if telehealth is used to serve those of us who have the capacity to use those services, but not made affordable and accessible for the entire population in any region. Specifically, allowing health plans to meet network adequacy standards through telehealth could potentially siphon insured patients away from local providers leaving them hard-pressed to continue serving others in the community.

The RUPRI Health Panel, supported by the Leona M. and Harry BV. Helmsley Charitable Trust, produced a detailed paper *(https://rupri.org/wp-content/uploads/The-Role-of-Telehealth-in-Post-Pandemic-HP-February-2023.pdf)* that provides a comprehensive assessment of the role of telehealth in achieving a high-performing rural health system. Our key consideration in that document reinforces my earlier response about the balance of gains and threats from telehealth use: "ability to attract local consumers to distant providers may threaten local infrastructure by attracting insured patients (and the revenue streams they generate) away from local providers. The remaining population, either publicly insured or uninsured, may not generate sufficient revenue to sustain local practitioners. Services provided via telecommunications, even when appropriate, may pose challenges to affordability if they change direct out-of-pocket responsibilities of low-income residents. On balance, potential advances to achieving the HPRHS [high-performing rural health system] as a result of telehealth appear to outweigh risks to access and affordability, but vigilance is required."

The Panel's specific analysis identified other considerations related to optimum use of telehealth:

- Expanding access to broadband capacity in rural households.
- Matching telehealth services to the capacity of rural patients, including the use of audio-only technology.
- Assessing the value of specific telehealth services in the context of avoiding more expensive utilization of services resulting from delays in seeking care.

Question. Rural providers and patients can face substantial access barriers to cutting-edge medical devices and treatments, as well as AI-enabled tools and technologies. Many of these innovations offer the potential for cost savings in the long run, along with improved health outcomes, but high up-front costs—coupled with ill-suited reimbursement models and regulations—can pose hurdles.

How have you approached these types of common access gaps, and what steps could Congress or CMS take to help bridge them?

Answer. Drawing on interviews of health system leaders focused on rural needs recently completed by the RUPRI Center for Rural Health Policy Analysis, with funding support from the Federal Office of Rural Health Policy, I offer these observations:

- Ensuring ubiquitous high quality broadband access continues to be a rural need.
- Continued investment in electronic health record capability is necessary; grant programs targeting low-revenue providers could be helpful.
- Technology that uses mobile units to make specialty services available (for example, by miniaturizing some of the diagnostic equipment and connecting to remote specialists through telehealth) helps bridge gaps in access to specialty care. There may be implications for allowable costs in Medicare payment policies.

Question. Alternative payment models, or APMs, could offer potential opportunities for rural providers, but to date, participation has remained low, due in part to administrative burden and up-front costs, as well as to certain design features.

For rural hospitals and clinicians that do participate, attracting specialists also remains a widespread challenge. Roughly two-thirds of rural counties, for instance, lack an oncologist, despite higher rates of cancer mortality.

What steps could Congress or CMS take to make APMs a more viable option for rural providers and what lessons should we take away from previous efforts to increase adoption of these models in rural communities?

Answer. The following steps could be taken through legislation and regulatory policies:

- Limit downside risk for rural-based health-care organizations: CMS recently took an important step in this direction for new, low-revenue ACOs.
- Provide investment capital, either as a guaranteed loan to be repaid from future savings, or as an outright grant.
- Facilitate cross-state licensing and credentialing.
- Understand dynamics of all revenue streams; *e.g.,* the CEO of Genesis Health in southeast Ohio testified on June 4th to the House Energy and Commerce Subcommittee on Oversight that savings realized from 340B enabled investment in service lines such as oncology, which in turn enabled more effective participation in value-based payment models.
- Establish alignment across quality measures and reporting to reduce burden; especially for small rural (RHV documents from summit and more recent document).

REFERENCES

- Advancing Value-Based Payment Policies Relevant to Rural Areas—Continued Challenges and New Opportunities. *Rural Health Value*. 2023. *https://ruralhealthvalue.public-health.uiowa.edu/files/Advancing%20Rural%20VBP.pdf.*
- How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report. *Rural Health Value*. *https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf.*

Question. Research shows that small rural hospitals paid under Medicare's traditional inpatient payment system are also facing certain financial stressors.

Do you believe that some small rural hospital financial difficulties stem from a lack of commercial payer reimbursement?

What would be an appropriate Medicare margin for these small rural hospitals to make?

What Medicare policy changes would be most impactful in both the short and long term?

How has Medicaid expansion, specifically the shift from private health coverage to Medicaid, impacted the long term financial viability of rural hospitals?

Answer. The short answer is "no." Nearly all rural hospital CEOs and CFOs I have talked to or heard speak in public forums identify commercial payer reimbursement as their most favorable source of payment. But there are nuances: commercial contracts are not all alike and there may be some that pay less than Medicare; even if they are the best source of payment commercial payers may have negotiated less favorable terms in the past 2 years; and Medicare Advantage plans are a form of commercial payment and there is growing concern from hospital leaders that the net payment (after the costs of appealing denials, and negotiations on final prices) is less than they had been paid by traditional Medicare.

This is not an easy question to answer because of variability in measuring operating costs, which of course affects margins. That complication aside, any net positive margin from Medicare payment would be helpful to rural hospitals.

In the immediate and short term Congress should continue current payment policies that recognize the financial circumstances of rural hospitals (CAH, SCH, MDH, RRC, and REH). Per the discussion during the hearing and answers to subsequent questions, I could support making those policies either permanent or guaranteed for extended years. Long-term, though, policies should employ a tiered payment design for qualified hospitals, which recognizes the fixed costs of assuring access to services

in places where the volume of patients paying at or above costs will not support all costs. The RUPRI Panel, with Clint MacKinney as lead author, published a description of this approach in 2023: MacKinney, C., Mueller, K., A. F., Knudson, A., Lundblad, J. & McBride, T. (2023). Modernizing payment to critical access hospitals: A proposal for the next iteration of the Flex Program. *The Journal of Rural Health* 39 (4) 716–718. DOI: *http://dx.doi.org/10.1111/jrh.12750.*

Designing this policy is challenging under any circumstances; the changing landscape of health system organizations makes it even more complicated, but not impossible.

The underlying dynamic that policies need to address is achieving the dual goals of preserving the safety net while modernizing the payment structure. A two-tiered approach accommodates this by using one payment stream associated with well-defined characteristics of safety-net status and a second payment stream that is consistent with general approaches to value-based payment. A study from the RUPRI Center found a higher fixed-to-operating-cost ratio in small rural hospitals (Barker AR, MacKinney AC, and McBride TD, Policy implications of fixed-to-total-cost ratio variation across rural and urban hospitals. *Journal of Rural Health* 39 (4) autumn 2023, 734–745; *https://onlinelibrary.wiley.com/toc/17480361/2023/39/4*).

The impact of Medicaid expansion on private insurance has been studied using different techniques, yielding different results. A recent study published by one of my colleagues, using sophisticated econometric methods, found a modest effect—a decline of 1.5 percentage points in private insurance rates in expansion States as compared to non-expansion States *(https://onlinelibrary.wiley.com/doi/10.1111/ssqu.13318)*. Other published studies have shown a strong association between being located in a non-expansion State and rural hospital closures. Given those two sets of findings, while there may be instances of Medicaid crowd out of private coverage affecting net hospital revenues, in the aggregate I have not seen research supporting that to be a an issue for most rural hospitals.

Question. Creating opportunities for rural providers to participate in value-based payment models is critical to transitioning to a health-care system that rewards quality instead of simply paying for the number of services provided.

There are a small number of ACO participants located in rural markets. How have some providers been successful in getting attributed Medicare patients to stay within the ACO network? Why are a few, select rural organizations able to meaningfully participate in an advanced ACO program while most rural providers struggle to join even in the non-risk-bearing ACO and Medicare Shared Savings Program (MSSP) models?

What statutory or regulatory changes would be necessary for ACOs located and operating in geographically rural and frontier parts of the country to take on two sided risk?

What changes do you think Congress and the administration should consider to help rural and frontier communities tailor value-based payment models that meet their unique circumstances?

Answer. Research conducted by the RUPRI Center through four case studies in 2021 identified these success factors:

- Prior collaboration experience.
- Volume-to-value transformation strategic focus.
- Clinician championship.
- Care coordination services.
- Data access and analysis.

The Center's analysis of secondary data in 2020 identified these factors:

- Fully implemented electronic health record systems.
- Medical homes for patients.
- Previous risk experience such as HMOs or PPOs or capitated or bundled payment contracts.

We have also examined characteristics of rural ACOs who transitioned to 2-sided risk ACOs, with these characteristics emerging:

- ACO size is related (*i.e.,* larger ACO's tend to be more successful).
- Affiliation with supporting organizations.
- Performance on quality and savings measures.

REFERENCES

- High-Functioning Rural Medicare ACOs—A Qualitative Review. RUPRI Center Policy Brief. February 2021. *https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/High-Perf%20Rural%20ACOs.pdf.*
- Rural Hospital Participation in Medicare Accountable Care Organizations. RUPRI Policy Brief. 2020. *https://rupri.public-health.uiowa.edu/publications/policybriefs/2020/Rural%20hospital%20participation%20in%20ACOs.pdf.*
- Medicare accountable care organization characteristics associated with participation in 2-sided risk. *Journal of Rural Health* 39 (1). *https://onlinelibrary.wiley.com/doi/10.1111/jrh.12672.*

The factors that may keep rural providers for considering advanced payment models are: (1) ability to have a sufficient pool of beneficiaries to justify the investment and operational costs; and (2) inertia if they have established a pattern of financial stability.

Two actions could be helpful: (1) risk corridors that minimize the impact of downsided risk to a small percentage of total revenue; and (2) investment capital up front and perhaps again on first or second renewal.

Work referred to earlier by the Rural Health Value team provides insights:

- Advancing Value-Based Payment Policies Relevant to Rural Areas—Continued Challenges and New Opportunities. *Rural Health Value.* 2023. *https://ruralhealthvalue.public-health.uiowa.edu/files/Advancing%20Rural%20VBP.pdf.*
- How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report. *Rural Health Value. https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf.*

Question. In 2022, the National Quality Forum (NQF) released an updated report outlining a core set of 37 quality measures tailored to address the needs of rural populations. The new measure set included 21 hospital measures and 16 ambulatory care measures. These quality measures had certain characteristics in common, making them relevant to rural communities. They were cross-cutting, resistant to low case volume, and focused on the coordination of care transitions for high-acuity patients.

Rural hospitals and providers want to demonstrate the high quality of care they deliver, but often cannot report on the same types of quality measures as urban facilities. Certain rural stakeholders argue that the NQF measure sets missed the mark—focusing more on process measures than on outcomes measures. Do you have any suggestions on how to most effectively implement value based reimbursement for rural hospitals and providers?

Answer. I would be happy to have more time to look up the reports done for the National Qualify Forum on this question. In my years engaging with them we processed special studies of how to design measures for low-volume providers, and developed measures specifically for rural providers (mostly hospitals). That work is, I believe, being continued by the new CMS contractor, Batelle.

A general recommendation is to alignment quality measures across payers so that the same measures are used by all. This would increase the number of cases with the same measure, creating the opportunity to have the volume needed to make the measures meaningful. That is, the data could be aggregated across all payers.

Question. Because not every rural town can support a full-service hospital, rural researchers, stakeholders, and nonpartisan public policy think tanks have called on Congress to give States and communities more flexibility to design locally driven health-care solutions.

Given the currently available range of special Medicare rural hospital designations and provider payment add-ons, what specific changes do you recommend this committee consider to help vulnerable hospitals maintain community access to needed medical care?

How can the Federal Government continue to partner with States and local communities, but give local leaders the freedom and the flexibility to design solutions that work best for them?

Answer. Previous answers have touched on this somewhat. A further consideration would be to end sequestration in hospital payment, perhaps for a specific group based on classification and size. Another consideration is to instruct CMS to

be certain that when new payment models are implemented to be sure that any necessary adjustments are made to Conditions of Participation. The best example I can report of this was a change to COPs after evidence demonstrated the efficacy of telehealth for emergency room presence of a physician; the COP requiring the physical presence of a physician was changed. As mentioned in an earlier answer, all revenue streams that are helpful to rural hospitals as they struggle to maintain essential services in their communities should be considered, such as 340B, and swing beds for post-discharge care. Similarly, policies reducing revenue such as sequestration should be reconsidered.

Another idea for working with State and local communities would will require a great deal more thought and development. HHS could make grants available to local consortia who submit plans to improve sustainability of services in their areas—the consortia could be defined to be two or more entities. The proposal would be required to include plans for consolidated payment from multiple sources. This could initially be a demonstration program, perhaps building off of the current network grant program in HRSA.

Question. One reason that rural hospitals can struggle financially is due to the fact that reimbursements may not cover high fixed costs. Some rural stakeholders have called on Congress to increase the cost-based reimbursement percentage that CAHs receive from the Medicare program to furnish health-care services. Today CAHs are paid 101 percent of cost per case. Some would like to see that figure increase substantially, which would be an extremely expensive policy change.

If Congress were to increase the cost-based reimbursement percentage, would hospitals still have incentives to be efficient in providing health-care services?

What, if any, other reforms should Congress consider in tandem with a payment increase to promote movement toward lower costs and improved health outcomes?

Answer. I am answering these questions assuming sequestration is ended, which would result in CAHs being paid 101 percent of cost. My direct answer to the first question is "yes." Not all payers would use the same cost-based reimbursement, unless as a platform for making their payment a percentage of the Medicare payment. Therefore, hospitals would still gain from continuous improvement in efficiencies. Further, given workforce needs, all health-care organizations need to be efficient using scarce resources. As described in an earlier answer there are short-term needs to continue the current array of services in rural communities, and longer-term needs to redesign payment policies to promote and reward high-quality, low-cost care.

A key reform to help move toward value-based payment and determine reasonable total costs in a rural setting is a shared savings model structured with incentives to achieve an optimal balance of services across the care continuum. If hospitals see a pathway to secure sufficient revenues to continue essential services, they could shift mix and site of services to meet community needs, their mission. For hospitals to succeed in such a transformation, many will need extensive technical assistance. Current programs funded by USDA and HRSA are demonstrating results in improving hospital finance and enabling change. The two-tiered approach to hospital payment described earlier would be helpful.

Question. The Biden administration recently finalized a controversial regulation implementing minimum nurse staffing standards in skilled nursing facilities and long-term care nursing facilities nationwide. CMS now estimates this one-size-fits-all, unfunded mandate will cost facilities $43 billion over 10 years, an increase of $2.4 billion compared to the proposed rule. According to KFF, only 19 percent of facilities nationwide will be able to meet the new staffing standards once the rule is fully implemented.

Given existing workforce shortages in rural areas, how will the administration's nurse staffing mandate affect rural hospitals' ability to hire high quality providers?

The CMS final rule does not include financial resources to hire the staff necessary to comply with the mandate. Is there a risk that these new staffing minimums will either force facilities to limit patient capacity or close altogether?

Answer. To preface my answer, there is a need to expand the total pool of labor across all health professions, including nursing at all levels; this means considerations for hiring foreign-trained professionals, training more local workforce, and engaging all institutions (hospitals, nursing homes, clinics). Given that reality, if any one group of providers (nursing homes) succeeds in recruiting large numbers of nurses, another (hospitals) may not be able to meet their needs. There are many

variables in play that make projections risky: the staffing requirement is phased in, with extended time for all nursing homes, 3 years in urban areas and 5 in rural areas. The rule creates an exemption for nursing homes in shortage areas that are unable to recruit additional staffing. As was at least inferred during the hearing, even these adjustments may not be sufficient to address rural needs. The RUPRI Panel recommended CMS consider even longer time lines, especially given the reality that nearly 80 percent of all nursing homes could not currently meet the new ratios.

While the new standards may pose hardships for facilities, the goal of improving quality in all nursing homes is laudable. Over time CMS could move from a measure based on *inputs* such as staffing ratios, to one based on *outcomes* independent of staffing arrangements. Additionally, CMS could use existing programs to focus on assistance to nursing homes by providing guidance and technical assistance. Specifically, quality improvement organizations could be engaged through their scope of work, and state surveyors could help identify specific needs for improvement and technical assistance.

The Panel's comment letter on the proposed rule *(https://rupri.org/wp-content/uploads/RUPRI-Panel-Letter-re-Minimum-Staffing-Standards-11.05.pdf)* included these recommendations:

- Increase base funding, and funding for training and technical support for State surveyors, as well as better coordination between State surveyors and the CMS-designated Quality Innovation Network Quality Improvement Organizations.
- Create a policy focus to increase the quantity and composition of the staffing pool in a way that does not pull resources from elsewhere, which could include decentralizing training programs into rural environments, and pooling staff in geographic regions.
- CMS should implement, to the extent possible within statutory constraints, other recommendations of the Committee on the Quality of Care in Nursing Homes, National Academies of Sciences.
- CMS should consider including all nurse staffing categories to deliver services available to and needed by residents in underserved areas, including use of licensed practice nurses, an especially vital component of rural nursing home staffing.

Yes, there is at least some risk that enforcement of the standards could lead to closure of rural nursing homes. The cost of meeting the regulations could also result in changes in patterns of care, another reason to use outcome measures.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. In recent Finance Committee hearings with Health and Human Services Secretary Becerra, we have discussed the Department of Health and Human Services' inaction to fill open spots in the Rural Community Hospital Demonstration program. Right now, the Centers for Medicare and Medicaid Services (CMS) is only using 25 of its statutory 30 hospital spots for this program. At my request, the Center for Medicare and Medicaid Innovation Director met with two rural Iowa hospitals interested in joining the program. However, that is where progress has stalled. CMS explained that to fill the open spots, it would require 12 months of work and too many hospitals would be interested. If CMS has the tools to help one rural hospital, they should use those tools.

Why do you think there is agency resistance to utilizing the Rural Community Hospital Demonstration program?

Answer. I could only speculate, and I will not do so without at least collecting additional information.

Question. We know that hemorrhages are a major underlying cause of pregnancy-related deaths. Better prenatal care, telehealth, remote monitoring, training for rural emergency rooms, and novel medical devices can all play an important role in preventing maternal deaths.

What community-driven actions are important to ensuring women have access to maternal health care when a local hospital closes its labor and delivery unit?

Are there Federal regulations or administrative burdens that drive up costs for rural providers? If so, what are they?

Answer. I do not have an immediate answer to this question, as our Center and Panel have not addressed this issue directly. I would be happy to investigate the subject matter, given time for a literature review and consultation with colleagues who are subject matter experts on this topic.

Question. I often hear how hard it is for rural hospitals to keep up with prior authorization requests from insurance companies. Some of this additional burden is driven by the growth of Medicare Advantage in rural counties. While I am a supporter of the competition that Medicare Advantage offers, we must aggressively hold these plans accountable. In January 2024, CMS finalized regulations that establish prior authorization timeliness requirements for Medicare Advantage. CMS estimates that the current annual cost of prior authorization paperwork for an individual physician is $54,642 per year. CMS estimates when this regulation goes into effect in 2026 that those costs will be reduced by $21,026, or 38 percent.

Will the administrative burden be 38 percent less because of these new regulations?

Are there current insurance companies or payers more willing to adopt administrative simplifications? If so, who are they and what have they been able to simplify?

Answer. I have no reason to question the CMS estimate, so my answer to the first question is "yes." RUPRI's research on insurance markets has not included investigating the second question, so I do not have a direct answer. However, similar to an earlier response, I can say there is a great deal of variation in contracts across health plans and over time. Therefore, I would not be surprised to learn of instances where the negotiated payment contract between plans and providers includes administrative simplification. We need to collect evidence directly from either the providers or the plans.

Question. CMS has over 2,000 quality metrics in its inventory that health-care providers submit data for. In 2005, the Finance Committee held a hearing on quality metrics in Medicare. I said at the time, we did not want to overburden providers with reporting requirements and it is important to develop quality measures by consensus.

Should CMS go on a quality metrics diet? What quality measures do patients care about and which ones should be kept to best capture outcomes in health care?

Answer. CMS has a process to retire quality measures; I reviewed some of those during my time on an advisory committee created and staffed by NQF; I assume that is continuing through the CMS contract with Battelle. I suggest a conversation with CMS/Battelle to see how the process for retiring measures is progressing. A process is in place for considering new measures and, in my experience chairing NQF's rural health workgroup, that process includes considering administrative burden. The best way of doing so is to develop measures based on data already being collected that can be pulled for this purpose. I agree that those processes should result in the number of measures being both meaningful for rural providers and not burdensome to administer.

As stated in another answer, an important step to reduce provider burden is to align measures used by CMS/Medicare with those used by private health plans and Medicaid plans. To the greatest extent possible, the metrics should be measured using data already collected in patient records or billing claims.

Question. Rural communities and hospitals are facing an ever-growing challenge of staffing ambulances for emergency and transport services. I am aware that CMS is conducting a multiyear data collection of ground ambulance services.

Are there successful rural models to sustain ambulatory services? If so, what makes them sustainable?

Answer. I am not aware of studies of rural-based ambulance services that have taken actions that make them sustainable going forward. However, there have been efforts to do so which are not yet tested with longitudinal analysis: using ambulance staff, particularly paramedics, in other health-related roles in their communities to create full-time jobs with livable wages; and regional EMS network development that realizes maximum efficiencies. The RUPRI Health Panel, in work supported by the Helmsley Charitable Trust, has offered these policy recommendations at the Federal level:

- Pay ambulance fixed and standby costs—adjust the ambulance fee schedule to reflect their role as health-care providers and continue the add-on payments until the fee schedule is adjusted to reflect total costs.
- Acquire ambulance agency workforce and other data to better understand needs and projections.
- Apply Occupational Safety and Health Administration guidelines to public sector employees, ambulance service equipment, and workplace processes.
- Support ambulance agency volunteers with continuing education, health insurance, and workers' compensation coverage.
- Test new ambulance agency workforce models.
- Require annual reports from the Federal Interagency Committee on EMS (FICEMS).
- Expand the FICEMS to other departments with resources to support rural ambulance agencies.
- The FICEMS could use data from the Medicare Ground Ambulance Data Collection System to design and recommend ambulance quality improvement strategies.

The Panel also made recommendations for State policy considerations:

- Designate EMS as an essential service and provide a portion of the funding necessary to support costs of maintaining essential service.
- State EMS advocacy organizations should promote, and support with educational grants, professional EMS management certification low-volume ambulance agency directors.
- State-based EMS regulatory boards should create (or modify existing) EMS zones to comprehensively include rural areas.
- State legislatures should preferentially direct ambulance agency funding to cover standby costs and support EMS coordination with EMS zones.

SOURCES

(1) Characteristics and Challenges of Rural Ambulance Agencies—A Brief Review and Policy Considerations. 2021. *https://rupri.org/wp-content/uploads/Characteristics-and-Challenges-of-Rural-Ambulance-Agencies-January-2021.pdf.*
(2) State-Based Recommendations to Support Rural Ambulance Agencies. 2023. *https://rupri.org/wp-content/uploads/State-Based-Ambulance-2023.pdf.*

Question. My bipartisan Healthy Moms and Babies Act includes a provision to establish a national expert group to evaluate the maternity care workforce's training practices. It also requires a study of the role of doula services and community health workers to help achieve better rural maternal and infant health outcomes.

What do we know about the role of doulas and community health workers in maternal health care? What can we do to improve access to these services?

Answer. I consulted with a colleague in the Carver College of Medicine at the University of Iowa who is active in the State and nationally in supporting maternal health care (Lastascia Coleman, CNM, ARNP, MSN, FACNM), and she offered these responses:

1. Doulas and community health workers provide essential services and support for patients, with deep knowledge of the resources and strengths found in communities.
2. Doulas and CHWs that are integrated into the current public health and health-care system have strong evidence showing they make a positive difference and improve outcomes for mothers and babies. This includes decreasing cesarean rates, higher rates of successful breastfeeding and improving detection of mental health conditions like postpartum depression.
3. Consideration should be given to how these services can also be delivered via telehealth as this improves access and may be preferable to this generation of mothers.

Question. In your written testimony you mentioned the number of rural health clinics and Critical Access Hospitals participating in Accountable Care Organizations. You noted that in some instances rural providers have found a positive impact on their revenue.

Which rural providers have seen this positive impact? Are there certain factors that have contributed to this success?

Answer. RUPRI Center research has shown an association between Medicare Shared Savings Program (MSSP) participation and increases in patient revenue,

Medicare revenue, inpatient revenue share, and Medicare revenue share, as well as a reduction in allowance and discount rate (*Health Services Research* 58(1), 2023). Earlier work published by the center explored variables associated with rural ACO transition to two-sided risk SSP (*Journal of Rural Health* 39 (1) 302–308), finding that ACO size, affiliation of supporting organizations, and performance were positively associated with the transition. Our earliest work investigating factors associated with rural ACO success, measured as performance in shared savings and quality metrics, found these to be related:

- Prior collaboration experience.
- Volume-to-value transformation strategic focus.
- Clinician championship.
- Care coordination services.
- Data access and analysis.
- Fully implemented electronic health record systems.
- Medical homes for patients.
- Previous risk experience such as HMOs or PPOs, or capitated or bundled payment contracts.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. As you know, in many rural communities pharmacies are often the only place to access health-care services. You have done research on the difficulties rural pharmacies face, despite being a vital, trusted and accessible point of care for so many members of rural communities.

I have introduced a bill with Senator Warner—the Equitable Community Access to Pharmacist Services Act (ECAPS)—which would provide coverage under Medicare Part B for some services related to testing, treatment and vaccination for several common illnesses where State scope of practice laws allow pharmacists to deliver such services.

Along with providing access to vital services for vulnerable seniors, this would also provide another revenue stream to help keep rural pharmacies viable.

Do you think this type of policy could help improve access to health care in rural communities?

Answer. Yes. RUPRI Center work during the recent public health emergency examined the role of rural independent pharmacies in providing vaccines, demonstrating that in many States the only way to reach rural residents through established patterns of accessing medications was to contract with local independent pharmacies (RUPRI Policy Brief released February 2021: *https://rupri.publichealth.uiowa.edu/publications/policybriefs/2020/COVID%20Pharmacy%20Brief.pdf*). Further, as I said during the hearing, pharmacists are necessary members of any comprehensive health team. Their roles are expansive, as you state in the preamble to your question.

Question. In your testimony you cite the challenges recent nursing homes closures have created in the availability of services for the aging population in rural communities.

This is acutely problematic for States like South Dakota where the next available nursing home bed could be hundreds of miles away from home and away from friends and family.

CMS's final rule mandating minimum staffing standards for long-term care facilities puts onerous and unworkable staffing mandates on our Nation's nursing homes that would exacerbate this problem and undoubtedly force more facilities to close their doors.

In light of the current health care workforce shortage in rural areas, how would CMS's one-size-fits all mandate impact facilities' ability to provide services?

Answer. I would like to provide a full context to my answer, so I am using the same text I used to respond to an earlier question on this issue. A quick response is that a more nuanced approach to assuring high-quality care in our nursing homes, which recognizes the complementary nature of tasks performed by different levels of trained workforce, could be more sensitive to special circumstances in rural places. Further, I am not prepared to state with certainty the impact of the new rule, especially given the timelines to meet standards and exemptions. The discussion during the hearing was instructive as to possibilities.

To preface my answer, there is a need to expand the total pool of labor across all health professions, including nursing at all levels. This means considerations for hiring foreign-trained professionals, training more local workforce, and engaging all institutions (hospitals, nursing homes, clinics). Given that reality, if any one group of providers (nursing homes) succeeds in recruiting large numbers of nurses, another (hospitals) may not be able to meet their needs. There are many variables in play that make projections risky: the staffing requirement is phased in, with extended time for all nursing homes, 3 years in urban areas and 5 in rural areas. The rule creates an exemption for nursing homes in shortage areas that are unable to recruit additional staffing. As was at least inferred during the hearing, even these adjustments may not be sufficient to address rural needs. The RUPRI Panel recommended CMS consider even longer timelines, especially given the realty that near 80 percent of all nursing homes could not currently meet the new ratios.

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Yes, there is at least some risk that enforcement of the standards could lead to closure of rural nursing homes. The cost of meeting the regulations could also result in changes in patterns of care, another reason to use outcome measures.

QUESTION SUBMITTED BY HON. JAMES LANKFORD

Question. It seems that financial incentives have overtaken care quality incentives in the health-care sector, and this shows up even more so in rural America, since actually there are much higher needs in those communities, but decreased access to care.

This committee recently held a hearing on reforms to the physician fee schedule to work toward more value-based payment models within the Medicare physician fee schedule.

What are the most impactful changes we can make to better align our health systems' financial incentives with our care quality incentives?

How did we get to this current level of crisis in rural health care, and what active steps can Congress do to undo some of the damage?

Answer. A transformation from payment based solely on volume (patient encounter regardless of need or outcome) to one incorporating incentives linked to quality (value) is well underway. To answer your first question, accelerating the pace of change to value-based payment, but recognizing the need to be responsive to special rural circumstances regarding covering fixed costs, is a path forward. The Rural Health Value team has gathered information from rural innovators that can be useful in designing policies, summarized in these two documents:

- Advancing Value-Based Payment Policies Relevant to Rural Areas—Continued Challenges and New Opportunities. *Rural Health Value.* 2023. *https://ruralhealthvalue.public-health.uiowa.edu/files/Advancing%20Rural%20VBP.pdf.*
- How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report. *Rural Health Value. https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf.*

The adjustments to traditional Medicare payment, as well as incentives being implemented through Medicare Advantage, are quality incentives adjusting payment within the structure of current payment policies. There are also incentives for cost reduction (*e.g.,* shared savings). And there are financial incentives that combine both (*e.g.,* MSSP). But the key questions include asking if current quality measures are specific, measurable, actionable, relevant (especially for rural), and timely. Furthermore, are incentives significant enough to lead to improvement? In rural plans, do the measures not require high volumes and does improvement require resources and experience that are readily available?

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. The Medicare-Dependent Hospital designation and the Low-Volume Hospital payment adjustment help maintain access to hospital care in rural areas, including more than 20 hospitals serving rural areas in Pennsylvania. Congress has traditionally reauthorized these programs together for limited periods. The current authorization runs through December 31, 2024, requiring Congress to enact another extension this year. Given the last-minute timing of these extensions, rural hospitals are not given time to adequately budget for the continuation of this financial support. For years, Senator Grassley and I have introduced the Rural Hospital Support Act to permanently extend these programs, so that we can provide financial consistency and stability for rural hospitals.

How would long-term certainty in these programs help rural hospitals plan ahead to most effectively serve their communities?

Answer. A major concern in rural health is sustainability of the services currently available in most rural communities. We cannot fully address the future, which could include different payment policies and different methods of delivering services, unless we have a continuous platform from which to build. Therefore, long-term certainty in programs designed to maintain adequate revenues is critical. The security provided by that platform can facilitate a willingness to innovate.

QUESTION SUBMITTED BY HON. MAGGIE HASSAN

Question. Hospital consolidation has increased in recent years, which can increase health-care costs for patients and limit patients' choices in rural communities.

When a hospital system buys up all the medical facilities in a community or even across many States, it often increases prices, which can make it even more difficult for families to afford their health care.

At the same time, we need to identify how to better support small rural hospitals that operate on thin margins.

What can Congress do to support the financial viability of rural hospitals? How do we balance support for rural facilities with affordability for patients in those communities?

Answer. In the rural context, one reason for higher prices for some services, as compared to urban prices, is the need to recover fixed costs across a smaller total volume of services. This is the point made in a recent article from RUPRI Center work, published in *The Journal of Rural Health* (Barker AR, MacKinney AC, and McBride TD, Policy implications of fixed-to-total-cost ratio variation across rural and urban hospitals, 2023 *The Journal of Rural Health* 39(4) 737–745; *https://onlinelibrary.wiley.com/doi/epdf/10.1111/jrh.12767*). Given that reality, public payment policies designed to help assure continuous access need to account for the higher fixed-cost ratio. Current policies build that into the payment per service, which can affect the deductibles paid by patients. To address that challenge, consideration should be given to a two-tiered payment that accounts for the fixed costs without building that cost into the calculations of beneficiary deductibles. This

would assure a stable source of revenue for the hospital, enabling strategic planning to meet community needs.

PREPARED STATEMENT OF LORI RODEFELD, MS, DIRECTOR OF GME DEVELOPMENT, WISCONSIN COLLABORATIVE FOR RURAL GRADUATE MEDICAL EDUCATION (WCRGME), RURAL WISCONSIN HEALTH COOPERATIVE

Chairman Wyden, Ranking Member Crapo, and members of the committee, my name is Lori Rodefeld, and I serve as the director of GME Development for the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME), a program of the Rural Wisconsin Health Cooperative. In addition to this role, I serve as the director of GME Development for the Rural Residency Planning and Development (RRPD) and Teaching Health Center Planning and Development (THCPD) Technical Assistance Centers. I have been engaged in rural workforce development for nearly 20 years working at a technical college, a rural hospital, and now in support of growing the physician workforce not only in Wisconsin but in rural communities across the country. Living in rural Wisconsin, I see firsthand the shortages within our health-care system and how it impacts access to care with fewer health-care professionals available to fill critical positions.

The issues facing the rural health workforce are complex, and I will not have time during my testimony to cover all issues and potential solutions. My focus will be on the shortage of health-care professionals in rural areas and how policy can help address this issue leaning on my experience with rural physician workforce strategies.

To address the shortage of rural health-care professionals, action must be taken including:

- Foster the expansion of rural residency training through policy that supports growth and sustainability for this successful model of training.
- Develop strategies that bolster expansion of rural training for other health professionals including nurses, physician assistants, pharmacists, dentists, medical assistants, laboratory technicians, physical therapists, social workers, and others.
- Explore ways to amplify local and State level efforts to innovate and develop programs to expand training that will address shortages of health-care professionals through the development of partnerships.

Workforce Is the Top Issue Facing Rural Health-care Organizations

Rural health care has long faced challenges in recruiting and retaining qualified physicians and other health-care professionals.[1] This isn't just an inconvenience—it threatens the fabric of health care in rural communities. An aging workforce combined with a declining younger populations to assume these positions could lead to a crisis within rural health care. The hospitals and health-care facilities in my State of Wisconsin are already stretched thin, serving patients around the clock to meet their community's needs. Unlike other industries, their hours can't be scaled back. Emergency rooms, trauma centers, inpatient services, and labor and delivery units—these critical services rely on a strong, stable workforce to keep the doors open.

My testimony will not only include examples from Wisconsin, but also a national perspective as we look to strategies that will address rural workforce shortages. I'll work to highlight innovative approaches as we explore ways to support not only rural physician training but also the training of other health professionals. The extensive research in rural medical education offers insights that can be applied across health-care professions.

Rural Residency Training Provides a Successful Framework to Build Upon

To address the doctor shortage in rural areas, the answer is clear: invest in rurally based GME training. It's a proven strategy that has been in place for decades. Unfortunately the growth in rural training has not kept pace with the growth of GME as a whole. It's estimated that only 2 percent of residency training takes place

[1] Rural Health Research Gateway. Trends in Health Workforce Supply in the Rural. U.S. *https://www.ruralhealthresearch.org/projects/926*. Accessed May 12, 2024.

in rural communities[2] despite nearly 20 percent of the population living in a rural community.[3]

A common misconception is that rural hospitals can't participate in GME programs due to lack of interest, infrastructure, volume, or experience, which simply isn't true. Efforts to grow rural residency training have emerged not only in my home State of Wisconsin but across the country. High quality training has developed in a number of hospitals ranging from larger sole community hospitals with multiple programs to smaller critical access hospitals hosting family medicine residency programs to community health centers launching psychiatry residency programs.

For years the State of Wisconsin was impacted by the closure of five rural track programs (RTPs) which were launched as partnerships between larger urban hospitals and rural hospitals. Working to overcome this loss in the training of rural doctors, the State launched a GME program development grant which served a catalyst for growth of new programs. Hospitals were eligible to receive up to $750,000 in support of planning and infrastructure development to host an accredited residency program. One of the first hospitals to take advantage of this funding was the SSM Monroe Hospital who launched the first new family medicine residency in Wisconsin in nearly 2 decades. SSM Monroe has seen success with nearly 50 percent of its graduates retained within the health system, a majority of graduates practicing in rural and underserved areas, and over 90 percent of the graduates have remaining in the State of Wisconsin.

The success of the RRPD program is another example of the growing interest by rural hospitals in creating new GME programs. Administered by HRSA, within the U.S. Department of Health and Human Services, this program offers crucial start-up funding and technical assistance to launch GME programs within rural health facilities. Forty-six new rural residency programs have achieved accreditation by the Accreditation Council for Graduate Medical Education (ACGME). These programs translate to a significant increase in physician training opportunities, with 575 approved resident positions at full capacity. This includes 441 positions in family medicine, 68 in psychiatry, 51 in internal medicine, and 15 in general surgery.[4]

Growing the Rural Physician Workforce Requires Both State- and Federal-Level Support

The shortage of rural physicians has been an ongoing issue not only in Wisconsin but across the country as stakeholders are taking action to address these critical health disparities. There is a growing body of evidence showing that training in rural places leads to practice in rural places. Recent studies have demonstrate physicians who complete at least half of their GME in rural areas are 5 times more likely to practice in rural areas versus those without rural training.[5]

Interest by rural facilities in creating GME experiences continues to grow. In Wisconsin, there are 27 rural programs which is an increase from six rural programs in 2012. The State has over 30 established rural rotations with continued interest by rural hospitals, clinics, and health centers in serving as a rotation or GME site. There are currently seven new GME programs under development in Wisconsin with interest from additional sites. Additionally, the Rural Residency Planning and Development (RRPD) Technical Assistance Center has identified 145 GME-naïve hospitals in rural communities with characteristics and volumes similar to established teaching hospitals that could be strong candidates for future development.[6]

The Consolidated Appropriations Act (CAA) of 2021 aimed to address the critical shortage of rural physicians at the Federal level, with three key sections related to

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[2] U.S. Government Accountability Office: Physician Workforce. *https://www.gao.gov/assets/gao-17-411.pdf.* Accessed April 20, 2024.

[3] United States Census. Nation's Urban and Rural Populations Shift Following 2020 Census. *https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html#:~:text=The%20rural%20population%20%E2%80%94%20the%20population%20in%20any,from%2019.3%25%20in%202010%20to%2020.0%25%20in%202020.* Accessed May 12, 2024.

[4] Rural Residency Planning and Development Technical Assistance Center. *https://www.ruralgme.org.* Accessed May 12, 2024.

[5] Patterson DG, Shipman SA, Pollack SW, et al. Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. Health Serv Res. 2024;59(1):e14168. doi: 10.1111/1475-096773.14168.

[6] Adhikari M, Hawes E, Sanner L, Holmes GM. Characteristics of Hospitals by Graduate Medical Education Expense Category: Implications for Rural Residency Program Expansion. Acad Med. 2023 December 7th. doi: 10.1097/ACM.0000000000005589. Epub ahead of print. PMID: 38060405.

rural GME. Under section 126, 10 percent of new residency slots were to be allocated to rural hospitals and data shows the majority of these slots were not distributed to geographically rural hospitals.[7,8] In Wisconsin, Marshfield Clinic did not receive slots under section 126 for its internal medicine residency program in the first two rounds of distributions despite being geographically rural. Other rural hospitals have not applied for slots because they do not have a Health Professionals Shortage Area (HPSA) designation.

Under section 127 of the CAA, a complex separate accreditation requirement was removed allowing for the expansion of existing accredited programs through a permanent complement increase and FTE cap increase allowing for the creation of new rural positions.[9] This legislation has allowed hospitals interested in rural GME the opportunity to create new positions with reduced startup costs and less administrative expenses that can be associated with separate accreditation. This has led to the creation of new rural residency programs including two new programs at Creighton in psychiatry and internal medicine[10] as well as a psychiatry residency at West Virginia University.[11]

Section 131 of the CAA provided a one-time opportunity for certain hospitals to reset their Medicare reimbursement rates for graduate medical education.[9] This was specifically aimed at hospitals with low FTE (full-time equivalent) resident caps or Per Resident Amount (PRA) figures. The time frame for this reset will expire on December 26, 2025.

Expanding rural rotations offers a promising strategy to strengthen the rural physician workforce.[12] This approach shifts residents' training into rural sites providing diverse training experiences outside of programs in larger communities. Additionally, rural rotations are less resource-intensive making them a more accessible entry point for building academic-rural partnerships while also creating a solid foundation for future GME growth. Section 131 allows for residents to rotate at rural hospitals for up to 1.0 FTE without triggering a FTE cap.[9]

Wisconsin stands as a leader in supporting State-level GME growth, particularly in rural communities. Collaboration between several key stakeholders including the Wisconsin Hospital Association, Wisconsin Council on Medical Education and Workforce, the Rural Wisconsin Health Cooperative, medical schools, and existing GME programs, has allowed for the creation of an ecosystem to train future rural physicians. State-level GME funding has yielded impressive results. Hospitals looking to develop new programs or expand existing programs have helped support an increase of over 60 additional resident positions each year[13] and over 20 new programs in high need specialties including family medicine, psychiatry, general surgery, and obstetrics and gynecology. In the last legislative session, support for increased funding per slot and removal of caps were approved with strong support. Both Medicare and Medicaid funding combined with State appropriations have been essential to grow our workforce.

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[7] Rains J, Holmes GM, Pathak S, Hawes EM. The Distribution of Additional Residency Slots to Rural and Underserved Areas. JAMA. 2023 Sep 12;330(10):968–969. doi: 10.1001/jama.2023.14452.

[8] Rodefeld L, Adhikari M, Hawes EM. Overview of Residency Programs Selected for CAA Sec. 126 Round Two Graduate Medical Education Slots. *https://www.ruralgme.org/wp-content/uploads/2023/12/CAA-Sec-126-Round-Two-Analysis-Dec-2023.pdf.* Accessed May 12, 2024.

[9] Hawes EM, Holmes M, Fraher EP, et al. New opportunities for expanding rural graduate medical education to improve rural health outcomes: Implications of the Consolidated Appropriations Act of 2021. Acad Med. 2022;97(9):1259–1263.

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[11] West Virginia University. WVU plans rural psychiatry residency training to help patients with limited access to care in North Central W.Va. *https://medicine.wvu.edu/News/Story?headline=wvu-plans-rural-psychiatry-residency-training-to-help-patients-with-limited-access-to-care-in-north-*. Accessed May 12, 2024.

[12] Hawes EM, Rodefeld L, Weinstein DF. Academic Medicine and Rural Health System Partnerships: Enhancing Education While Advancing Physician Workforce Priorities. Acad Med. 2024 May 2. doi: 10.1097/ACM.0000000000005753. Epub ahead of print. PMID: 38704825.

[13] Wisconsin Hospital Association. WHA-Crafted GME New Program Development Grants. *https://www.wha.org/vv-physician-03-26-2024/2.* Accessed May 12, 2024.

Beyond Wisconsin, there are 44 other States developing strategies to utilize Medicaid GME funding as an investment in physician workforce.[14] Some States are focused on growing or supporting positions in rural or high need specialty areas. Medicaid GME allows for States to address maldistribution of physicians by geography, specialty, setting, or by responding to population growth.[15] Approaches vary significantly with some States providing supplemental funds, allocating additional GME slots, supporting planning and development, or offering technical assistance. There is an opportunity to create new learnings across States and share approaches as a way to developing and sustaining residency programs that will meet our population health needs.

Opportunities to Bolster Training of Other Health Professionals

With the demonstrated success of expanding rural physician training as a workforce strategy, there's an opportunity to apply these learnings to other health professions. Evidence shows that one of the factors most closely associated with healthcare professionals choosing to practice in a rural area is being raised in a rural area.[16] Therefore, strategies to engage a pipeline of rural students and providing rural experiences are vital to addressing rural workforce shortages. In Wisconsin and other States, efforts are underway to provide resources and support specifically for training other health professionals. These initiatives range from State grants and funding to collaborative partnerships which further develop our future rural workforce.

One such initiative is a Wisconsin State grant program launched in 2017.[17] This program supports the development of training opportunities for allied health professionals giving a preference for those in rural areas. Hospitals and health-care facilities can receive up to $125,000 in funding to support the expansion of training health-care professionals in their facilities who provide direct patient care and has supported education for a number of students including those training to become behavioral health specialists, counselors, laboratory technicians, and other critical health-care professions. Since its implementation, this program has funded the establishment of 50 educational partnerships, allowing for a significant expansion of clinical training sites, primarily in rural areas.

This approach is echoed in Minnesota's innovative Medical Education and Research Costs (MERC) program. Established in 1996, MERC uses Medicaid funding to support training not just for physicians, but also for other crucial health professionals in their State.[18] The program has continually adapted, expanding eligibility in 2013 to encompass training programs for social workers, community health workers, paramedics, dental therapists, and psychologists. Similarly, the State of Washington is exploring using Medicaid funds to support training for Advanced Practice Providers, aiming to increase the number of primary care and behavioral health providers in rural and underserved areas.[19]

These efforts, coupled with initiatives that spark early interest in health-care careers among rural youth, offer a promising path towards a more robust rural healthcare workforce. Attracting middle or high school students, especially those in rural communities, is essential. Many rural hospitals in Wisconsin have invested in programs like "club scrub," youth apprenticeships, and even a health careers high school. The Rural Wisconsin Health Cooperative is developing an interactive com-

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[14] Henderson T. Medicaid Graduate Medical Education Payments: Results From the 2022 50-State Survey. 2023. *https://store.aamc.org/downloadable/download/sample/sample_id/590/*.

[15] Fraher, Erin P., Ph.D., MPP1; Rains, Jacob A., MPH2; Bacon, Thomas J., DrPH3; Spero, Julie, MSPH4; Hawes, Emily, PharmD, BCPS, CPP5. Lessons Learned From State-Based Efforts to Leverage Medicaid Funds for Graduate Medical Education. Academic Medicine ():10.1097/ACM.0000000000005678, February 27, 2024. | DOI: 10.1097/ACM.0000000000005678.

[16] Fritsma T, Henning-Smith C, Gauer JL, et al. Factors Associated with Health Care Professionals' Choice to Practice in Rural Minnesota. JAMA Network Open. 2023;6(5):e2310332. doi: *https://doi.org/10.1001/jamanetworkopen.2023.10332.*

[17] Wisconsin Department of Health Services. Allied Health Professional Education and Training Grant. *https://publicnotices.wisconsin.gov/NoticeView.asp?lnid=1537388.* Accessed May 12, 2024.

[18] State of Minnesota. Medical Education and Research Costs. *https://www.health.state.mn.us/facilities/ruralhealth/merc.* Accessed May 12, 2024.

[19] Washington State Healthcare Authority. Medicaid Funding Options for Clinical Training Programs. *https://www.hca.wa.gov/assets/program/gme-funding-leg-report-20240129.pdf.* Accessed May 12, 2024.

puter game to allow students to explore rural health careers, increasing awareness and interest in the vast options available.[20]

Wisconsin's technical colleges are playing a key role as well. One example is the "Need for Nurses" program at Southwest Technical College.[21] Partnering with six rural hospitals, this program secured funding to double its enrollment and offer nursing degrees in both fall and spring semesters. The public-private partnership goes beyond program costs; it's an investment in student success, promoting continuous enrollment, retention, and completion.

Recruitment of Medical Assistants (MAs) in Wisconsin is an issue not only for rural hospitals but also rural health centers. Recognizing that training can occur in an academic institution or through an apprenticeship model, community health centers have worked to develop their own training program providing virtual instruction shared amongst health centers with hands-on learning occurring at local centers.[22] This centralized model allows for leveraging of shared resources while giving students an opportunity to "earn while they learn." MA positions are unique as they allow for further career growth as they can later pursue other health careers including nursing, pharmacy, or medicine.[22]

Finally, I would like to highlight an example of rural innovation at Gundersen's Hillsboro Hospital. They recognized the critical need for mental health services in their local schools and established a partnership with a nearby college to create a solution by bringing social work (LCSW) students into their local schools.[23] These students gain invaluable clinical experience working directly in the schools allowing students to fulfill their licensure requirements while also providing much-needed mental health care to students, fostering a healthier learning environment.

Despite Progress Made to Grow Rural Workforce, Challenges Remain

Despite Federal and State efforts to increase the number of residency positions, significant challenges remain for rural hospitals looking to develop or sustain rural residency programs. Primary challenges include the cost to develop a program, Medicare funding complexities, varied definitions of rural, limited timeline to reset a FTE cap or PRA, and financial uncertainty for the Teaching Health Center Graduate Medical Education (THCGME) program.

Financing to support and sustain a residency program can serve as a barrier to expanding GME in rural areas. For hospitals looking to launch a new program, the initial investment can be substantial. The cost to develop a residency program in a rural hospital has not been studied extensively; however, new programs in Wisconsin are seeing financial estimates of over $2 million to launch a smaller size six-resident family medicine residency program. Federal grant support like the RRPD program or State grants like those developed in Wisconsin can help offset the initial up-front costs in launching a new GME program.

As programs develop, there are challenges associated with starting a program which include funding inequities based on hospital type. Certain rural hospital payment methodologies do not result in full Medicare GME funding for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs). Financial projections estimate reductions in indirect medical education (IME) payments based on Medicare Advantage utilization. Allowing full IME payments for these hospitals or treating SCHs or MDHs as nonhospital sites in a manner similar to the payment models for Critical Access Hospitals could be potential policy solutions.

While the Consolidated Appropriations Act has included provisions in support of rural GME expansion, there are opportunities to further support rural hospitals. The FTE Cap and/or PRA reset deadline under section 131 will sunset in December 2025. While some hospitals have utilized this opportunity, others have struggled

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[20] Wisconsin Roads to Rural Health Careers. *https://www.rwhc.com/About-Us/RWHC-Healthy-Wisconsin/RWHC-Healthy-Wisconsin-Articles/Rural-Roads-to-Health-Careers.* Accessed May 12, 2024.

[21] Southwest WI Technical College. Ribbon cuttings mark unique health-care partnerships. *https://www.swtc.edu/news/press-releases/ribbon-cuttings-mark-unique-healthcare-partnerships.* Accessed May 12, 2024.

[22] Wisconsin Primary Health Care Association. Community Health Center Workforce. *https://www.wphca.org/wp-content/uploads/2022/08/Wisconsin-Community-Health-Center-Workforce-Issue-Brief-August-2022.pdf.* Accessed May 12, 2024.

[23] Rural school district, Gundersen join to provide mental health resources to students. *https://www.news8000.com/news/local-news/rural-school-district-gundersen-join-to-provide-mental-health-resources-to-students/article_b2c9c884-37b8-5fc4-914b-72b74711665a.html.* Accessed May 12, 2024.

with accreditation and/or necessary program partnerships to take on training of residents in order to reset low FTEs and PRAs. A policy solution could include an extension of the deadline for FTE Cap and/or PRA resets allow additional time for impacted hospitals. Policy could also be considered to broaden the ability of rural programs to grow further by allowing a hospital in a geographically rural area with less than 12 FTEs to reset a FTE cap or PRA at any time which would allow for more substantial growth beyond the additional slots offered through section 126.

Current limitations on the definition of "rural" are hindering the growth of GME programs in Wisconsin and across the country. The Centers for Medicare and Medicaid Services (CMS) use a metropolitan or nonmetropolitan county designation to authorize payment for funding of GME programs. An alternative may be to consider using the Federal Office of Rural Health Policy (FORHP) definition which looks at additional variables like census tracts in addition to non-metropolitan areas. The CMS definition has excluded hospitals in Wisconsin which meet the FORHP definition from participating in Rural Track Programs (RTPs). Transitioning to a new definition would broaden the pool of hospitals eligible to create RTPs especially in western States with geographically large counties. This would benefit not only urban residency programs eager to partner with rural hospitals but also rural hospitals interested in developing GME programs who are currently ineligible due to CMS's stricter definition.

HRSA administers programs to provide funding to support education in rural and underserved settings. The THCGME program supports 81 residency programs which include 30 percent who train residents in rural communities. The THCPD program supports the startup of 93 new THCGME programs expanding this reach even further.[24] One example of a THCPD program making an impact is the Marshall University Consortium Rural Psychiatry Program which recently received ACGME approval and has already recruited 4 residents to join the program this year. The program will provide psychiatry services to a rural county in West Virginia that currently has no psychiatrists. Marshall faculty are filling this void and providing access to a community that desperately is in need of psychiatrists. There is not a current THCGME funding opportunity for THCPD grantees who are committed to training doctors and dentists in rural and underserved areas.

To impact health workforce, grants and support for development of local or State level clinical training infrastructure through technical assistance could help rural health-care entities expand their training capabilities. Building on the success of other technical assistance center models, consideration could be given to develop assistance for States looking to further develop their own strategies utilizing public-private partnerships or Medicaid GME support to further build their workforce in rural communities and shortage areas. An organization working to support identification of best practices and innovations would ensure rural health pipeline successes are shared and can be replicated. State-based efforts have proven to be an effective strategy through bringing together key stakeholders to identify specific workforce needs in a responsive manner.

Although State-level efforts can make an impact, Federal funding models should be explored to help rural communities expand clinical training in a variety of health professions with career pathway models to support progression within health professions. Additionally, support for rural middle and high school students in career pathways and skill development is critical as a strategy to build our future rural health workforce. Resources are needed to help build infrastructure, develop partnerships, and support training site development.

Conclusion

Thank you, Chairman Wyden, Ranking Member Crapo, and members of the Senate Committee on Finance, for the opportunity to testify today regarding rural health workforce. The future of rural health care depends on our ability to cultivate a strong workforce. It is an honor to share the successes we have seen in Wisconsin and across the Nation in supporting rural residency development as a framework to further promote rural health careers across all health professions. With continued investment and policy development, we can work to build a pipeline of talented health-care professionals who are interested and prepared to serve in rural communities. Federal policy can serve as a catalyst for building upon the work already underway in support of rural health care.

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[24] Health Services Resources Administration. Teaching Health Center Graduate Medical Education Program. *https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education.* Accessed May 12, 2024.

QUESTIONS SUBMITTED FOR THE RECORD TO LORI RODEFELD, MS

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. The shortage of primary and specialty care providers is a critical issue facing rural communities across the country. Difficulty recruiting and retaining physicians and other members of the care team can result in longer patient wait times and reduced access to care.

What concrete policy ideas would you suggest this committee pursue to help attract more providers to rural America?

Answer. There are many strategies that could make an impact on rural physician recruitment and retention. Here are some targeted policy changes that could be implemented by the Senate Finance Committee to address this issue:

Broaden Definition of Rural to Foster GME Expansion: Update CMS funding eligibility criteria to encompass all geographically defined "rural" areas designated by the Federal Office of Rural Health Policy (FORHP), regardless of metropolitan status which is currently the mechanism used by CMS. This change could unlock GME funding for several hospitals who are currently unable to participate in rural track programs. In Wisconsin, there are at least two critical access hospitals interested in GME that are located in metropolitan counties yet are designated as rural by FORHP making them ineligible for traditional Medicare funding as a rural track program.

Incentivize Rural Rotations: Develop policies that support academic medical centers and residency programs to offer rotations in rural settings. Recent changes allow critical access hospitals and rural emergency hospital to be treated as non-provider settings when residents rotate in these facilities. Implementing a similar strategy for other hospital types would allow residents to more easily train in any rural setting thereby leading to growth in the number of residents being exposed to rural practice. This could have a significant impact on rural workforce as evidence shows at least 2 months of rural training can influence eventual rural practice by up to 45 percent.[1]

Strengthen Financial Incentives for Rural Practice: The existing HPSA bonus payment program provides a valuable financial incentive for physicians practicing in underserved areas. Financial incentives like this can have a significant role in both physician recruitment and retention in rural areas.

According to the WWAMI Rural Health Research Center, there are approximately 169 rural residency programs operating through the Rural Residency Planning and Development Program. Yet there is still very little rural training happening. Only 3 to 4 percent of family medicine residents attend a rural residency. Fewer than 10 percent of family medicine residents do any rural training.

Question. How do we shift from focusing on the total number of GME slot allocations to addressing the maldistribution of trainees that impedes a rural community's ability to recruit and retain providers?

How does Wisconsin leverage other sources of Federal funds, such as Medicaid GME, to creatively support rural workforce program development?

Answer. Increasing the number of residents training in rural communities requires a multipronged investment at the State and Federal level. In Wisconsin, we've successfully used a strategy that incentivizes not only expansion of GME positions through State grant programs but also the establishment of new programs and growth of rural rotation experiences. This approach, with commitment from key stakeholders and technical assistance support, can be replicated in other States.

The Wisconsin Collaborative for Rural GME has supported the growth of rural residency programs from 6 in 2012 to 27 in 2024. We also have over 30 rural hospitals offering rotations to residents in high-need specialties, and the majority of primary care residency programs offer rural training experiences.

Beyond simply allocating new slots to rural hospitals, a key strategy is to replicate successful State-level infrastructure development. States like Arizona, New Mexico, and Missouri are utilizing Medicaid GME funding to support expansion, program development, and offer technical assistance. At the State level, investments

[1] Bowman RC, Penrod JD. Family practice residency programs and the graduation of rural family physicians. Fam Med. 1998;30(4):288–292.

can be targeted to high-need specialties or regions where there are more significant physician shortages. Additionally, some States leverage this funding to grow their nonphysician workforce.

Growing this type of infrastructure requires sharing of successful strategies and best practices. A national technical assistance center offering State-level workforce development support for GME and other health professions could have a significant impact on increasing the workforce practicing in rural areas.

Question. Wisconsin Collaborative for Rural Graduate Medical Education was established using State funds in 2012. WCRGME's work to design, launch, and operate innovative workforce initiatives strengthening Wisconsin's rural workforce is impressive. These efforts led to the development of the first rural obstetrics and gynecology residency program in the Nation.

How did this State investment allow for growth in both the total number of GME residency positions, rural GME sites, and rural residency rotations?

What lessons can this committee learn from your success in developing more diverse and sustainable rural health-care workforce training options?

Answer. Thank you for recognizing the Wisconsin Collaborative for Rural Graduate Medical Education's (WCRGME) efforts. Our success is a testament to the combined power of strategic investment, collaboration, and a commitment to building a sustainable rural health-care workforce.

When Wisconsin embarked on this journey in 2010, we faced a significant challenge: the loss of five rural residency programs due to financial constraints and lack of support. Through a comprehensive, State-funded GME strategy, we've achieved significant growth.[2]

As you've noted, we have expanded residency opportunities not only in primary care but also in high-need specialties like obstetrics/gynecology (OB/GYN), psychiatry, and general surgery. Supporting these programs through grant funding has been crucial. Inconsistent patient volumes and limited faculty in rural settings can make establishing these residencies difficult. State funding helps bridge this gap by supporting GME expansion slots which creates a pathway for rural program sustainability.[3]

Our approach has been inclusive, offering funding for a variety of specialties, from family medicine to internal medicine and pediatrics and others. Stakeholders and workforce reports[4] have had an impact on the funding for GME expansion to ensure growth in communities and specialties that most need physicians. By offering flexible options through early exploration and rural rotation grants,[5] we have empowered residencies and hospitals to tailor their GME efforts to their unique strengths and needs, ensuring growth in the communities and specialties facing physician shortages.

Developing GME programs takes time and patience. While Wisconsin started its strategy in 2010, we're just starting to see a more significant return on investment. We have over 70 percent of residents who train in our State remaining here to practice, with a majority serving in rural communities.[6]

Our experience underscores that rural hospitals are eager to participate in GME but need support. A strategic investment in growing GME is necessary to support not only primary care but high need specialties through targeted funding. As efforts are launched at the State and national level, an inclusive approach must be used to build a well-rounded rural workforce. Identifying and supporting high need specialties in addition to primary care can have a significant impact on rural health.

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[2] Bruksch-Meck, K, Crouse, B, Quinn, G, McCart, L, Traxler, K. Graduate Medical Education Initiatives to Develop the Physician Workforce in Rural Wisconsin. WI Med Society Journal. *https://wmjonline.org/wp-content/uploads/2018/117/5/201.pdf*. Accessed June 5, 2024.

[3] State of WI. GME Expansion Grants. *https://publicnotices.wisconsin.gov/NoticeView.asp?lnid=1537444*. Accessed June 5, 2024.

[4] WI Council on Medical Education and Workforce. Reports. *https://www.wcmew.org/reports*. Accessed June 5, 2024.

[5] Wisconsin Rural Physician Residency Assistance Program. Funding Opportunities. *https://www.fammed.wisc.edu/rural/funding-opportunities*. Accessed June 5, 2024.

[6] WI Hospital Association. GME Expansion Grants. *https://www.wha.org/MediaRoom/WHANewsletter/2021/08-19-2021/Reminder-Applications-for-GME-Residency-Expansion*. Accessed June 5, 2024.

Question. The Consolidated Appropriations Act of 2021 added 1,000 new Medicare-funded GME residency training slots. This was the largest increase in Medicare GME slots in over 25 years. A minimum threshold of 10 percent of these new residency positions were set aside to help more residents get experience practicing in rural settings. Despite the law requiring a floor on the number of expanded residency slots allocated to rural hospitals, only 6 percent of those slots went to hospitals geographically located in a rural area. CMS distributed another 42 percent to urban hospitals that have reclassified as rural for certain payment purposes. According to CMS, the agency received applications from a total of 13 geographically rural hospitals, but only seven of them were awarded slots. CMS says they have worked with the Health Resources and Services Administration's Office of Rural Health Policy to educate eligible rural entities about the application process.

Why do you think that rural entities are not applying for the newly funded Medicare GME slots?

Answer. Rural hospitals are interested in expanding residency programs; however, current policy limits their eligibility and participation. Several hospitals located in geographically rural communities with adequate faculty and strong patient volumes are not eligible due to not being located in a Health Professional Shortage Area (HPSA).

Legislation has also allowed hospitals "treated as rural" to qualify for slots designated for rural communities. Several of these hospitals have higher HPSA scores which has impacted rural hospitals that did apply for slots in the first two rounds like Marshfield Clinic in Wisconsin. Other rural hospitals have chosen not to apply as they are not located in a HPSA and are unlikely to receive slots based on the current methodology.

To address this issue in future distribution rounds, consider removing any requirements that a hospital be located in a HPSA and expand to a more precise definition of rural like the one used by the Federal Office of Rural Health Policy (FORHP). These changes would foster increased participation by eligible rural hospitals with less restrictions and more rural hospital applicants who are eligible.

Question. Workforce shortages are exceedingly persistent and challenging to fix. Since 1965, the Federal Government has incentivized physicians to practice in high-need areas of the country through the Health Professional Shortage Areas (HPSA) designation. Despite being in place for almost 60 years, and appropriating billions of discretionary and mandatory dollars each year, recent research has found limited evidence of the HPSA program's effectiveness at reducing geographic disparities in both access to care and health outcomes. Fundamental improvements may be needed in order for this program to achieve intended results.

While the supply of primary care physicians per 100,000 population in rural versus urban counties has remained virtually the same over the past 25 years, it is encouraging to see that the nurse practitioner and physician assistant provider supply is growing. What changes should Congress consider to modernize current Federal programs to better reflect current rural health provider practice location patterns?

Answer. While it's encouraging to see the growing supply of nurse practitioners and physician assistants in rural areas, stagnant primary care physician growth does demonstrate the need to grow new programs and approaches that will influence practice location patterns. States like Wisconsin have pioneered successful programs to expand training of physician assistants and nurse practitioners. These programs demonstrate the importance of investing in high-quality rural educational experiences for APCs through partnerships, faculty development, and infrastructure support.

To further strengthen the rural nonphysician workforce, efforts should be made to create programs like the Advanced Practice Clinician (APC) Expansion Grant[7] in Wisconsin to support planning and implementing of rural training experiences. This program not only supports the costs associated with launching a program but also tuition for students training in rural settings. At SSM Monroe Hospital, a grant successfully led to an increase of 30 percent in APC student rotation experiences, enhanced faculty development, curriculum development, and engagement of APCs,

[7] WI Department of Health Services. APC Expansion Grant. *https://www.dhs.wisconsin.gov/primarycare/apc-grant.htm.* Accessed June 5, 2024.

and the increased recruitment of students into APC roles after completion of training.

Support for growing initiatives like this could can help build upon the success of rural physician training models to grow rural workforce for other health professions. This could be done through Federal grants or the establishment of a technical assistance center that fosters collaboration and knowledge sharing of successful State models.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Thank you for answering my questions about how the Centers for Medicare and Medicaid Services (CMS) are currently distributing 1,200 additional graduate medical education slots. As I stated at the hearing, I wrote to CMS last year on their efforts to implement these additional GME slots to rural and underserved areas. I also asked CMS about the reforms Congress made to the rural training track program. The agency claimed it takes years for programs to ramp up.

What meaningful data should Congress be looking for to determine if changes to the rural training track program have been effective?

Answer. Absolutely, evaluating the effectiveness of changes to the Rural Training Track Program (RTP) requires a multi-faceted approach that considers both program development timelines and long-term outcomes.

As you mentioned, developing residency programs, especially in rural areas, can be a lengthy process due to accreditation, faculty recruitment, financial considerations, and participation in the National Resident Matching Program (NRMP) match to recruit residents. On average it takes 3–5 years to launch a rural program, sometimes longer depending on partnerships and recruitment of key staff including program directors. With this in mind, focusing solely on the number of newly launched programs might not provide a complete picture.

In considering effectiveness, I would recommend looking at the total number of programs, trainees, and graduate practice locations. While acknowledging the time frame for development, tracking the number of new and expanded programs demonstrates program growth and potential future impact as it relates to rural physician workforce. It may also be worthwhile to monitor the total number of residents training in RTPs as this reflects both new programs developed and positions expanded over time. Finally and more significantly, tracking the practice location of graduates, particularly those practicing in rural areas, is an important metric of program effectiveness.

Development of mechanisms to track these metrics could help showcase how rural programs are contributing to the physician workforce while also identifying any significant challenges or opportunities. Supporting an organization or entity in gathering this type of data could inform future rural GME policy updates related to funding, slot allocations, or broader Graduate Medical Education (GME) innovations.

Question. In my 99-county tour of Iowa, I frequently hear about the workforce shortages in health care. Some rural hospitals have established community-led strategies to address their workforce needs. This includes proactive engagement with middle and high school students, supporting or developing a pipeline of health-care professionals with a local college, professional school training opportunities, and a robust recruitment strategy.

What should a comprehensive workforce strategy look like for a rural hospital? If possible, please provide leading examples of rural hospitals deploying a successful community-led strategy.

Answer. A comprehensive workforce strategy for a rural hospital should focus on building a pipeline of talent through community-led initiatives. We know that health-care professionals who train in rural settings are more likely to practice rurally.[8] With this in mind, rural health-care facilities are working to grow additional experiences for health-care professional students. Key elements of a successful strat-

[8] Fritsma T, Henning-Smith C, Gauer JL, et al. Factors Associated with Health Care Professionals' Choice to Practice in Rural Minnesota. JAMA Network Open. 2023;6(5):e2310332. doi: 10:1001/jamanetworkopen.2023.10032.

egy include grow your own initiatives, growth of health professionals training, creation of new medical education expansion, and early exploration opportunities.

Here is are some highlights from a couple of rural Wisconsin hospitals successfully leading the way:

Grow-Your-Own Programs: Partnerships with local schools to expose students to health-care careers by offering training within a rural hospital. One model is the Tamarack Health partnership with Hayward High School to offer nursing assistant training at their critical access hospital.[9]

Health Professionals Training: Prairie Ridge Health is a critical access hospital offering robust clinical training to students including laboratory technician, medical imaging, nursing, surgical technician, and others. Recognizing this significant need, the team has implemented new partnerships and learning opportunities in their facilities with the support of State grant funding.[10]

Medical Education Expansion: Rural hospitals are increasingly becoming partners in training of medical providers training both students and resident physicians. Tamarack Health in Ashland has long been a site for resident rotations for psychiatry and family medicine residency programs in addition to medical students. They recently launched an emergency medicine fellowship and have plans to develop a family medicine residency in partnership at the critical access hospitals in Hayward and Ashland with the support of a State GME program development grant.[9]

Early Exploration: Several rural hospitals have created programs to expose middle and high school students to health careers. One example of this is Prairie Ridge Health which offers a "Club Scrub" program for middle school students [10] which showcases the variety of health-care career options with hands on activities.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. Researchers expect that the Nation will face a shortage of over 80,000 physicians by 2035. Rural communities are already having an especially difficult time finding enough health-care workers. Currently, only 11.4 percent of the Nation's doctors practice in rural areas, even though 20 percent of the population lives in rural areas.

Even in rural communities that do have enough staff, the physician workforce is aging and there are not enough doctors in the pipeline to take over for retiring doctors.

In rural Ferry County in northeast Washington, over 70 percent of physicians providing direct care to patients are 55 or older. When these physicians move on to retirement, we will not have enough new staff set up to replace them.

Rural locations may have a harder time recruiting and retaining health workers for a variety of reasons, including inability to compete with urban locations for wages, limited access to housing, higher workloads, and few job opportunities for workers' relatives.

Those challenges aren't limited to physicians. Rural communities also have a smaller proportion of behavioral health workers like psychiatrists/counselors and social workers, than urban communities do. These communities have also been hit hard by the fentanyl crisis, but they don't have the resources or staffing to get people the treatment they need to recover.

The Substance Use Disorder Treatment and Recovery Loan Repayment Program provides loan repayment to behavioral health workers who practice in high-need communities, including in some rural areas. Yet the program is so underfunded that in the last fiscal year, no Washingtonians received relief through it.

Would expanding the number of people who can benefit from this program help relieve problems with behavioral health workforce shortages in underserved areas?

Providers in Washington State have told me that they have never heard of this program, even though it has been in existence since 2018.

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[9] WI Health News. WI Leaders Share Strategies to Meet Workforce Demands. *https://wisconsinhealthnews.com/2024/06/04/hospital-leaders-share-strategies-to-meet-workforce-demands.* June 4, 2024.

[10] Prairie Ridge Health. Building Tomorrow's Workforce Today. *https://www.prairieridge.health/en/education.* Accessed June 5, 2024.

Do you agree that the Department of Health and Human Services needs to do more to promote awareness of this program?

Answer. As you've shared, there is a critical challenge facing our health-care system as we look at recruitment of not only rural health professionals but also behavioral health professionals. This shortage leaves many communities underserved and with limited access to services. Student debt burdens are a major factor impacting our ability to sustain a rural health workforce. According to the AAMC, medical school graduates now owe an average of over $200,000,[11] which can make practicing in an underserved area at a lower salary, a less-attractive option.

Loan repayment programs like the Substance Use Disorder Treatment and Recovery program, are one strategy to address this issue. Another longstanding example is the National Health Service Corps (NHSC) which offers scholarships and loan repayment to primary care and behavioral health clinicians in exchange for service in underserved areas. Notably, ongoing data from NHSC demonstrates that this investment is effective with at least 80 percent of NHSC participants continuing to serve their communities after they conclude their commitment.[12]

Unfortunately, as you noted, many rural hospitals and health professionals lack awareness of these programs. In my experience here in Wisconsin, there have been instances where medical students or residency program graduates were unable to find participating rural sites due to a lack of program knowledge at the hospital or health center level. Educating both health-care facilities and future health-care professionals regarding these loan repayment opportunities is crucial to expanding our rural workforce.

QUESTION SUBMITTED BY HON. MAGGIE HASSAN

Question. Hospital consolidation has increased in recent years, which can increase health-care costs for patients and limit patients' choices in rural communities. When a hospital system buys up all the medical facilities in a community or even across many States, it often increases prices, which can make it even more difficult for families to afford their health care.

At the same time, we need to identify how to better support small rural hospitals that operate on thin margins. What can Congress do to support the financial viability of rural hospitals? How do we balance support for rural facilities with affordability for patients in those communities?

Answer. Thank you for your commitment to supporting the financial health of rural hospitals. These institutions are essential for countless communities, facing unique challenges that necessitate a multifaceted approach. Here's how Congress can help, while keeping patient affordability and access to local care in mind:

Permanence for COVID Flexibilities: Support for making temporary flexibilities implemented during the public health emergency become permanent could have a significant impact on financial sustainability and patient access to care. These include the exemption to the 96-hour rule for Critical Access Hospitals (CAHs), the 3-day hospital stay requirements for Skilled Nursing Facility (SNF) benefits, and the expansion of telehealth services.

Providing Security for Rural Health Extenders: Consider permanent authorization of the Rural Health Extender programs including the Medicare-Dependent Hospital (MDH) and Low-Volume Hospital (LVH) designations as well as the rural EMS add-on payments. These programs offer a lifeline to rural hospitals by recognizing the higher costs incurred by providing care in a rural area with lower volumes and higher proportion of Medicare patients. The rural EMS add-on payment benefits rural hospitals by providing increased revenues keeping their services in rural and remote areas financially viable while improving the quality of patient care.

Expanding REH Capabilities: Further bolster the Rural Emergency Hospital (REH) designation allowing for hospitals to offer a wider range of services including observation stays, additional outpatient procedures, and even swing bed services. This would allow hospitals to better meet the needs of their communities while also

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[11] AAMC. Physician Education Debt and the Cost to Attend Medical School. *https://www.aamc.org/data-reports/students-residents/report/physician-education-debt-and-cost-attend-medical-school.* Accessed June 5, 2024.

[12] National Health Service Corps, Health Resources and Services Administration. Mission, Work, and Impact. *https://nhsc.hrsa.gov/about-us.* Accessed June 6, 2024.

allowing for additional revenue streams as they treat a broader range of patients. Expanding these services would reduce the need to transfer patients and keep patients in their local communities. Depending on which services are deemed eligible, hospitals could qualify for higher reimbursement rates from Medicare adding to their financial sustainability.

I want to also highlight that Medicare Advantage (MA) has attracted an increasing number of existing and newly eligible Medicare patients. According to a Chartis study [13] released in February, "between 2019 and 2023, Rural MA enrollment increased 48 percent. This rapid increase is highlighting differences between traditional Medicare and MA that have unique implications for rural hospitals. MA net reimbursement to CAHs is often lower for similar services than traditional Medicare because MA does not follow cost-based reimbursement. MA may not cover all traditional Medicare services, including swing beds, often a strong source of revenue stability for rural hospitals."

Implementing these strategies can help strengthen rural hospitals provide continued access to high quality healthcare in rural communities.

PREPARED STATEMENT OF MICHAEL TOPCHIK, EXECUTIVE DIRECTOR, CHARTIS CENTER FOR RURAL HEALTH

Chairman Wyden, Ranking Member Crapo, and members of the committee, good morning and thank you for the opportunity to discuss the state of rural health care and the implications for the 46 million Americans who call rural communities home.

My name is Michael Topchik, and I am the executive director of the Chartis Center for Rural Health. Chartis is a Chicago-based advisory firm dedicated to helping clients create and embrace solutions that make U.S. health care more affordable, accessible, and safe; and my work within the Center focuses exclusively on rural health care.

America's rural communities are older, less affluent, and less healthy than their urban counterparts. Rural America is more vulnerable than nonrural America across nearly all the population health metrics we track at the Chartis Center for Rural Health. Rates for the leading causes of death are all higher in rural areas and with "deaths of despair," rural areas exhibit the worst despair-related mortality outcomes.[1, 2]

Recent history has been difficult for the safety net serving America's rural population, particularly hospitals. Since 2010, we have lost more than 170 rural hospitals.[3] Half of all rural hospitals are now operating in the red and in States without Medicaid expansion, the metric rises to 55 percent.

Even when hospitals remain open, access to care is constrained as facilities are challenged to keep programs open. For example, we have lost 25 percent of America's rural obstetrics care capacity since 2011. For expecting mothers in these communities, the journey for labor and delivery may now require 30, 45, or even 60 minutes in the car.

As dismal as this sounds, our research indicates the future will be tougher still. Indeed, our data indicates that 418 hospitals are vulnerable to closure right now. This is a national threat that will send shockwaves through communities if unchecked. When rural hospitals close, accessing care becomes harder and jobs in those communities—jobs at the hospital and related roles—disappear.

There are three key factors threatening rural hospitals today:

- **First, rural hospitals have high operating costs and low reimbursement:** The unintended consequences related to the sequestration and bad

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[13] Chartis. Rural Study. Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory. *https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf.* Accessed June 6, 2024.

[1] Tanya Lewis, *People in Rural Areas Die at Higher Rates Than Those in Urban Areas,* Scientific American, December 14, 2022.

[2] Beseran et al., *Deaths of Despair: A Scoping Review on the Social Determinants of Drug Overdose, Alcohol-related Liver Disease and Suicide,* International Journal of Environment Research and Public Health, September 29, 2022.

[3] The Cecil G. Sheps Center for Health Services Research, the University of North Carolina. May 2024.

debt reimbursement, for example, continue to chip away at rural hospital reimbursement. To counter operational and financial pressure, nearly 60 percent of rural hospitals are now affiliated with a health system. While system affiliation is shown to help protect against closure in our vulnerability model, it is not a panacea.

- **Second, rural hospitals treat a low volume of patients:** There are too few patients and even fewer medical professionals to deliver care, meaning for many hospitals, the math just does not work.
- **Finally, rural hospitals are plagued by staffing shortages:** While rural hospital staffing shortages are not new, the pandemic transformed a challenge into a full-blown crisis. These shortages impact patient care today and threaten the introduction and delivery of services rural communities will need tomorrow.

Walmart recently announced it is leaving health-care delivery after just 5 years in the business, citing staffing and reimbursement challenges. If Walmart can't achieve scale to make this work, it's no wonder rural hospitals and their communities are struggling to see a future in which their situation improves.

At the Chartis Center for Rural Health, my team is actively involved in researching and analyzing the factors driving instability throughout the rural health safety net. As I noted, the mission of the safety net to serve under-resourced communities is unraveling. The latest research conducted by the Chartis Center for Rural Health points to continued pressures that threaten rural hospitals. Key findings from our research [4] include:

- The percentage of America's rural hospitals operating in the red jumped from 43 percent to 50 percent in the last 12 months.
- Fifty-five percent of independent rural hospitals are operating in the red, while 42 percent of health system-affiliated rural hospitals are operating at a loss. Nearly 60 percent of rural hospitals are now affiliated with a health system.
- Access to inpatient care continues to deteriorate as more than 170 rural hospitals since 2010 have either closed or converted to a model that excludes inpatient care.
- Four hundred eighteen rural hospitals are "vulnerable to closure" according to our recent, expanded statistical analysis.
- Between 2011 and 2021, 267 rural hospitals dropped OB services. This represents nearly 25 percent of America's rural OB units.
- Between 2014 and 2022, 382 rural hospitals have stopped providing chemotherapy services.

Rural Hospitals Sink Into the Red

Our research has always used rural hospital operating margin as a foundation for understanding the stability of the safety net (*e.g.,* "no margin, no mission"). Today, 50 percent of America's rural hospitals are operating in the red. This is the highest percentage of rural hospitals losing money in the past decade. The jump from 43 percent operating in the red last year to 50 percent this year is the single largest percentage change we have seen in a 12-month period.

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[4] Chartis's analysis of rural hospital operating margins for this study utilized CMS's Healthcare Cost Report Information System (HCRIS) Q3 2023. Operating margin is computed in accordance with Flex Monitoring Team guidance. Outliers are excluded. Hospitals for which data are unavailable are excluded. Reported COVID–19 PHE Funds (Worksheet G–3 line 24,50) excluded from operating margin. Adjustments made to operating margin to reflect full 2-percent sequester. Policy impact data utilizes a number of sources including the Budget Control Act 2011, the Middle-Class Tax Relief and Job Creation Act of 2023, the National Center for Rural Health Works 2016, the World Bank 2021, and the Budget Enforcement Act of 1990.

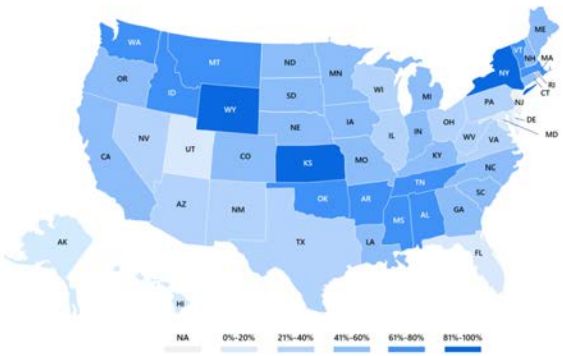
Rural hospital vulnerability utilizes a multilevel logistic regression model developed by Chartis. A methodology for the vulnerability analysis can be found at *https://email.chartis.com/hubfs/CCRH/INDEX%20Top%20100/CCRH_Vulnerability%20Research%20Methodology%20FINAL%2002.12.2024.pdf*.

The baseline period for the chemotherapy service line loss is 2014–2021 and utilizes Medicare SAFOP. Chemotherapy services were identified using HCPCs codes recommended by The Surveillance, Epidemiology, and End Results (SEER) Program for identifying Chemotherapy Administration and Drugs in Medicare analyses. HCRIS data is used to determine the loss of obstetrics in rural communities. The baseline period for the analysis is 2011–2021. Medicare enrollment and penetration analysis utilized most recently available HCRIS data as of March 1, 2023.

Our analysis also found that in 19 States, the median operating margin is in the red. States with the highest percentage of rural hospitals operating at a loss include Kansas (89 percent in the red), New York and Wyoming (83 percent each), Vermont (75 percent), and Alabama (74 percent). In Kansas, which is home to 99 rural hospitals, the median operating margin is −10 percent. With the exception of Delaware (home to just 2 rural hospitals), Utah is the only State where the percentage of rural hospitals in the red is less than 20 percent.

Although rural hospital instability is national in scale, facilities in States that have not expanded Medicaid have consistently performed worse financially than their expansion State counterparts. This year's analysis not only shows a continuation of that trend but a similar jump in the percentage of rural hospitals operating in the red.

Figure 1: State-level percentage of rural hospitals with negative operating margin



Across the 10 remaining non-expansion States (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming), the percentage of facilities with a negative operating margin increased year over year from 51 percent to 55 percent. These States are home to more than 600 rural hospitals in total. Several of these States are among the most severely affected by hospital closures and a loss of access to care.

While the pandemic provided a measure of stability to rural hospital finances through various government intervention programs, this year's analysis indicates that any positive, residual financial effects have all but disappeared. Other government policies (*e.g.,* sequestration and bad debt reimbursement) continue to chip away at rural hospital revenue.

For example, our analysis shows that sequestration will cost rural hospitals more than $500 million this year and the equivalent of 9,000 health-care jobs. Cuts in so-called bad debt reimbursement (*i.e.,* the delivery of charity care to rural patients unable to pay for medical services) will claim approximately $175 million in revenue and the equivalent of an additional 3,100 health-care jobs.

Our analysis also uncovered that 58 percent of rural hospitals are now affiliated with a health system—up from 56 percent in 2019. The median operating margin for these affiliated hospitals is 1.7 percent, compared to −2.2 percent for independent rural hospitals. Additionally, only 42 percent of health system-affiliated rural hospitals are operating in the red, compared to 55 percent of independent rural hospitals. While system affiliation may not make rural hospitals immune to the issues facing the rural health safety net, this data does confirm that affiliation can be financially and operationally advantageous. We expect the percentage of health system-affiliated rural hospitals to continue to grow. As it does, understanding the full impact of affiliation will be a priority.

Medicare Advantage Affects Historical Rural Hospital Reimbursement Practices

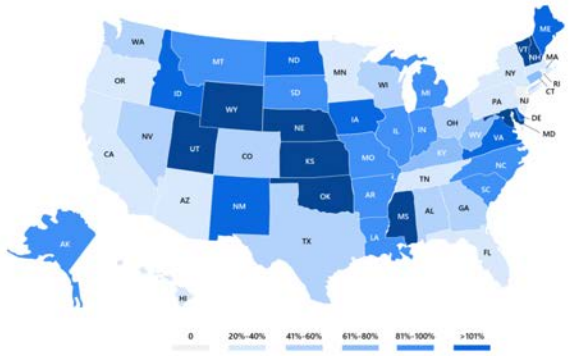
Traditional Medicare reimburses Critical Access Hospitals based on the cost of services provided. Since the advent of the Critical Access Hospital designation in

1997, this cost-based reimbursement has offset a rural hospital's typically low patient volume and revenue.

Recently, Medicare Advantage has attracted an increasing number of existing and newly eligible Medicare patients. Our analysis indicates that between 2019 and 2023, enrollment in Medicare Advantage in rural communities increased 48 percent. This rapid increase is highlighting differences between traditional Medicare and Medicare Advantage that have unique implications for rural hospitals. In particular:

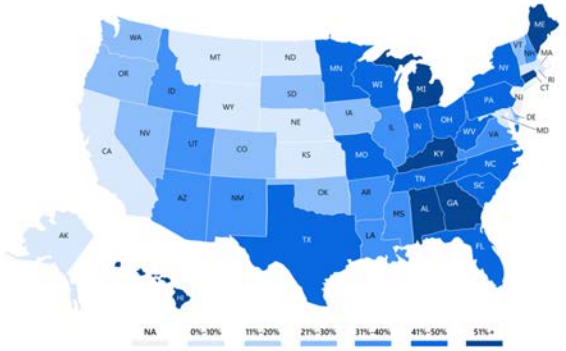
- Common reimbursement models that are employed by Medicare Advantage and other private health plans differ from traditional Medicare as they often follow fee-for-service reimbursement at a percent of Medicare rates and not a retrospective cost-based reimbursement.
- While Medicare Advantage plans are required to provide all medically necessary services that traditional Medicare covers, there are targeted examples where the reimbursement policies may not recognize certain services the same way, including swing beds, which provide skilled nursing care for patients and are often a strong source of revenue stability for rural hospitals.
- Private health plans, including Medicare Advantage plans, commonly have administrative requirements such as prior authorizations. Rural providers may not be equipped to efficiently navigate these administrative requirements, which can lead to increased denials that rural hospitals must navigate.
- Traditional Medicare has standard data reporting which is made available to rural hospitals. While Medicare Advantage plans are required to submit data to CMS, this data is not made available to rural hospitals which may impede a facility's ability to fully understand their population's health-care experience and needs.

Figure 2: Percentage growth of Medicare Advantage enrollees in rural communities between 2019 and 2023



Across rural and urban communities, the popularity of Medicare Advantage has increased over the course of the last 5 years. According to Chartis's national data, penetration in these combined communities was less than 40 percent in 2019 but is now approaching 50 percent. Within communities that are home to a rural hospital, the increasing penetration of Medicare Advantage has been no less stunning.

Figure 3: Medicare Advantage penetration (%) within rural communities in 2023



According to our analysis, the number of residents in rural communities enrolled in Medicare Advantage increased from 6.3 million to 9.2 million between 2019 and 2023. As a result, Medicare Advantage plans now account for 38 percent of all Medicare-eligible patients in rural communities. In 7 States (Alabama, Connecticut, Georgia, Hawaii, Kentucky, Maine, and Michigan), that percentage now exceeds 50 percent. Close behind this group is a large cluster of 15 States in which Medicare Advantage now serves between 40 percent and 49 percent of all Medicare beneficiaries.

Erosion of Care Accelerates Through Closures and Conversions

As we have seen over the last 14 years, persistent downward pressure on rural hospitals often results in dire consequences for local care. Since 2010, more than 170 rural hospitals have either closed or adopted an operating model that excludes inpatient care (*e.g.,* Rural Emergency Hospital conversion, urgent/emergency care center).[5]

When a rural hospital closes, the ripple effects are felt throughout the community. Within many rural communities, the hospital is often among the largest employers and thus a major contributor to the local economy. Our analysis shows that when a rural hospital closes its doors, the loss of hospital jobs is nearly 220 at the median. The loss of nonhospital jobs in the community is 73 at the median.

Measuring the loss of access to inpatient care reveals that 2023 was a record-breaking year for rural health care. Inpatient care disappeared in 28 rural communities—easily surpassing the previous high of 18 set in 2020. Hospital closures and the loss of inpatient care continue to be concentrated highest in States such as Texas (26), Tennessee (15), Kansas (10), Missouri (10), and Georgia (10).

More Than 400 Facilities Vulnerable to Closure

In 2020, Chartis published an extensive, first-of-its-kind analysis of rural hospital vulnerability through a multilevel logistic regression model that determined the probability of closure. At the time, the model identified 453 rural hospitals vulnerable to closure. In the 4 years since the publication of that study, 30 of the facilities identified as vulnerable have closed. Utilizing an updated data model and more expansive methodology, our newest assessment indicates that 418 (approximately 20 percent) of America's rural hospitals are vulnerable to closure.

[5] The Cecil G. Sheps Center for Health Services Research. Closed and converted count as of May 2024.

Figure 4: Number of rural hospitals closed or ceasing inpatient care since 2010

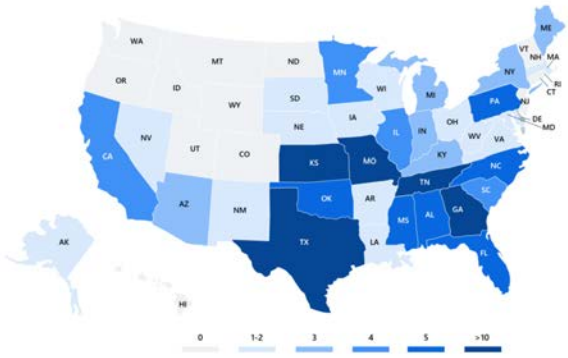
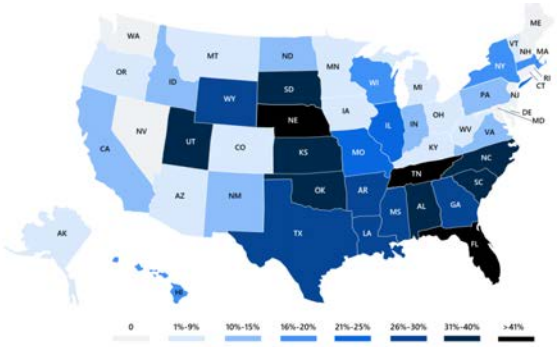


Figure 5: Percentage of state rural hospitals determined to be vulnerable



Our 2024 vulnerability data model analyzed 16 indicators and determined 9 to be statistically significant in predicting hospital closure. Among these 9 indicators, those most likely to decrease the risk of closure are case mix index, government control status, Medicaid expansion, and average daily census for swing beds/skilled nursing facility (SNF).

A particularly noteworthy protective measure against closure is the average daily census for swing beds/SNF. Despite the financial importance of swing beds and the benefits they provide to patients, they are not allowed as part of the new Rural Emergency Hospital (REH) designation.

Table 1: In our vulnerability model, 9 indicators were identified as statistically significant

VULNERABILITY MODEL INDICATORS	
Case Mix Index	**State Status for Medicaid Expansion**
Government Control Status	Traditional Medicare Percent Days
Critical Access Hospital	Medicare HMO Percent Days
Number of Beds	Traditional Medicaid Percent Days

Table 1: In our vulnerability model, 9 indicators were identified as statistically significant—Continued

VULNERABILITY MODEL INDICATORS	
Average Daily Census Swing/SNF	Medicaid HMO Pct Days
Occupancy	**Years Negative Operating Margin**
Average Age of Plant	**Change in Net Patient Revenue**
Average Length of Stay	Social Vulnerability Index

Our analysis of rural hospital vulnerability found the highest levels across the whole of the Southeast, part of the Southwest, and up into the Great Plains. States with the highest percentage of vulnerable rural hospitals are Florida (43 percent), Nebraska (41 percent), Tennessee (41 percent), North Carolina (40 percent), Kansas (38 percent), and Utah (38 percent). With several of these States, there is noticeable overlap with other metrics indicating vulnerability, such as operating margin and the loss of access to inpatient care.

When we shift our focus from State-level percentages to the highest number of vulnerable rural hospitals, many of the same States top the list. Texas has the most rural hospitals vulnerable to closure in our analysis: 45. Next are: Kansas (38), Nebraska (29), Oklahoma (22), North Carolina (19), and Georgia and Mississippi (18 each).

Although vulnerability stretches nationwide, our analysis shows a small number of States do not have any vulnerable rural hospitals. States such as Connecticut and Delaware may not be surprising inclusions, given the small number of rural hospitals in those States. But Washington (45), Maine (24), New Hampshire (15), and Nevada (14) are notable. Washington and New Hampshire interestingly have also thus far avoided any rural hospital closures or conversions to models that exclude inpatient care.

REH Offers a Lifeline for Some Facilities

In 2023, 19 rural hospitals took advantage of CMS's new Rural Emergency Hospital (REH) designation.[6] Introduced in January 2023, the REH designation offers a pathway for struggling rural hospitals to retain some health-care services within their communities. Rural hospitals converting to REH are no longer able to provide inpatient care, participate in the 340B drug program, or take advantage of swing beds.

Last year, Chartis developed a unique data model that assessed the likelihood of REH-eligible facilities in pursuing conversion. We found that nearly 400 rural hospitals fell into the model's first quadrant (*i.e.,* most likely to consider pursuing conversion). Of this group, 77 hospitals fell in the 0 to 4th percentile overall and were identified as "ideal candidates" for REH conversion.

Given that this program is in its infancy, more time may be required for conversions to pick up speed. REH conversions will likely increase as individual States complete the required regulatory approval processes and more hospitals give REH greater consideration in the wake of the different pressure points discussed within this study.

That said, we may also see adjustments to the requirements governing REH conversion. The 340B program, for example, has provided a wide range of benefits to rural hospitals. Allowing hospitals converting to REH to maintain participation in the 340B program may open the door for some rural hospitals to consider the new designation more strongly.

A survey conducted in 2023 by Chartis in partnership with the National Rural Health Association found that nearly 80 percent of respondents had been participating in the 340B program for more than 5 years, and 38 percent said that their hospital's estimated annual 340B benefit was $750,000 or more.

When asked to identify how 340B savings are utilized, most survey respondents selected "support workforce/staffing needs," "add or expand clinical services," and

[6] The Cecil G. Sheps Center for Health Services Research. REH conversion count as of February 2, 2024.

"provision of charity care." This provides an insightful lens into just how rural hospitals put the 340B savings to use to support care delivery.

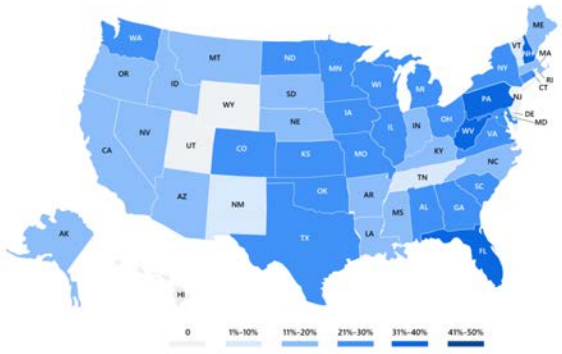
America's Rural Care Deserts Keep Growing

Diminishing access to care within rural communities is not limited to instances of hospital closure or conversion to a model such as REH. As part of our safety net analysis, we have been tracking the loss of other services, most notably OB.

When we first assessed the availability of OB services in rural communities in 2019, our analysis indicated that access to OB services disappeared in 152 rural communities between 2011 and 2018. Our latest analysis reveals a dramatic escalation, especially during the height of the pandemic. Nearly 25 percent of America's rural hospitals (267) have stopped providing OB services since 2011. During the peak years of the pandemic (2020 and 2021), 63 rural hospitals ceased to provide OB services.

West Virginia has the highest percentage of rural hospitals dropping OB services from 2011 to 2021. Nearly half (46 percent) of the rural hospitals that offered OB services in West Virginia eliminated them during our review period. Close behind are Florida (43 percent), Pennsylvania (41 percent), and New Hampshire (40 percent). In West Virginia, Florida, and New Hampshire, the number of rural hospitals left in the State offering OB services is fewer than 10.

Figure 6: Percentage of rural hospitals that stopped offering OB between 2011 and 2021



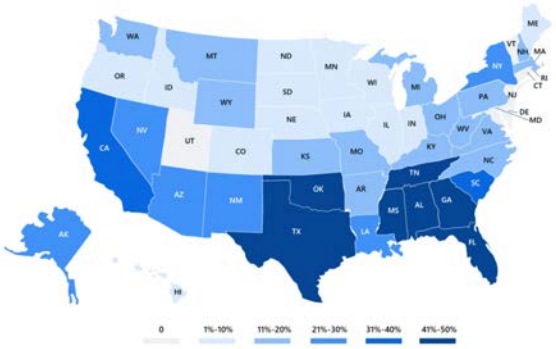
Looking at States losing the greatest overall number of rural OB units between 2011 and 2021, Minnesota (22), Iowa (20), Texas (17), Wisconsin (16), and Kansas (14) are at the top of the list. States such as Utah and Wyoming (with 20 and 16 rural hospitals offering OB services, respectively) have not yet lost any rural OB units.

Across the safety net, OB is not the only service closing. Our analysis also indicates that access to chemotherapy is diminishing at an equally worrisome rate. Between 2014 and 2022, 382 rural hospitals stopped providing chemotherapy in their communities—an increase from the 353 reported in our 2023 safety net study.

Texas has the highest percentage of rural hospitals eliminating chemotherapy from 2014 to 2022. Within Texas, 47 percent of rural hospitals that offered chemotherapy have since stopping offering the service. After Texas, Alabama (46 percent), Mississippi (45 percent), Tennessee (44 percent), and Florida (39 percent) round out the group of 5 States with the highest percentage losses.

As is the case with our OB analysis, some of the same States suffering the greatest percentage loss have also seen the greatest number of rural hospitals drop chemotherapy. The State of Texas (57) again tops the list, followed by Oklahoma (23), Georgia (23), Tennessee (22), and Mississippi (21).

Figure 7: Percentage of rural hospitals that stopped offering chemo between 2014 and 2022



Responding to the Reality Within the Data

The fact that 50 percent of rural hospitals are operating in the red and nearly 420 are vulnerable to closure should serve as an urgent call to accelerate efforts at the State and national levels to reinforce the rural health safety net and ensure access to care for underresourced and socioeconomically disadvantaged communities.

The new REH designation, a larger stake in rural health care at the health system level, and the resourcefulness and collaboration born from the pandemic all have laid a foundation upon which hospital leaders, advocates, and elected officials can build to release some of the pressures driving rural hospitals into the red. These efforts, however, will have to be accompanied by innovative ideas that can ensure rural communities have appropriate and affordable access to the care they need.

America's rural hospitals have proven capable of incredible resiliency and an unwavering commitment to serve their communities. Our annual recognition of Top 100 performers serves as a lens into rural hospital success stories. The experiences, insights, and best practices from these types of facilities could jumpstart the exchange of ideas across the whole of the rural health safety net.

Today's hearing is important and timely. I have dedicated the last 20 years of my career to advancing rural health care in America, and I am deeply invested in helping rural hospitals deliver quality, affordable care to some of our most vulnerable communities.

I would like to express sincere thanks to Chartis leadership, including Anneliese Gerland who is here today for her support; and William Balfour, Troy Brown, Melanie Pinette, and Ana Wiesse of the Chartis Center for Rural Health whose research informed this testimony.

Thank you again for the opportunity to speak before you today. I look forward to your questions.

Links

https://www.chartis.com/rural-health

https://www.chartis.com/insights/shifting-market-medicare-advantage-shows-continued-growth

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https://www.chartis.com/top-performing-rural-hospitals

https://email.chartis.com/hubfs/CCRH/INDEX%20Top%20100/CCRH_Vulnerability%20Research%20Methodology%20FINAL%2002.12.2024.pdf

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QUESTIONS SUBMITTED FOR THE RECORD TO MICHAEL TOPCHIK

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. I often hear how hard it is for rural hospitals to keep up with prior authorization requests from insurance companies. Some of this additional burden is driven by the growth of Medicare Advantage in rural counties. While I am a supporter of the competition that Medicare Advantage offers, we must aggressively hold these plans accountable. In January 2024, the Centers for Medicare and Medicaid Services (CMS) finalized regulations that establish prior authorization timeliness requirements for Medicare Advantage. CMS estimates that the current annual cost of prior authorization paperwork for an individual physician is $54,642 per year. CMS estimates when this regulation goes into effect in 2026 that those costs will be reduced by $21,026, or 38 percent).

Will the administrative burden be 38 percent less because of these new regulations?

Answer. We support the efforts of the United States Congress and Federal agencies such as CMS to devise solutions that could create more efficiency in the delivery of care, particularly as it relates to rural care delivery and access. That said, my team has not analyzed this specific dimension of the CMS regulation, so it is not appropriate for me to comment on those estimates.

Question. Are there current insurance companies or payers more willing to adopt administrative simplifications? If so, who are they and what have they been able to simplify?

Answer. Our discussions with stakeholders from across the rural health-care spectrum indicate that yes, there are parties willing to work proactively together to ease different challenges associated with administrative requirements. These discussions have been general in nature. Because they have not included actions by specific organizations, or their efficacy, they do not support additional comment from us at this time.

Question. You mentioned in your written statement that nearly 60 percent of rural hospitals are now affiliated with a health system. A rural hospital's affiliation with a health system can take on several different definitions and arrangements.

Does rural hospital affiliation look the same in every instance? Are there certain types of affiliations that are more advantageous for rural hospitals?

Answer. In my opening statement, I noted that 50 percent of America's rural hospitals are in the red. For those facilities affiliated with a health system, however, the metric is a slightly more positive 42 percent. For rural hospitals struggling to keep their doors open or to find the staff necessary to maintain access to specific services, affiliation can offer a pathway that supports their mission.

Our research tells us that rural communities are vulnerable and underserved. The business- and care-related drivers surrounding affiliation may differ from one instance to the next. But this type of partnership can, and in many instances does, introduce resources (*e.g.,* staff, technology, and physical locations) that help to improve the local delivery of care. We have found that today, nearly 60 percent of rural hospitals are system-affiliated, though the specifics of these affiliation models and arrangements differ across organizations. While our research has identified the extent of affiliation across the rural safety net, it does not offer a full assessment of outcomes tied to specific arrangements for individual rural hospitals that would inform a viewpoint on that aspect of your question at this time. I expect we will continue to see growth in affiliation models, given persistent pressures surrounding rural hospital delivery, access, affordability, and equity.

Question. You mentioned in your written statement that Medicare fee-for-service data is made available to rural hospitals while data from Medicare Advantage plans is not made available.

Are there certain data points more helpful to rural hospitals? What is the barrier to making this data available?

Answer. Accessing and analyzing complex data sets can be challenging for rural hospitals, given the types of resource constraints and staff recruitment challenges we have discussed as part of this hearing. In our experience, hospital leadership teams generally desire to leverage sophisticated data and analytics as part of their strategic decision-making process. The reality, however, is that financial, technical, and staffing requirements often create barriers that can be difficult to overcome. Whether the data sets are related to Medicare Advantage or other aspects of hospital operations, I would encourage those with a stake in rural health care to explore opportunities to reduce those barriers.

Question. In my 99-county tour of Iowa, I frequently hear about the workforce shortages in health care. Some rural hospitals have established community-led strategies to address their workforce needs. This includes proactive engagement with middle and high school students, supporting or developing a pipeline of health-care professionals with a local college, professional school training opportunities, and a robust recruitment strategy.

What should a comprehensive workforce strategy look like for a rural hospital? If possible, please provide leading examples of rural hospitals deploying a successful community-led strategy.

Answer. All the components you reference in your question (*e.g.,* robust recruiting, building a pipeline, and proactively engaging younger students) are essential and should be part of any rural hospital's workforce strategy. Strategies that will be most effective will blend traditional practices with innovative, out-of-the-box thinking, such as the workforce housing program Mr. Jeremy Davis from Grande Ronde Hospital described during the hearing. I would also refer to the expertise offered by other witnesses, including Lori Rodefeld, who offered very helpful perspective on rural communities and GME, and Dr. Keith Mueller, who shared perspective on workforce dynamics across the full care team, including not only physicians and nurses but also community health workers, behavioral health specialists, pharmacists, and others who are essential to the provision of rural care.

QUESTION SUBMITTED BY HON. JOHN CORNYN

Question. In a February 2023 paper on 340B, your organization notes the "program is at a crossroads as it needs greater transparency and accountability." Additionally, further reports highlight 340B's lax rules incentivize urban hospitals to attain designation as a Rural Referral Center (RRC), and they are ramping up 340B drug purchases faster than any other type of 340B hospital (+700 percent over 5 years). However, about 82 percent of Rural Referral Centers in the 340B program were not located in areas designated as rural by HRSA, and only about 23 percent of the patients treated by RRCs live in an area designated as rural by HRSA.

I am curious to learn what reform ideas Chartis can share to improve program accountability, increase transparency of how 340B impacts rural patient affordability, and ensure a direct benefit for all Medicare patients?

Answer. For rural hospitals, the 340B program is an important tool for offsetting reimbursement pressure. A survey we conducted in 2023 in partnership with the National Rural Health Association, for example, showed that nearly 40 percent of respondents estimated that their annual 340B benefit was $750,000 or more. Most rural hospital leaders who participated in the survey said the 340B savings are used to support their workforce needs, add or expand clinical services, and accommodate charity care. Beyond understanding how the current program is utilized by rural hospitals, we have not delved into specific policy or program design, so I cannot comment on those areas specifically.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. Rural health access goes beyond hospitals and is especially pertinent in discussions around access to long-term care services. We need to support the rural health-care workforce, so older adults and people with disabilities receiving care at home and in congregate settings receive high quality care that prioritizes their safety, health, and dignity. The connection between staffing levels in nursing homes and the safety and quality of care is well established. The new Federal standard takes a step towards ensuring residents receive this high-quality care by establishing commonsense staffing minimums and improving enforcement. A number of States, in-

cluding my home State of Pennsylvania, already have staffing requirements in place. I appreciate that staffing minimums may be difficult to implement in some areas of the country and was glad to see the Federal rule offer additional flexibilities for rural nursing homes. Rural communities would greatly benefit from bipartisan support for policies that not only protect residents, but also bolster access to nursing home care, like increased Medicaid funding. That is why I recently introduced the Long-Term Care Workforce Support Act, which would ensure that caregiving can be a sustainable, lifelong career by providing substantial new funding to support workers in every part of the long-term care industry. My bill includes a grant program to support the rural health-care workforce. I urge my colleagues on both sides of the aisle to work with me and other long-term care champions to address rural workforce concerns while also protecting the quality of long-term care.

What are some policy proposals that Congress should consider to ensure people with disabilities and older adults in rural communities have access to long-term care services?

Answer. Across rural America, the delivery of care is constrained by staffing shortages and challenging economics. Over the last 2 decades, rural areas have experienced a steady erosion of services, ranging from long-term care to home health and hospice, and even emergency medical services (EMS).

Our rural communities are older, less healthy, and less affluent than their urban counterparts, and more than 60 percent of Healthcare Professional Shortage Areas (HPSAs) are in rural locations. I applaud efforts like the Long-Term Care Workforce Support Act, which aims to create a more viable pathway for individuals wanting to be part of the health-care ecosystem in rural communities. We also cannot overlook reimbursement and other related policy levers. To the extent Congress can consider special rural reimbursements for long-term care or EMS, for example, we would expect to see greater sustainability of services in rural communities.

Question. Unfortunately, like many Americans, Pennsylvanians know the effect of hospital and service closures all too well. In your testimony, you note that nearly 25 percent of America's rural hospitals have stopped providing OB services since 2011. In my home State of Pennsylvania, 32,000 women now live in maternity care deserts. These closures are coupled with America's dismal maternal mortality and morbidity rates, creating even greater barriers to healthy mothers and babies.

What policy options should Congress consider to make certain hospitals can maintain their labor and delivery services, ensuring women and families are never too far from the care they need?

Answer. As our research has shown, America's rural OB deserts are widening at a rapid rate. Expecting mothers must not only drive further for delivery but also for prenatal and postnatal care. Providing labor and delivery services is a costly endeavor for a rural hospital. Most births in rural communities are reimbursed by Medicaid—which is the single largest payer for births in this country and widely known for its relatively lower reimbursement rates. Given their financial duress and the challenging economics of labor and delivery services, many rural hospitals are unable to sustain these programs.

If we are to turn the tide on the loss of access to OB, we need to identify more opportunities for Federal and State partnerships around Medicaid that have the potential to increase rural hospital reimbursements for maternal care and expand the scope of care from prenatal through postpartum into the newborn's first year of life. Legislative efforts in Washington, DC, such as the Healthy Moms and Babies Act (H.R. 4605/S. 948) and the CARE for Moms Act (H.R. 5568), and ongoing work by groups like the American College of Obstetricians and Gynecologists have the potential to improve maternal and infant care within rural communities.

At the same time, initiatives to address reimbursement pressure and improve maternal care through policy should be complemented by care delivery innovation. Hybrid models that harness telehealth's ability to bridge geographical gaps, for example, may offer viable avenues for some rural hospitals or health systems with rural affiliates to provide prenatal care closer to home while centralizing deliveries at larger facilities.

QUESTION SUBMITTED BY HON. MAGGIE HASSAN

Question. Hospital consolidation has increased in recent years, which can increase health-care costs for patients and limit patients' choices in rural communities.

When a hospital system buys up all the medical facilities in a community or even across many States, it often increases prices, which can make it even more difficult for families to afford their health care.

At the same time, we need to identify how to better support small rural hospitals that operate on thin margins.

What can Congress do to support the financial viability of rural hospitals? How do we balance support for rural facilities with affordability for patients in those communities?

Answer. When the mission of a rural hospital and its health system are aligned (as they most frequently are), then rural hospitals and their communities tend to benefit from access to additional resources and services availed by such an affiliation. It is in these instances, for example, where we commonly see clinical services introduced into rural areas to meet unmet community health needs. There are also financial benefits to affiliation: the data shows that 42 percent of system-affiliated rural hospitals are in the red, as opposed to 55 percent of independent facilities. That said, even many independent facilities engage in softer affiliations and partnerships with health systems to support their communities through improved access across the continuum of care.

Congress can best support affiliated and independent rural hospitals by exploring opportunities to relieve downward pressure on hospital reimbursement, expand insurance coverage, and create new opportunities for investment in rural communities. These include clinical care innovation afforded by new digitally enabled models and workforce development efforts.

For example, our research suggests that rural hospitals in States that have not implemented Medicaid expansion are more vulnerable than their peers in expansion States. Pressure from other policies, such as sequestration and bad debt reimbursement, also continues to negatively impact reimbursement. According to our analysis, sequestration will cost rural hospitals more than $500 million this year and the equivalent of 9,000 health-care jobs. Similarly, cuts in bad debt reimbursement will claim approximately $175 million in revenue and the equivalent of an additional 3,100 health-care jobs.

Cost-based reimbursement via the Critical Access Hospital program has helped to offset some of the financial challenges rural hospitals face and allowed these facilities to continue to serve their communities. There may be opportunities to revisit equivalent programmatic changes that could apply to the approximately 800 rural hospitals that are not designated as critical access and thus unable to capture the benefits associated with cost-based reimbursement.

SUBMITTED BY HON. ELIZABETH WARREN,
A U.S. SENATOR FROM MASSACHUSETTS

Congress of the United States

Washington, DC 20515

May 5, 2024

Lucinda M. Baier
President, Chief Executive Officer, and Director
Brookdale Senior Living
111 Westwood Place, Suite 400
Brentwood, Tennessee 37027

Ms. Baier:

We are contacting you to seek an explanation for the discrepancy between Brookdale Senior Living Inc.'s massive payouts in executive salaries, stock buybacks and dividends, and the nursing home industry's simultaneous opposition—based on claims that they are too expensive—to new rules to increase staffing and protect nursing home residents.

These two competing claims do not add up. A new analysis conducted by my office reveals that the for-profit nursing home industry diverts hundreds of millions of dollars in cash away from nursing home staff and patient care, and into the pockets of company executives and shareholders. This analysis reveals that three of the

largest publicly traded nursing home companies have paid out nearly $650 million in dividends, buybacks, and compensation to top executives since 2018.[1]

Between 2018 and 2023, Brookdale Senior Living handed out nearly $68 million in dividend payments and stock buybacks, and you and other top executives received almost $50 million in pay and other compensation between 2018 and 2022.[2] These massive expenditures to enrich shareholders and executives undermine the claim that nursing homes cannot afford to pay for enough staff to meet the Biden administration's new nursing home staffing standards.[3]

Strong Nursing Home Staffing Standards Would Improve Nursing Home Resident Care

On April 22, 2024, the Centers for Medicare and Medicaid Services (CMS) finalized a new rule to set a floor for minimum staffing requirements in nursing homes.[4] The rule requires that Medicare and Medicaid-certified nursing home facilities meet a minimum staffing ratio of 0.55 hours of registered nurse (RN) care per patient per day and 2.45 hours of nurse aide (NA) care per patient per day, as well as an overall total of 3.48 hours of nurse care per patient per day.[5] In addition, the new standards require that all nursing homes have at least one registered nurse on site 24 hours per day, 7 days a week.[6] Several independent studies support even stronger staffing standards to ensure resident safety and improved care outcomes.[7]

Nursing home staffing is directly linked to the quality of care residents receive. A report prepared by Senators Warren, Sanders, and Blumenthal in November 2023 revealed that nursing homes with higher staffing levels have higher overall quality ratings, lower levels of patient abuse, and higher quality care.[8] Another study of nursing facilities found that increasing nursing home staffing by 20 minutes per resident per day was associated with 22 percent fewer confirmed cases of COVID–19 and 26 percent fewer COVID–19 deaths.[9] Understaffing in nursing homes is also associated with the misdiagnosis and over-medication of residents, increasing risks of death.[10] Finally, a joint investigation in 2023 by the Senate Committee on Finance and the Senate Special Committee on Aging found that understaffing at nursing homes contributes to inadequate emergency preparedness.[11] Strong staffing

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[1] S&P Capital IQ Data, CY 2018–CY 2023, on file with the Office of Elizabeth Warren; Senior Living, "The Largest Assisted Living and Senior Care Companies," Jeff Hoyt, March 13, 2024, *https://www.seniorliving.org/companies/*. Staff eliminated facilities that were not publicly traded, and/or not nursing home facilities. This analysis focuses on the financial data of three of the largest, publicly traded nursing home facilities—Brookdale Senior Living, Ensign Group, and National HealthCare Corporation.

[2] *Id*.

[3] AHCA/NCAL, "New Analysis Finds Federal Staffing Mandate Would Require 100,000 Additional Nurses and Nurses' Aides, Cost $6.8 Billion Per Year," September 26, 2023. *https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Analysis-Finds-Federal-Staffing-Mandate-Would-Require-100%2C000-Additional-Nurses-and-Nurses%E2%80%99-Aides%2C-Cost-%246-8-Billion-Pe.aspx*.

[4] CMS, "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442–F)," press release, April 22, 2024, *https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0*.

[5] *Id*.

[6] *Id*.

[7] Abt Associates Inc., "Nursing Home Staffing Study: Comprehensive Report," June, 2023, *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf;* National Library of Medicine, "The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008–2014)," 2015, Mary Ellen Dellefield, Nickolas G Castle, Katherine S McGilton, Karen Spilsbury, *https://pubmed.ncbi.nlm.nih.gov/26281280/;* National Library of Medicine, "Nurse Staffing and Coronavirus Infections in California Nursing Homes," August 2020, Charlene Harrington, Leslie Ross, Susan Chapman, Elizabeth Halifax, Bruce Spurlock, Debra Bakerjian, *https://pubmed.ncbi.nlm.nih.gov/32635838/*.

[8] Offices of Senators Elizabeth Warren, Bernie Sanders, and Richard Blumenthal, "Residents at Risk: Quality of Care Problems in Understaffed Nursing Homes and the Need for a New Federal Nursing Home Staffing Standard," November 16, 2023, *https://www.warren.senate.gov/imo/media/doc/Nursing%20Home%20Report%20110823.pdf*.

[9] *Journal of the American Geriatrics Society,* "COVID–19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates," Yue Li, Helena Temkin-Greener, Gao Shan, and Xueya Cai, June 18, 2020, *https://doi.org/10.1111/jgs.16689*.

[10] *New York Times,* "Phony Diagnoses Hide High Rates of Drugging at Nursing Homes," Katie Thomas, Robert Gebeloff, and Jessica Silver-Greenberg, September 11, 2021, *https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html*.

[11] Majority Staff of U.S. Senate Finance Committee and U.S. Senate Special Committee on Aging, "Left in the Dark: The Impact of the 2021 Texas Blackout on Long-Term Care Residents

standards are essential to ensure quality of care for millions of residents. The nursing home industry's opposition to the rule is alarming.

The Nursing Home Industry Opposes New Standards

Despite the significant benefits of safe staffing for nursing home residents, the for-profit nursing home industry has fiercely opposed the staffing mandate—and is gearing up to kill the rule now that it has been finalized. Hours after CMS finalized the rule on April 22, 2024 nursing home trade group the American Health Care Association (AHCA) said it would "vigorously defend nursing home members by any means necessary and is exploring all options," with legal experts anticipating the industry will bring the rule to court.[12] Just over 1 week later, on April 30th, the House Energy and Commerce Committee considered legislation recently approved out of Ways and Means in March that would prevent CMS "from implementing or enforcing" the Biden administration's rule,[13] and in the Senate, some members are "considering other legislation to roll back the regulation or to overturn it through the Congressional Review Act," an act that allows Congress to rescind final rules that Federal agencies issue.[14]

The AHCA—the largest association representing long-term and post-acute care providers in the U.S. (and an organization to which Brookdale Senior Living belongs)[15]—in its campaign against the rule, has cited concerns about "increased operating costs" and a shortage of available nursing home staff.[16] You submitted a public comment to CMS on behalf of Brookdale Senior Living Inc. strongly encouraging CMS to abandon the rule, arguing that it would force homes to "cease operations" due to an inability to meet the rule's "onerous requirements."[17]

This opposition makes little sense on the most obvious level: thousands of nursing homes already meet the CMS staffing requirements.[18] Additionally, despite claims that there is a nursing shortage, the number of nurses passing the nursing licensure exam has steadily grown since 2017.[19] However, turnover is high due to poor working conditions, understaffing of facilities, and low pay—conditions that you are in

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and the Need to Improve Emergency Preparedness," February 22, 2023, *https://www.finance.senate.gov/imo/media/doc/022223%20Left%20in%20the%20Dark%20Two%20Pager.pdf*.

[12] Modern Healthcare, "Legal challenges likely for nursing home staffing mandate," Diane Eastabrook, April 29, 2024, *https://www.modernhealthcare.com/providers/nursing-home-staffing-rule-court-lawsuit-ahca.*

[13] Axios, "E&C considers bills overturning Biden rules," Victoria Knight, April 30, 2024, *https://www.axios.com/pro/health-care-policy/2024/04/30/gop-bills-overturn-biden-rules;* McKnights Long-Term Care News, "Bill to block staffing rule, other LTC measures to headline Congressional hearing," Kimberly Marselas, April 29, 2024, *https://www.mcknights.com/news/bill-to-block-staffing-rule-other-ltc-measures-to-headline-congressional-hearing/*.

[14] Modern Healthcare, "Legal challenges likely for nursing home staffing mandate," Diane Eastabrook, April 29, 2024, *https://www.modernhealthcare.com/providers/nursing-home-staffing-rule-court-lawsuit-ahca.*

[15] AHCA/NCAL, Facility Directory, *https://members.ahcancal.org/Membership/Facility-Directory.* A facility directory search reveals Brookdale has many facilities associated with the AHCA.

[16] AHCA/NCAL, "New Analysis Finds Federal Staffing Mandate Would Require 100,000 Additional Nurses and Nurses' Aides, Cost $6.8 Billion Per Year," press release, September 26, 2023, *https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Analysis-Finds-Federal-Staffing-Mandate-Would-Require-100%2C000-Additional-Nurses-and-Nurses%E2%80%99-Aides%2C-Cost-%246-8-Billion-Pe.aspx.*

[17] Comment on CMS–2023–0144–0001, "Brookdale Senior Living Comment on CMS SNF Staffing Proposed Rule," Lucinda Baier, October 27, 2023, p. 1, *https://www.regulations.gov/comment/CMS-2023-0144-19593.*

[18] KFF, "What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?" Alice Burns, Priya Chidambaram, Tricia Neuman, and Robin Rudowitz, September 18, 2023, *https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/*.

[19] National Nurses United Memorandum to Interested Parties, "Nurses insist: There is no 'shortage,' but there is a serious hospital staffing crisis," May 15, 2023, p. 2, *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/Reporter_Memo_Hospital_Staffing_Crisis.pdf.*

position to rectify.[20] CMS' new rule to set a minimum staffing standard would make these jobs more attractive to workers.[21]

Three of the Largest For-Profit Nursing Homes Handed Out Nearly $650 Million in Buybacks, Dividends, and CEO Salaries since 2018

Contrary to the industry's claims that nursing homes are cash strapped and unable to afford the additional staff needed to comply with the rule and provide better care for residents, my staff's review of the financial data from three of the Nation's largest publicly traded nursing home chains—National HealthCare Corporation, Brookdale Senior Living Inc., and the Ensign Group Inc.—reveals that the industry has repeatedly chosen to enrich shareholders and executives, rather than reinvest in its facilities and workforce to ensure quality care. In fact, the industry spent nearly $650 million since 2018 on stock buybacks, dividend payments, and rich rewards to top executives.[22]

1. Stock Buybacks and Dividends

The data analyzed by my staff reveals that these three large, for-profit nursing homes handed out over $423 million in dividends and stock buybacks since 2018. (Table 1) These buybacks and dividends represent excess revenues that could have been used to improve quality of care, increase staff wages, offer staff trainings, or hire new staff. Instead, they were used to enrich executives and shareholders.

Combined, the three companies paid out over $423 million in buybacks and dividends between 2018 and 2023, and Brookdale Senior Living gave out nearly $68 million. (Table 1)

Table 1. Dividend Payments and Stock Buybacks by Three of the Largest Publicly Traded Nursing Home Companies in the U.S. 2018–2023 [23]

Year	Company Name		
	National HealthCare Corporation	The Ensign Group, Inc.	Brookdale Senior Living Inc.
2018	$30,700,000	$9,420,000	$7,320,000
2019	$32,080,000	$17,080,000	$27,270,000
2020	$31,970,000	$36,750,000	$22,160,000
2021	$32,870,000	$23,380,000	$4,820,000
2022	$44,500,000	$43,750,000	$4,290,000
2023	$38,040,000	$14,820,000	$1,920,000
TOTAL	**$210,160,000**	**$145,200,000**	**$67,780,000**

These estimates represent only three of the largest publicly traded nursing home companies. Thousands of nursing homes are owned by private equity firms, private real estate investment trusts, or other private corporations that do not make their profits publicly available and therefore cannot be included in these estimates.[24]

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[20] National Nurses United Memorandum to Interested Parties, "Nurses insist: There is no 'shortage,' but there is a serious hospital staffing crisis," May 15, 2023, *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/Reporter_Memo_Hospital_Staffing_Crisis.pdf;* Institute for Women's Policy Research, "Solving the Nursing Shortage through Higher Wages," Vicky Lovell, 2006, p. 8, *https://people.umass.edu/econ340/rn_shortage_iwpr.pdf.*

[21] Institute for Women's Policy Research, "Solving the Nursing Shortage through Higher Wages," Vicky Lovell, 2006, pp. 8–9, *https://people.umass.edu/econ340/rn_shortage_iwpr.pdf.*

[22] S&P Capital IQ Data, CY 2018–CY 2023, on file with the Office of Elizabeth Warren.

[23] S&P Capital IQ Data.

[24] Fortune, "For-profit groups have vacuumed up over 70% of America's nursing homes, and health advocates are worried: 'The care gets really bad,'" Harris Meyer and KFF Health News, March 12, 2024, *https://fortune.com/2024/03/12/nursing-homes-for-profit-private-equity/*.

2. High Executive Salaries

The data analyzed by my staff further indicates that Brookdale Senior Living and other large for-profit nursing home chains are richly rewarding their top executives, paying them hundreds of millions of dollars, while refusing to invest in safe staffing levels, even as seniors are forced to live in nursing homes with deplorable conditions.[25] In total, these three nursing home chains paid their top executives over $220 million from 2018–2022. (Table 2)

You personally received over $15 million in compensation from 2018–2022. Your other top directors and executives also made millions of dollars. Brookdale Senior Living's Former Executive VP and CFO received nearly $6 million in this 5-year period, and your former Executive Vice President of Strategic Operations made over $3 million in only 3 years (2018–2020).[26] In total, Brookdale's top executives and directors were paid nearly $50 million in this 5-year period (see Table 2). The other four large nursing home companies also paid out millions of dollars in compensation for executives and board members.

Table 2. Total Executive Compensation of Three of the Largest Publicly Traded For-Profit Nursing Homes in the U.S. 2018–2022 [27]

Year	Company Name		
	National HealthCare Corporation	The Ensign Group, Inc.	Brookdale Senior Living Inc.
2018	$4,434,788	$19,592,785	$12,661,803
2019	$5,555,999	$24,424,196	$6,918,521
2020	$4,505,937	$30,537,187	$9,245,697
2021	$7,633,198	$29,679,865	$10,154,726
2022	$4,402,202	$40,568,813	$9,960,760
TOTAL	**$26,532,124**	**$144,802,846**	**$48,941,507**

3. Nursing Homes Use Other Schemes to Hide Profits and Enrich Executives at the Expense of Resident Care

Massive payouts to executives and shareholders are not the only way that nursing home revenues are diverted from patient care. A detailed new analysis released earlier this month revealed that nursing homes artificially decrease their profit margins by redirecting profits to "related parties."[28] By paying especially high rents or management service fees to a related party that shares the same owner as the nursing homes, these businesses are able to hide up to two thirds of their profits.[29] Nursing homes are increasingly using this deceptive tactic to bolster their arguments to Congress that it can't meet quality standards, when in reality their reported losses are funneled back into their own pockets: between 2001 and 2021, nursing home payments to related parties more than doubled.[30] This is additional evidence that nursing homes can afford to meet higher staffing standards, but are simply unwilling to do so.

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[25] Human Rights Watch, "US: Concerns of Neglect in Nursing Homes," March 25, 2021, *https://www.hrw.org/news/2021/03/25/us-concerns-neglect-nursing-homes.*

[26] S&P Capital IQ Data.

[27] *Id.*

[28] STAT, "Nursing home owners can hide nearly two-thirds of their profits, new study shows," Brittany Trang, March 7, 2024, *https://www.statnews.com/2024/03/07/nursing-homes-hide-profits-with-related-party-ploys/*.

[29] *Id.*

[30] National Bureau of Economic Research, "Tunneling and Hidden Profits in Health Care," Ashvin Gandhi and Andrew Olenski, March 4, 2024, p. 10, *https://www.nber.org/system/files/working_papers/w32258/w32258.pdf.*

Conclusion

There are approximately 1.2 million nursing home residents in the United States.[31] We are grievously disappointed by the nursing home industry's opposition to the administration's efforts to ensure these residents receive high quality care, and seek an explanation for why Brookdale Senior Living and other for-profit nursing home companies—which handed out nearly $650 million in buybacks and dividends and have richly rewarded their top executives—claim they cannot afford to meet CMS' new minimum staffing standards. We therefore request that you provide the following information by May 20, 2024:

1. How does the Board of Brookdale Senior Living determine executive compensation and bonuses for you and other top executives?
   a. What considerations are factored into bonuses received by you and other top executives?
   b. Specifically, are any bonuses determined by quality of care metrics?
   c. Are bonuses tied to profits?
   d. Do you receive any kind of bonus tied to reducing staff or other expenses?
2. What is the average annual compensation for registered nurses (RNs) and nurse aides (NAs) at Brookdale Senior Living facilities?
3. What is the rate of turnover of nursing staff in Brookdale Senior Living facilities?
   a. What is the average tenure of licensed nurses?
   b. What is the average tenure of nurse aides?
4. How much does Brookdale Senior Living spend annually on training for its nursing staff?
5. Please provide any complaints or comments submitted to the company by nurses or other staff including the words "under-staffed," "staffing," and "salary".
6. Please provide a list of all lobbying or advocacy expenditures by Brookdale, including contributions to the AHCA that may have been used to lobby or advocate against the finalized nursing home staffing standards from January 2021 through the present.

Thank you for your attention to this matter.

Sincerely,

Elizabeth Warren
United States Senator

Bernard Sanders
United States Senator

Richard Blumenthal
United States Senator

Lloyd Doggett
Member of Congress

Jan Schakowsky
Member of Congress

Congress of the United States

Washington, DC 20515

May 5, 2024

Christopher R. Christensen
Executive Chairman
The Ensign Group, Inc.
29222 Rancho Viejo Rd, Suite 127
San Juan Capistrano, CA 92675

Mr. Christensen:

We are contacting you to seek an explanation for the discrepancy between the Ensign Group Inc.'s massive payouts in executive salaries, stock buybacks and dividends, and the nursing home industry's simultaneous opposition—based on claims

[31] U.S. Department of Health and Human Services, Office of Inspector General, "Nursing Homes," February 29, 2024, *https://oig.hhs.gov/reports-and-publications/featured-topics/nursing-homes/*.

that they are too expensive—to new rules to increase staffing and protect nursing home residents.

These two competing claims do not add up. A new analysis conducted by my office reveals that the for-profit nursing home industry diverts hundreds of millions of dollars in cash away from nursing home staff and patient care, and into the pockets of company executives and shareholders. This analysis reveals that three of the largest publicly traded nursing home companies have paid out nearly $650 million in dividends, buybacks, and compensation to top executives since 2018.[1]

Between 2018 and 2023, the Ensign Group handed out over $145 million in dividend payments and stock buybacks, and you and other top executives received nearly $145 million in pay and other compensation between 2018 and 2022.[2] Your executives received more in pay and compensation than executives at the other two nursing home chains combined. These massive expenditures to enrich shareholders and executives undermine the claim that nursing homes cannot afford to pay for enough staff to meet the Biden administration's new nursing home staffing standards.[3]

Strong Nursing Home Staffing Standards Would Improve Nursing Home Resident Care

On April 22, 2024, the Centers for Medicare and Medicaid Services (CMS) finalized a new rule to set a floor for minimum staffing requirements in nursing homes.[4] The rule requires that Medicare and Medicaid-certified nursing home facilities meet a minimum staffing ratio of 0.55 hours of registered nurse (RN) care per patient per day and 2.45 hours of nurse aide (NA) care per patient per day, as well as an overall total of 3.48 hours of nurse care per patient per day.[5] In addition, the new standards require that all nursing homes have at least one registered nurse on site 24 hours per day, 7 days a week.[6] Several independent studies support even stronger staffing standards to ensure resident safety and improved care outcomes.[7]

Nursing home staffing is directly linked to the quality of care residents receive. A report prepared by Senators Warren, Sanders, and Blumenthal in November 2023 revealed that nursing homes with higher staffing levels have higher overall quality ratings, lower levels of patient abuse, and higher quality care.[8] Another study of nursing facilities found that increasing nursing home staffing by 20 minutes per resident per day was associated with 22 percent fewer confirmed cases of COVID–19 and 26 percent fewer COVID–19 deaths.[9] Understaffing in nursing homes is also

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[1] S&P Capital IQ Data, CY 2018–CY 2023, on file with the Office of Elizabeth Warren; Senior Living, "The Largest Assisted Living and Senior Care Companies," Jeff Hoyt, March 13, 2024, *https://www.seniorliving.org/companies/*. Staff eliminated facilities that were not publicly traded, and/or not nursing home facilities. This analysis focuses on the financial data of three of the largest, publicly traded nursing home facilities—Brookdale Senior Living, Ensign Group, and National HealthCare Corporation.

[2] *Id.*

[3] AHCA/NCAL, "New Analysis Finds Federal Staffing Mandate Would Require 100,000 Additional Nurses and Nurses' Aides, Cost $6.8 Billion Per Year," September 26, 2023, *https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Analysis-Finds-Federal-Staffing-Mandate-Would-Require-100%2C000-Additional-Nurses-and-Nurses%E2%80%99-Aides%2C-Cost-%246-8-Billion-Pe.aspx.*

[4] CMS, "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442–F)," press release, April 22, 2024, *https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0.*

[5] *Id.*

[6] *Id.*

[7] Abt Associates Inc., "Nursing Home Staffing Study: Comprehensive Report," June 2023, *https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf;* National Library of Medicine, "The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008–2014)," 2015, Mary Ellen Dellefield, Nickolas G Castle, Katherine S McGilton, Karen Spilsbury, *https://pubmed.ncbi.nlm.nih.gov/26281280/;* National Library of Medicine, "Nurse Staffing and Coronavirus Infections in California Nursing Homes," August 2020, Charlene Harrington, Leslie Ross, Susan Chapman, Elizabeth Halifax, Bruce Spurlock, Debra Bakerjian, *https://pubmed.ncbi.nlm.nih.gov/32635838/*.

[8] Offices of Senators Elizabeth Warren, Bernie Sanders, and Richard Blumenthal, "Residents at Risk: Quality of Care Problems in Understaffed Nursing Homes and the Need for a New Federal Nursing Home Staffing Standard," November 16, 2023, *https://www.warren.senate.gov/imo/media/doc/Nursing%20Home%20Report%20110823.pdf.*

[9] *Journal of the American Geriatrics Society,* "COVID–19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates," Yue Li, Helena Temkin-Greener, Gao Shan, and Xueya Cai, June 18, 2020, *https://doi.org/10.1111/jgs.16689.*

associated with the misdiagnosis and over-medication of residents, increasing risks of death.[10] Finally, a joint investigation in 2023 by the Senate Committee on Finance and the Senate Special Committee on Aging found that understaffing at nursing homes contributes to inadequate emergency preparedness.[11] Strong staffing standards are essential to ensure quality of care for millions of residents. The nursing home industry's opposition to the rule is alarming.

The Nursing Home Industry Opposes New Standards

Despite the significant benefits of safe staffing for nursing home residents, the for-profit nursing home industry has fiercely opposed the staffing mandate—and is gearing up to kill the rule now that it has been finalized. Hours after CMS finalized the rule on April 22, 2024 nursing home trade group the American Health Care Association (AHCA) said it would "vigorously defend nursing home members by any means necessary and is exploring all options," with legal experts anticipating the industry will bring the rule to court.[12] Just over 1 week later, on April 30th, the House Energy and Commerce Committee considered legislation recently approved out of Ways and Means in March that would prevent CMS "from implementing or enforcing" the Biden administration's rule,[13] and in the Senate, some members are "considering other legislation to roll back the regulation or to overturn it through the Congressional Review Act," an act that allows Congress to rescind final rules that Federal agencies issue.[14]

The AHCA—the largest association representing long-term and post-acute care providers in the U.S. (and an organization to which the Ensign Group belongs)[15]—in its campaign against the rule, has cited concerns about "increased operating costs" and a shortage of available nursing home staff.[16]

The Ensign Group has been particularly strategic in its opposition to the rule. Barry Port, your Chief Executive Officer and Director,[17] said during the Ensign Group's 2023 third quarter earnings call that nursing home industry stakeholders should "shape" the proposed CMS staffing rule—arguing that railing against the proposal completely would be futile, but changing (or weakening) the measure could be more successful—and prepare to later on overturn it with a "legal challenge down the road."[18]

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[10] *New York Times,* "Phony Diagnoses Hide High Rates of Drugging at Nursing Homes," Katie Thomas, Robert Gebeloff, and Jessica Silver-Greenberg, September 11, 2021, *https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html.*

[11] Majority Staff of U.S. Senate Finance Committee and U.S. Senate Special Committee on Aging, "Left in the Dark: The Impact of the 2021 Texas Blackout on Long-Term Care Residents and the Need to Improve Emergency Preparedness," February 22, 2023, *https://www.finance.senate.gov/imo/media/doc/022223%20Left%20in%20the%20Dark%20Two%20Pager.pdf.*

[12] Modern Healthcare, "Legal challenges likely for nursing home staffing mandate," Diane Eastabrook, April 29, 2024, *https://www.modernhealthcare.com/providers/nursing-home-staffing-rule-court-lawsuit-ahca.*

[13] Axios, "E&C considers bills overturning Biden rules," Victoria Knight, April 30, 2024, *https://www.axios.com/pro/health-care-policy/2024/04/30/gop-bills-overturn-biden-rules;* McKnights Long-Term Care News, "Bill to block staffing rule, other LTC measures to headline Congressional hearing," Kimberly Marselas, April 29, 2024, *https://www.mcknights.com/news/bill-to-block-staffing-rule-other-ltc-measures-to-headline-congressional-hearing/.*

[14] Modern Healthcare, "Legal challenges likely for nursing home staffing mandate," Diane Eastabrook, April 29, 2024, *https://www.modernhealthcare.com/providers/nursing-home-staffing-rule-court-lawsuit-ahca.*

[15] AHCA/NCAL, Facility Directory, *https://members.ahcancal.org/Membership/Facility-Directory;* the Ensign Group, "Locations," *https://ensigngroup.net/map/.* A cross-check of the Ensign Group's facility names and the AHCA/NCAL facility directory search reveals Ensign has many facilities associated with the AHCA.

[16] AHCA/NCAL, "New Analysis Finds Federal Staffing Mandate Would Require 100,000 Additional Nurses and Nurses' Aides, Cost $6.8 Billion Per Year," press release, September 26, 2023, *https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Analysis-Finds-Federal-Staffing-Mandate-Would-Require-100%2C000-Additional-Nurses-and-Nurses%E2%80%99-Aides%2C-Cost-%246-8-Billion-Pe.aspx.*

[17] Ensign Group, "Management," *https://investor.ensigngroup.net/governance/management/default.aspx.*

[18] Skilled Nursing News, "Ensign CEO: Efforts to Strike Down CMS Staffing Rule Appear 'Futile'-Cut It Can Be Shaped," October 26, 2023, *https://skillednursingnews.com/2023/10/ensign-ceo-efforts-to-strike-down-cms-staffing-rule-appear-futile-but-it-can-be-shaped/?itm_source=parsely-api?itm_campaign=parsely_recommended_widget-2&itmMedium=site_widget&itmSource=parsely_recommended_widget&itm_content=widget_item-1.*

This opposition makes little sense on the most obvious level: thousands of nursing homes already meet the CMS staffing requirements.[19] Additionally, despite claims that there is a nursing shortage, the number of nurses passing the nursing licensure exam has steadily grown since 2017.[20] However, turnover is high due to poor working conditions, understaffing of facilities, and low pay—conditions that you are in position to rectify.[21] CMS' new rule to set a minimum staffing standard would make these jobs more attractive to workers.[22]

Three of the Largest For-Profit Nursing Homes Handed Out Nearly $650 Million in Buybacks, Dividends, and CEO Salaries since 2018

Contrary to the industry's claims that nursing homes are cash strapped and unable to afford the additional staff needed to comply with the rule and provide better care for residents, my staff's review of the financial data from three of the Nation's largest publicly traded nursing home chains—National HealthCare Corporation, Brookdale Senior Living Inc., and the Ensign Group Inc.— reveals that the industry has repeatedly chosen to enrich shareholders and executives, rather than reinvest in its facilities and workforce to ensure quality care. In fact, the industry spent nearly $650 million since 2018 on stock buybacks, dividend payments, and rich rewards to top executives.[23]

1. Stock Buybacks and Dividends

The data analyzed by my staff reveals that these three large, for-profit nursing homes handed out over $423 million in dividends and stock buybacks since 2018. (Table 1) These buybacks and dividends represent excess revenues that could have been used to improve quality of care, increase staff wages, offer staff trainings, or hire new staff. Instead, they were used to enrich executives and shareholders.

Combined, the three companies paid out over $423 million in buybacks and dividends between 2018 and 2023, and the Ensign Group gave out over $145 million. (Table 1)

Table 1. Dividend Payments and Stock Buybacks by Three of the Largest Publicly Traded Nursing Home Companies in the U.S. 2018–2023 [24]

Year	Company Name		
	National HealthCare Corporation	The Ensign Group, Inc.	Brookdale Senior Living Inc.
2018	$30,700,000	$9,420,000	$7,320,000
2019	$32,080,000	$17,080,000	$27,270,000
2020	$31,970,000	$36,750,000	$22,160,000
2021	$32,870,000	$23,380,000	$4,820,000
2022	$44,500,000	$43,750,000	$4,290,000

[19] KFF, "What Share of Nursing Facilities Might Meet Proposed New Requirements for Nursing Staff Hours?" Alice Burns, Priya Chidambaram, Tricia Neuman, and Robin Rudowitz, September 18, 2023, *https://www.kff.org/medicaid/issue-brief/what-share-of-nursing-facilities-might-meet-proposed-new-requirements-for-nursing-staff-hours/*.

[20] National Nurses United Memorandum to Interested Parties, "Nurses insist: There is no 'shortage,' but there is a serious hospital staffing crisis," May 15, 2023, p. 2, *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/Reporter_Memo_Hospital_Staffing_Crisis.pdf*.

[21] National Nurses United Memorandum to Interested Parties, "Nurses insist: There is no 'shortage,' but there is a serious hospital staffing crisis," May 15, 2023, *https://www.nationalnursesunited.org/sites/default/files/nnu/documents/Reporter_Memo_Hospital_Staffing_Crisis.pdf;* Institute for Women's Policy Research, "Solving the Nursing Shortage through Higher Wages," Vicky Lovell, 2006, p. 8, *https://people.umass.edu/econ340/rn_shortage_iwpr.pdf*.

[22] Institute for Women's Policy Research, "Solving the Nursing Shortage through Higher Wages," Vicky Lovell, 2006, pp. 8–9, *https://people.umass.edu/econ340/rn_shortage_iwpr.pdf*.

[23] S&P Capital IQ Data, CY 2018–CY 2023, on file with the Office of Elizabeth Warren.

[24] S&P Capital IQ Data.

Table 1. Dividend Payments and Stock Buybacks by Three of the Largest Publicly Traded Nursing Home Companies in the U.S. 2018–2023 [24]—Continued

Year	Company Name		
	National HealthCare Corporation	The Ensign Group, Inc.	Brookdale Senior Living Inc.
2023	$38,040,000	$14,820,000	$1,920,000
TOTAL	**$210,160,000**	**$145,200,000**	**$67,780,000**

These estimates represent only three of the largest publicly traded nursing home companies. Thousands of nursing homes are owned by private equity firms, private real estate investment trusts, or other private corporations that do not make their profits publicly available and therefore cannot be included in these estimates.[25]

2. High Executive Salaries

The data analyzed by my staff further indicates that the Ensign Group and other large for-profit nursing home chains are richly rewarding their top executives, paying them hundreds of millions of dollars, while refusing to invest in safe staffing levels, even as seniors are forced to live in nursing homes with deplorable conditions.[26] In total, these three nursing home chains paid their top executives over $220 million from 2018–2022. (Table 2)

You personally received over $30.5 million in compensation between 2018 and 2022. Your other top directors and executives also made millions of dollars.[27] The Ensign Group's CFO, Executive VP, and Director made over $35 million in this 5-year period, and your Chief Investment Officer, Executive VP and Secretary made over $21 million.[28] In total, The Ensign Group's top executives and directors were paid nearly $145 million in this 5-year period (see Table 2)—more than any of the other large, for-profit nursing home chains.

Table 2. Total Executive Compensation of Three of the Largest Publicly Traded For-Profit Nursing Homes in the U.S. 2018–2022 [29]

Year	Company Name		
	National HealthCare Corporation	The Ensign Group, Inc.	Brookdale Senior Living Inc.
2018	$4,434,788	$19,592,785	$12,661,803
2019	$5,555,999	$24,424,196	$6,918,521
2020	$4,505,937	$30,537,187	$9,245,697
2021	$7,633,198	$29,679,865	$10,154,726
2022	$4,402,202	$40,568,813	$9,960,760
TOTAL	**$26,532,124**	**$144,802,846**	**$48,941,507**

1. Nursing Homes Use Other Schemes to Hide Profits and Enrich Executives at the Expense of Resident Care

Massive payouts to executives and shareholders are not the only way that nursing home revenues are diverted from patient care. A detailed new analysis released earlier this month revealed that nursing homes artificially decrease their profit mar-

[25] Fortune, "For-profit groups have vacuumed up over 70% of America's nursing homes, and health advocates are worried: 'The care gets really bad,'" Harris Meyer and KFF Health News, March 12, 2024, *https://fortune.com/2024/03/12/nursing-homes-for-profit-private-equity/*.

[26] Human Rights Watch, "US: Concerns of Neglect in Nursing Homes," March 25, 2021, *https://www.hrw.org/news/2021/03/25/us-concerns-neglect-nursing-homes.*

[27] S&P Capital IQ Data.

[28] *Id.*

[29] *Id.*

gins by redirecting profits to "related parties."[30] By paying especially high rents or management service fees to a related party that shares the same owner as the nursing homes, these businesses are able to hide up to two thirds of their profits.[31] Nursing homes are increasingly using this deceptive tactic to bolster their arguments to Congress that it can't meet quality standards, when in reality their reported losses are funneled back into their own pockets: between 2001 and 2021, nursing home payments to related parties more than doubled.[32] This is additional evidence that nursing homes can afford to meet higher staffing standards, but are simply unwilling to do so.

Conclusion

There are approximately 1.2 million nursing home residents in the United States.[33] We are grievously disappointed by the nursing home industry's opposition to the administration's efforts to ensure these residents receive high quality care, and seek an explanation for why the Ensign Group and other for-profit nursing home companies—which handed out nearly $650 million in buybacks and dividends and have richly rewarded their top executives—claim they cannot afford to meet CMS' new minimum staffing standards. We therefore request that you provide the following information by May 20, 2024:

1. How does the Board of the Ensign Group determine executive compensation and bonuses for you and other top executives?
   a. What considerations are factored into bonuses received by you and other top executives?
   b. Specifically, are any bonuses determined by quality of care metrics?
   c. Are bonuses tied to profits?
   d. Do you receive any kind of bonus tied to reducing staff or other expenses?
2. What is the average annual compensation for registered nurses (RNs) and nurse aides (NAs) at Ensign facilities?
3. What is the rate of turnover of nursing staff in Ensign facilities?
   a. What is the average tenure of licensed nurses?
   b. What is the average tenure of nurse aides?
4. How much does the Ensign Group spend annually on training for its nursing staff?
5. Please provide any complaints or comments submitted to the company by nurses or other staff including the words "under-staffed," "staffing," and "salary".
6. Please provide a list of all lobbying or advocacy expenditures by the Ensign Group, including contributions to the AHCA that may have been used to lobby or advocate against the proposed nursing home staffing standards from January 2021 through the present.

Thank you for your attention to this matter.

Sincerely,

Elizabeth Warren
United States Senator

Bernard Sanders
United States Senator

Richard Blumenthal
United States Senator

Lloyd Doggett
Member of Congress

Jan Schakowsky
Member of Congress

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[30] STAT, "Nursing home owners can hide nearly two-thirds of their profits, new study shows," Brittany Trang, March 7, 2024, *https://www.statnews.com/2024/03/07/nursing-homes-hide-profits-with-related-party-ploys/*.

[31] *Id.*

[32] National Bureau of Economic Research, "Tunneling and Hidden Profits in Health Care," Ashvin Gandhi and Andrew Olenski, March 4, 2024, p. 10, *https://www.nber.org/system/files/working—papers/w32258/w32258.pdf.*

[33] U.S. Department of Health and Human Services, Office of Inspector General, "Nursing Homes," February 29, 2024, *https://oig.hhs.gov/reports-and-publications/featured-topics/nursing-homes/*.

Congress of the United States

Washington, DC 20515

May 5, 2024

Stephen F. Flatt
Chief Executive Officer and Inside Director
National HealthCare Corporation
100 East Vine Street
Murfreesboro, TN 37130

Mr. Flatt:

We are contacting you to seek an explanation for the discrepancy between National HealthCare Corporation's massive payouts in executive salaries, stock buybacks and dividends, and the nursing home industry's simultaneous opposition—based on claims that they are too expensive—to new rules to increase staffing and protect nursing home residents.

These two competing claims do not add up. A new analysis conducted by my office reveals that the for-profit nursing home industry diverts hundreds of millions of dollars in cash away from nursing home staff and patient care, and into the pockets of company executives and shareholders. This analysis reveals that three of the largest publicly traded nursing home companies have paid out nearly $650 million in dividends, buybacks, and compensation to top executives since 2018.[1]

Between 2018 and 2023, National HealthCare Corporation handed out over $200 million in dividend payments and stock buybacks, and you and other top executives received over $26.5 million in pay and other compensation between 2018 and 2022.[2] These massive expenditures to enrich shareholders and executives undermine the claim that nursing homes cannot afford to pay for enough staff to meet the Biden administration's new nursing home staffing standards.[3]

Strong Nursing Home Staffing Standards Would Improve Nursing Home Resident Care

On April 22, 2024, the Centers for Medicare and Medicaid Services (CMS) finalized a new rule to set a floor for minimum staffing requirements in nursing homes.[4] The rule requires that Medicare and Medicaid-certified nursing home facilities meet a minimum staffing ratio of 0.55 hours of registered nurse (RN) care per patient per day and 2.45 hours of nurse aide (NA) care per patient per day, as well as an overall total of 3.48 hours of nurse care per patient per day.[5] In addition, the new standards require that all nursing homes have at least one registered nurse on site 24 hours per day, 7 days a week.[6] Several independent studies support even stronger staffing standards to ensure resident safety and improved care outcomes.[7]

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[1] S&P Capital IQ Data, CY 2018–CY 2023, on file with the Office of Elizabeth Warren; Senior Living, "The Largest Assisted Living and Senior Care Companies," Jeff Hoyt, March 13, 2024, *https://www.seniorliving.org/companies/*. Staff eliminated facilities that were not publicly traded, and/or not nursing home facilities. This analysis focuses on the financial data of three of the largest, publicly traded nursing home facilities—Brookdale Senior Living, Ensign Group, and National HealthCare Corporation.

[2] *Id.*

[3] AHCA/NCAL, "New Analysis Finds Federal Staffing Mandate Would Require 100,000 Additional Nurses and Nurses' Aides, Cost $6.8 Billion Per Year," September 26, 2023. *https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/New-Analysis-Finds-Federal-Staffing-Mandate-Would-Require-100%2C000-Additional-Nurses-and-Nurses%E2%80%99-Aides%2C-Cost-%246-8-Billion-Pe.aspx*.

[4] CMS, "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442–F)," press release, April 22, 2024, *https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0*.

[5] *Id.*

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Nursing home staffing is directly linked to the quality of care residents receive. A report prepared by Senators Warren, Sanders, and Blumenthal in November 2023 revealed that nursing homes with higher staffing levels have higher overall quality ratings, lower levels of patient abuse, and higher quality care.[8] Another study of nursing facilities found that increasing nursing home staffing by 20 minutes per resident per day was associated with 22 percent fewer confirmed cases of COVID–19 and 26 percent fewer COVID–19 deaths.[9] Understaffing in nursing homes is also associated with the misdiagnosis and over-medication of residents, increasing risks of death.[10] Finally, a joint investigation in 2023 by the Senate Committee on Finance and the Senate Special Committee on Aging found that understaffing at nursing homes contributes to inadequate emergency preparedness.[11] Strong staffing standards are essential to ensure quality of care for millions of residents. The nursing home industry's opposition to the rule is alarming.

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Despite the significant benefits of safe staffing for nursing home residents, the for-profit nursing home industry has fiercely opposed the staffing mandate—and is gearing up to kill the rule now that it has been finalized. Hours after CMS finalized the rule on April 22, 2024 nursing home trade group the American Health Care Association (AHCA) said it would "vigorously defend nursing home members by any means necessary and is exploring all options," with legal experts anticipating the industry will bring the rule to court.[12] Just over one week later, on April 30th, the House Energy and Commerce Committee considered legislation recently approved out of Ways and Means in March that would prevent CMS "from implementing or enforcing" the Biden administration's rule,[13] and in the Senate, some members are "considering other legislation to roll back the regulation or to overturn it through the Congressional Review Act," an act that allows Congress to rescind final rules that Federal agencies issue.[14]

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[15] AHCA/NCAL, "AHCA/NCAL Elects Board of Governors, Directors at Annual Convention," October 10, 2023, *https://www.ahcancal.org/News-and-Communications/Blog/Pages/AHCANCAL-Elects-Board-of-Governors-Directors-at-Annual-Convention.aspx*.

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1. Stock Buybacks and Dividends

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Combined, the three companies paid out over $423 million in buybacks and dividends between 2018 and 2023, and National HealthCare Corporation paid out over $210 million. (Table 1)

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These estimates represent only three of the largest publicly traded nursing home companies. Thousands of nursing homes are owned by private equity firms, private real estate investment trusts, or other private corporations that do not make their profits publicly available and therefore cannot be included in these estimates.[23]

2. High Executive Salaries

The data analyzed by my staff further indicates that National HealthCare Corporation and other large for-profit nursing home chains are richly rewarding their top executives, paying them hundreds of millions of dollars, while refusing to invest in safe staffing levels, even as seniors are forced to live in nursing homes with deplorable conditions.[24] In total, these three nursing home chains paid their top executives over $220 million from 2018–2022. (Table 2)

You personally received over $6.5 million in compensation between 2018–2022.[25] Your other top directors and executives also made millions of dollars. National HealthCare Corporation's President and COO made over $6 million during this 5-year period, and your Senior Vice President and Chief Information Officer, made over $2.5 million from 2019 through 2022.[26] In total, National HealthCare Corporation's top executives and directors were paid $26.5 million in this 5-year period (see Table 2).

Table 2. Total Executive Compensation of Three of the Largest Publicly Traded For-Profit Nursing Homes in the U.S. 2018–2022 [27]

Year	Company Name		
	National HealthCare Corporation	The Ensign Group, Inc.	Brookdale Senior Living Inc.
2018	$4,434,788	$19,592,785	$12,661,803
2019	$5,555,999	$24,424,196	$6,918,521
2020	$4,505,937	$30,537,187	$9,245,697
2021	$7,633,198	$29,679,865	$10,154,726
2022	$4,402,202	$40,568,813	$9,960,760
TOTAL	**$26,532,124**	**$144,802,846**	**$48,941,507**

3. Nursing Homes Use Other Schemes to Hide Profits and Enrich Executives at the Expense of Resident Care

Massive payouts to executives and shareholders are not the only way that nursing home revenues are diverted from patient care. A detailed new analysis released earlier this month revealed that nursing homes artificially decrease their profit mar-

[23] Fortune, "For-profit groups have vacuumed up over 70% of America's nursing homes, and health advocates are worried: 'The care gets really bad,'" Harris Meyer and KFF Health News, March 12, 2024, *https://fortune.com/2024/03/12/nursing-homes-for-profit-private-equity/*.

[24] Human Rights Watch, "US: Concerns of Neglect in Nursing Homes," March 25, 2021, *https://www.hrw.org/news/2021/03/25/us-concerns-neglect-nursing-homes*.

[25] S&P Capital IQ Data.

[26] *Id.*

[27] *Id.*

gins by redirecting profits to "related parties."[28] By paying especially high rents or management service fees to a related party that shares the same owner as the nursing homes, these businesses are able to hide up to two thirds of their profits.[29] Nursing homes are increasingly using this deceptive tactic to bolster their arguments to Congress that it can't meet quality standards, when in reality their reported losses are funneled back into their own pockets: between 2001 and 2021, nursing home payments to related parties more than doubled.[30] This is additional evidence that nursing homes can afford to meet higher staffing standards, but are simply unwilling to do so.

Conclusion

There are approximately 1.2 million nursing home residents in the United States.[31] We are grievously disappointed by the nursing home industry's opposition to the administration's efforts to ensure these residents receive high quality care, and seek an explanation for why National HealthCare Corporation and other for-profit nursing home companies—which handed out nearly $650 million in buybacks and dividends and have richly rewarded their top executives—claim they cannot afford to meet CMS' new minimum staffing standards. We therefore request that you provide the following information by May 20, 2024:

1. How does the Board of National HealthCare Corporation determine executive compensation and bonuses for you and other top executives?
   a. What considerations are factored into bonuses received by you and other top executives?
   b. Specifically, are any bonuses determined by quality of care metrics?
   c. Are bonuses tied to profits?
   d. Do you receive any kind of bonus tied to reducing staff or other expenses?
2. What is the average annual compensation for registered nurses (RNs) and nurse aides (NAs) at National HealthCare Corporation facilities?
3. What is the rate of turnover of nursing staff in National HealthCare Corporation facilities?
   a. What is the average tenure of licensed nurses?
   b. What is the average tenure of nurse aides?
4. How much does National HealthCare Corporation spend annually on training for its nursing staff?
5. Please provide any complaints or comments submitted to the company by nurses or other staff including the words "under-staffed," "staffing," and "salary".
6. Please provide a list of all lobbying or advocacy expenditures by National HealthCare Corporation, including contributions to the AHCA that may have been used to lobby or advocate against the finalized nursing home staffing standards from January 2021 through the present.

Thank you for your attention to this matter.

Sincerely,

Elizabeth Warren
United States Senator

Bernard Sanders
United States Senator

Richard Blumenthal
United States Senator

Lloyd Doggett
Member of Congress

Jan Schakowsky
Member of Congress

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[28] STAT, "Nursing home owners can hide nearly two-thirds of their profits, new study shows," Brittany Trang, March 7, 2024, *https://www.statnews.com/2024/03/07/nursing-homes-hide-profits-with-related-party-ploys/*.

[29] *Id.*

[30] National Bureau of Economic Research, "Tunneling and Hidden Profits in Health Care," Ashvin Gandhi and Andrew Olenski, March 4, 2024, p. 10, *https://www.nber.org/system/files/working_papers/w32258/w32258.pdf*.

[31] U.S. Department of Health and Human Services, Office of Inspector General, "Nursing Homes," February 29, 2024, *https://oig.hhs.gov/reports-and-publications/featured-topics/nursing-homes/*.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

This morning the Finance Committee gathers to discuss the challenges and opportunities in rural communities when it comes to health care. I'm not going to mince words: without rural health care, you can't have rural life. It's just that simple. And yet across the country, rural health providers are struggling to keep their doors open.

Too many hospitals, doctors, pharmacies, and other providers in rural areas are operating on a knife edge, forced to choose between balancing the books and continuing to provide high-quality care to their communities. Half of all rural hospitals across the country operate in the red.

There's no better example of this than what Oregonians in Baker County experienced over the past year. In 1897, St. Elizabeth hospital opened in Baker City and began delivering babies. One hundred twenty-six years later, after being acquired by Trinity Health, the sixth largest hospital chain in the country, they closed their labor and delivery unit with less than 60 days notice. Trinity said delivering babies at St. Alphonsus was a money-loser.

Nobody saw this coming. The people of Baker City thought their hospital could have a brighter future by joining Trinity Health. When I arrived at a town hall in Baker City last year, there were hundreds of outraged families, including a number of expecting mothers who had planned to give birth at St. Alphonsus. The next closest hospital in that part of eastern Oregon is 45 miles away, along a freeway that can be closed during the winter because of icy conditions and during the rest of the year because of truck crashes. In fact, that hospital, Grande Ronde Hospital in La Grande, OR, is represented here today by Mr. Davis.

Despite efforts at the Federal, State, and local levels, St. Alphonsus in Baker City closed its labor and delivery unit completely last August. The community battled St. Alphonsus to keep basic labor and delivery equipment in Baker City—in the event the community can find their own solution in the near future. Rather than find ways to keep their obstetrics doors open, the hospital offered the paltry sum of $240,000 to the community. This lump sum amounts to less than $2,000 for each year the hospital has been in the community.

What happened at St. Alphonsus in Baker City is a textbook example of what's happening in rural communities across the country. These Americans deserve better. Between 2011 and 2021, one out of every four rural hospitals in America stopped providing obstetrics services. That's 267 communities across the country where giving birth locally is no longer an option. Make no mistake: if it is not practical to give birth within a reasonable distance of your home, your community is facing the prospect of becoming a maternity desert. In these areas, aspiring parents are going to be forced to make tough decisions about where they live and can start a family.

Everybody knows how hard it is to get enough nurses, let alone labor and delivery nurses, in rural areas. These hospitals see a low number of births each year, yet face high costs to keep these services available around the clock. I'm proposing a fresh approach with colleagues on this committee that combines steps to address economic conditions in these communities with extra financial support as long as large hospital chains don't take the money and run.

Now I'll briefly touch on two other areas where Congress has the opportunity to make a big-league difference supporting rural communities: telehealth and workforce.

Telehealth is vital to health care in rural areas. It's a game changer for seniors to contact their doctor through a telehealth service instead of spending half the day or more driving to the health clinic and back home. And it impacts young families who no longer have to take the day off work to help their grandparent. Congress has important work to do before the end of the year to renew and strengthen existing telehealth flexibilities, and I look forward to the Finance Committee leading that effort on a strong bipartisan basis.

There's still more Congress can do to expand telehealth. It's unfathomable that clinicians in Idaho or Nevada have to jump through so many extra hoops and pay for multiple licenses just to provide care via telehealth to a family in eastern Oregon. Likewise, a senior in Vancouver, WA can't receive care via telehealth from a doctor across the Columbia River in Portland—or a senior in southern Oregon from a doctor in northern California—without mountains of bureaucracy.

It's past time for these artificial barriers preventing Americans from receiving telehealth across State lines to be knocked down, and I'll be battling for common-sense improvements like this in Congress's upcoming work related to telehealth.

I'll wrap up by talking about the health-care workforce. Health-care jobs often represent an important economic engine for rural life. But it's becoming more and more difficult to attract qualified health-care workers to rural communities, in part due to the risk of closures that I've been discussing. It's going to take an all-hands-on-deck approach to get this fixed.

Step one is updating the graduate medical education program in Medicare to make sure rural areas and high-need urban areas are not given short shrift.

It also means boosting primary care, which is the backbone and front line of American health care and often experiences the greatest shortage of providers. And it means looking for innovative solutions like public-private partnerships to reach into high schools and bring in students interested in careers in health care.

The Federal Government invests a significant amount of taxpayer dollars into training the health-care workforce every year. My challenge to the committee is to make sure those dollars are being spent in the right places.

I know every single member of this committee is passionate about improving health care in the rural and underserved areas of the country they represent, both Democrats and Republicans. Making a difference for these communities is going to require listening to the needs of rural areas so this committee can support these communities and focus on innovative and pioneering approaches that make the most of the federal dollars this committee is responsible for.

COMMUNICATIONS

AFT
555 New Jersey Ave., NW
Washington, DC 20001
202–879–4400
https://www.aft.org/

May 21, 2024

The Honorable Ron Wyden
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Chairman Wyden:

On behalf of the 1.7 million members of the AFT, including educators, healthcare professionals and public service workers, I write to offer comments related to the Committee's May 16 hearing titled, "Rural Health Care: Supporting Lives and Improving Communities."

As you are aware, rural communities tend to have sicker, older, and poorer residents than the country as a whole; and their health systems often struggle with limited resources, staff shortages and inadequate infrastructure. Rural residents are more likely to have multiple health conditions and are at greater risk from numerous conditions, including heart disease, cancer, stroke, chronic lower respiratory disease, hypertension, diabetes and arthritis. Despite the clear need, the provision of healthcare in rural communities has been made more difficult by a significant number of hospital closures. Since 2010, more than 120 rural hospitals have closed; 39 have closed since 2018.[1] An additional 453 rural facilities can be considered "vulnerable" to closure based on performance levels.[2] That's nearly one-quarter of all rural hospitals in the nation.

When rural hospitals avoid closure, they often have their services hollowed out as they become feeder facilities for larger hospitals located farther away. Across the nation, for example, numerous rural labor and delivery departments have closed, forcing expectant parents to travel greater distances to give birth. While tele-health can assist rural patients in some cases, neither it, nor information kiosks, can serve as a comprehensive substitute for in-person care.

The impact of rural hospital closures goes beyond the immediate effect on patients. As Mark Holmes, of the University of North Carolina found, "rural hospitals are often an anchor institution, providing not only needed healthcare, but also a significant portion of jobs and billions of revenues in purchasing goods and services from

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[1] Ochieng, et al., "Funding for Health Care Providers During the Pandemic: An Update," Kaiser Family Foundation, Jan. 27, 2022. *https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/*.

[2] David Raths, "More Than 450 Rural Hospitals Vulnerable to Closure," Healthcare Innovation, Feb. 24, 2020. *https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/news/21126807/chartis-center-research-more-than-450-rural-hospitals-vulnerable-to-closure.*

other businesses. As a major employer in rural areas, hospitals and their closures have tremendous impacts on the economies of already vulnerable communities."[3]

Private equity's focus on profitability has also been uniquely detrimental to rural healthcare systems. Too many managers of private equity firms view healthcare as just another industry to strip for assets and hawk to the highest bidder, while banking stratospheric fees. These firms often prioritize cost-cutting measures and profit generation over access to, and the provision of, high-quality healthcare.

Members of our union have witnessed many of these issues firsthand. At some hospitals, patients and staff have weathered deep service cuts, department closures and other cutbacks. In one instance, administrators refused to repair or replace equipment needed for surgical procedures, resulting in unstable lighting, and conditions so hot and humid in the summer that surgeons were often sweating profusely over open incisions. In other hospitals, cutbacks have resulted in understaffing, at times putting the safety of patients and healthcare professionals at risk. The proliferation of private equity management in healthcare promises an increase in adverse patient outcomes, as research has already linked these harmful results with private equity ownership.[4]

Congress must act to address the impact of hospital closures. I urge you to pass legislation that requires for-profit hospitals to provide notifications and mitigation plans to the secretary of health and human services at least 180 days prior to the discontinuation of services or a full hospital closure. The mitigation plan should outline actions to preserve access to essential services via partnerships with surrounding facilities, including patient transportation plans, as well as steps to transition healthcare employees to other positions. To address the issue of private equity's involvement in healthcare more broadly, I urge you to consider the provisions included in Sen. Ed Markey's Health over Wealth Act.

In addition to addressing the broader structural issues, Congress should take action to help rural hospitals retain and recruit staff. Doing so requires passing legislation to reduce workplace violence and increasing funding to address the mental health needs of healthcare professionals. Congress should also help to expand the rural healthcare workforce through increasing funding for federal healthcare workforce programs and supporting high school-focused career outreach and training programs. High school career and technical education programs that are linked to local healthcare employers, for example, could be an invaluable way to improve the pipeline of staff willing to work in rural areas.

While we all work to strengthen economic and educational opportunities in rural communities—as the AFT has done in McDowell County, WV; St. Lawrence County, NY; Lordstown, OH; and in Montana—it is imperative to address the immediate healthcare challenges. I ask that you comprehensively move to address hospital closures, the impact of private equity firms, working conditions, and to improve the workforce pipeline. The AFT stands ready to help.

Sincerely,

Randi Weingarten
President

AHIP
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004
T 202–778–3200
F 202–331–7487
ahip.org

AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for millions of Americans. Collectively, our member plans provide access to health care for over 205 million people covered by employer-sponsored insurance, the individual insurance market, and public programs such as Medicare and Medicaid.

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[3] Mark Holmes, Ph.D., "Rural Hospital Closure and Effect on Local Economies," North Carolina Rural Health Research and Policy Analysis Center, March 2022. *https://www.ruralhealthresearch.org/projects/100002523.*

[4] Zirui Song, M.D., Ph.D., "At Private Equity-Owned Hospitals, Hospital-Acquired Conditions Increased," National Institute for Health Care Management, Feb. 15, 2024. *https://nihcm.org/assets/articles/PE-Hospitals-Hospital-Acquired-Events_NIHCM-RI_2024-02-15-143556_fyzl.pdf.*

AHIP is committed to ensuring that people living in rural America have stable and affordable health insurance coverage and access to high-quality providers convenient to them. To that end, we appreciate the opportunity to comment on the Committee's May 16th hearing on rural health and discuss policies that seek to strengthen rural health care and enhance the health of rural Americans.

Landscape

Sixty million Americans, one-fifth of the nation's population, live in rural areas.[1] Americans in these areas generally have worse health conditions than those living in urban and suburban areas.[2] Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts.[3] Rural Americans tend to have higher rates of cigarette smoking, high blood pressure, and obesity.[4]

One issue contributing to these health challenges is that people living in rural communities generally have far fewer choices of providers and services located in or near their communities. As just one example, a scarcity of specialists makes it difficult for people with complex conditions to receive the care they need,[5] and rural hospitals are closing at unprecedented rates.[6]

These challenges confront each rural community, impacting patients, their families, rural businesses, and taxpayers.

Medicare

Medicare Advantage Helps Rural Enrollees Meet Challenges in Accessing Quality Care

Of the 33 million Americans who have opted for a Medicare Advantage (MA) plan instead of fee-for-service (FFS) Medicare, 4.5 million live in rural areas. Since 2010, MA enrollment has nearly quadrupled in rural areas and eligible seniors and individuals with disabilities have more MA plan offerings than ever.[7]

A new study of rural hospitals in 14 states,[8] funded by the Agency for Healthcare Research and Quality (AHRQ), found that an increase in county MA enrollment was associated with an increase in hospital financial stability and reduction in risk of closure. Additionally, every percentage point increase in MA enrollment was associated with a 4% reduction in risk of hospital closure. "Our findings counter the notion that MA plans hurt rural hospitals by not paying them as generously as [FFS Medicare], the report said." The report does not study the reason for the findings but indicates potential reasons could be that MA rates are more generous or MA plans are directing patients to local sources of care.

Additional research has found that quality of care is also generally better for seniors in MA plans. MA enrollees have fewer readmissions, fewer preventable hospitalizations, and lower rates of high-risk medication use than people in FFS Medicare.[9] MA enrollees also were more likely to complete treatments,[10] such as a course of beta-blockers after a heart attack and statin therapy for cardiovascular disease, than enrollees in FFS Medicare. MA's unique design enables plans to offer benefits that can help rural patients overcome barriers to accessing this higher quality of care, including coverage for transportation needs, telehealth services, and in-home care.

Recommendations to Strengthen Rural Access for Medicare Beneficiaries

AHIP believes that Congress should consider expanding the ability of MA plans to use telehealth to meet certain network adequacy requirements to account for differences in provider availability in rural areas. This approach could increase the

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[1] *https://www.gao.gov/blog/why-health-care-harder-access-rural-america.*
[2] *Ibid.*
[3] *https://www.cdc.gov/rural-health/php/about/index.html.*
[4] *Ibid.*
[5] *https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2020/06/RHRC_PB167_Larson.pdf.*
[6] *https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.*
[7] *https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-in-rural-areas/.*
[8] *https://www.ajmc.com/view/medicare-advantage-in-rural-areas-implications-for-hospital-sustainability.*
[9] *https://www.globenewswire.com/en/news-release/2023/11/01/2771249/34825/en/New-Research-From-Inovalon-and-Harvard-University-Finds-Medicare-Advantage-Beneficiaries-Have-Superior-Quality-Outcomes-Relative-to-Traditional-Medicare.html.*
[10] *www.ahip.org/documents/202312-AHIP_HEDISMeasures-12.5.23.pdf.*

availability of MA options in rural areas by allowing for networks to consist of both in-person and virtual care options. We also support extending Medicare telehealth flexibilities that were put in place because of the COVID–19 pandemic that continue to allow for a great number of Medicare enrollees to have access to telehealth services.

Marketplace Coverage

Through the health insurance marketplaces, individuals and families who don't have employer-based or other coverage can shop for and compare plans, often with tax credits to help make coverage more affordable. Congress recently chose to bolster the amount of these tax credits to make coverage even more affordable. Recent findings [11] highlight that these tax credits provide significant benefits to rural residents.

On average, benchmark marketplace premiums weighted across all 50 states are about 10% higher in rural areas than urban areas.[12] Americans residing in rural areas have experienced substantial reductions in their premiums due to enhanced tax credits. The Robert Wood Johnson Foundation found that the value of enhanced tax credits is higher in rural areas than in urban areas, especially in certain states like California and Florida.[13] This has led to more affordable health insurance and, in turn, access to health care, for rural residents.

By making insurance more affordable, these changes have facilitated coverage gains in states that previously had high uninsured rates, including in these states' rural areas. Since 2020, the states with the fastest marketplace enrollment growth were also those with the highest uninsurance rates before enhanced tax credits were implemented.[14] Most of these states are more rural than the nation as a whole, with many having 25 to 44% of their populations living in rural areas.[15] The Kaiser Family Foundation found that 1.4 million Americans were newly eligible for tax credits for marketplace plans. This policy gives rural Americans more options for their health care coverage based on their individual needs and their financial situations. This underscores the importance of targeted policy interventions in addressing health care disparities and improving access to affordable coverage, particularly for vulnerable populations in rural areas.

Recommendation of Protecting Marketplace Affordability for Rural Americans

Ensure stability in coverage and care for millions of people in rural communities by extending current tax policies that have boosted affordability, choice, and competition in the individual market.

Addressing Gaps and Moving Towards Health Equity

There are also infrastructure, socioeconomic, and non-clinical challenges that create barriers to care for rural communities. For example, rural communities are likely to face challenges with reliable transportation, limited availability of broadband internet services, and fewer options to buy fresh and affordable foods.[16] Challenges in accessing clinical care and non-clinical resources result in different health outcomes for rural versus urban communities. Rural residents experience significant disparities in life expectancy and economic mobility, reflecting the complex relationship between health, opportunity, and geographic isolation. These disparate outcomes include high rates of:

- Childbirth complications [17] and infant mortality;[18]
- Mental, behavioral, and development disorders in children;[19]
- Suicide;[20]

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[11] *https://www.rwjf.org/en/insights/our-research/2022/05/american-rescue-plan-acts-enhanced-premium-subsidies-provide-particularly-large-benefits-to-residents-of-rural-areas.html.*
[12] *Ibid.*
[13] *Ibid.*
[14] *https://www.kff.org/policy-watch/where-aca-marketplace-enrollment-is-growing-the-fastest-and-why/.*
[15] *https://data.census.gov/all?q=total+rural+population.*
[16] *https://www.ruralhealthinfo.org/topics/social-determinants-of-health.*
[17] *https://www.marchofdimes.org/peristats/reports/united-states/maternity-care-deserts.*
[18] *https://publications.aap.org/pediatrics/article/146/5/e20200464/75318/Infant-Mortality-in-Rural-and-Nonrural-Counties-in.*
[19] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7681156/.*
[20] *https://pubmed.ncbi.nlm.nih.gov/33054927/.*

- Cancers related to modifiable risks, such as tobacco use, human papillomavirus (HPV), and preventive screening;[21]
- Chronic conditions such as obesity, diabetes, and injury;[22] and
- Dramatically higher rates of opioid overdose deaths.[23]

Health inequities are amplified for individuals from underserved and diverse communities and individuals in low-income brackets. Poor health outcomes are often correlated with lower educational opportunity and attainment and lower incomes. Compared to rural non-Hispanic White adults, rural adult American Indian/Alaska Native (AI/AN), non-Hispanic Black, and Hispanic adults have reported higher rates of poor health, and rural non-Hispanic Black and AI/AN adults were more likely to report having multiple chronic health conditions.[24] Health plans are fully committed to doing their part to reduce barriers to care for rural communities, while promoting affordable, quality, and patient-centered care.

Medicaid

Medicaid plays a vital role in providing health coverage to children and families in rural communities. Medicaid and CHIP cover a larger share of children and adults in rural counties than in urban communities—covering 47% of children and 18% of adults in small towns and rural areas, compared to 40% of children and 15% of adults in urban counties.[25] Plans took critical steps to reduce gaps in coverage and help Americans access health care during the redeterminations and coverage transitions.[26] In particular, MCOs partnered with states to amplify messaging, collect current contact information, partner with providers and community-based organizations, conduct direct outreach to members, and help with both renewal paperwork and transitions to other coverage.

To ensure eligible individuals have access to Medicaid and CHIP, AHIP encourages Congress to extend the Consolidated Appropriations Act, 2023 requirements for monthly state reports on eligibility application and renewal processing data, including the rates of *ex parte* renewal and procedural terminations, and to require CMS to continue to make this data public past the end of the unwinding period. These reports provide critical information about access to coverage, giving all interested stakeholders awareness of state operations impacting this particularly vulnerable population.

Recommendation for Protecting Rural Medicaid Beneficiaries

Medicaid plays a crucial role in helping millions of people with disabilities and functional impairments meet their medical and self-care needs through long-term services and supports (LTSS). Millions of Americans of all ages rely on LTSS because they live with physical, cognitive, and/or mental disabilities that challenge their ability to care for themselves. The importance of these services is even more apparent for rural Americans.[27]

- **Congress should protect rural Medicaid beneficiaries by protecting LTSS as a critical link between the most vulnerable rural Americans and their health.** The number of Americans requiring LTSS is also projected to increase significantly between 2020 and 2060.[28] More Americans who require assistance with daily living activities due to chronic illnesses, disabilities, or aging are going to rely on LTSS to maintain and improve the health and well-being.

Conclusion

AHIP and our members appreciate the Committee's attention on ways to strengthen the nation's rural health care infrastructure and how Congress can partner with

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[21] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9275775/#:~:text=Research%20shows%20that%20low%20screening,83%2C137%2D174).*

[22] *https://www.cdc.gov/mmwr/volumes/68/ss/ss6810a1.htm.*

[23] *https://www.cdc.gov/nchs/products/databriefs/db440.htm#:~:text=The%20rate%20of%20deaths%20involving%20psychostimulants%20with%20abuse%20potential%20was,in%20urban%20counties%20(4.0).*

[24] *https://www.ruralhealthinfo.org/topics/rural-health-disparities#:~:text=Rural%20risk%20factors%20for%20health%20disparities%20include%20geographic,healthcare%20specialists%20and%20subspecialists%2C%20and%20limited%20job%20opportunities.*

[25] *https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/.*

[26] *https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/.*

[27] *https://rupri.org/wp-content/uploads/Rural-Long-Term-Services-and-Supports-Primer-for-Rural-America.pdf.*

[28] *https://www.phinational.org/policy-research/key-facts-faq/.*

stakeholders to overcome key challenges for rural Americans. We look forward to working with Committee members and staff on solutions to enhance the health and protect the coverage of rural Americans.

AIR METHODS CORPORATION
5500 S. Quebec Street
Greenwood Village, CO 80111
303–792–7400
https://www.airmethods.com/

Statement of Jaelynn Williams, CEO

On behalf of Air Methods, one of the leading emergency air medical providers in the country, I would like to submit a statement for the record to the Senate Finance Committee for the hearing "Rural Health Care: Supporting Lives and Improving Communities." Air Methods provides emergency air medical services in 48 states. We currently operate 276 bases and over 400 air medical aircraft, staffed by approximately 5,000 medics, nurses, pilots, mechanics, and patient advocates. We proudly serve patients experiencing medical emergencies around the country, mostly in rural and highly rural locations.

Rural America is facing a growing health care crisis. More than 46 million Americans, or 15 percent of the U.S. population, live in rural areas as defined by the U.S. Census Bureau. Americans living in rural communities face numerous health challenges and disparities compared to their urban counterparts. Geographic distances, limited resources, rising infrastructure costs, and physician shortages often impede the delivery of timely and comprehensive care. More than one hundred rural hospitals have closed in the past decade, and hundreds of others are at risk. In most cases, the closure of these hospitals has resulted in the loss of the emergency department, and residents of the community must now travel much farther when they have a life-threatening event. Over the past few years, as the health care industry has faced labor shortages and continued resource challenges, we have seen a dramatic increase in demand for our services in rural America.

It is no exaggeration to say that air ambulance transport has become a lifeline to trauma care for millions of Americans, who can easily find themselves a long way from a medically appropriate trauma center when time is of the essence. Additionally, many rural hospitals are often unable to provide the necessary care due to the severity of the injury or illness, and the patient must be transferred to a higher level of care. Because of the sheer distance to that higher-level facility, such as a stroke center, cardiovascular center, trauma center, or neurosurgery center, these patients must be transported by air ambulances to receive the medically necessary specialty care in a timely way. Notably, the clinical care that can be provided to the patient on the air ambulance typically far exceeds the care that could be provided by a ground ambulance transport.

In 2023, our crews transported more than 100,000 individuals across the country. Of those, 40% were Medicare beneficiaries who were experiencing life threatening conditions such as head trauma, stroke, and cardiac events, and 60% were in rural America. For example, last year we transported a 77-year-old individual from Pagosa Springs Medical Center in Pagosa Springs, CO, a beautiful small town surrounded by the San Juan Mountains with a population of 1,700, to University of Colorado Health Memorial Central in Colorado Springs, CO to the cardiac unit—60 minutes air versus 500 minutes by ground. In some states where access is more challenging for rural Americans, the majority of our transports are from rural areas. For example, in Idaho 75% of our transports were in rural areas and in Tennessee 71% were in rural communities and transported to higher-level facilities typically located in urban areas. In all cases, the decision to transport the patient to the closest, most appropriate facility for care is made by the attending physician or the first responder. Air medical crews never self-dispatch, and when they transport a patient, they do not know, and they do not ask, what type of insurance coverage the patient has.

Unfortunately, the emergency air ambulance industry is facing significant challenges when it comes to reimbursement for our services. The current Medicare reimbursement rate for air medical services is determined by the air ambulance fee schedule. CMS first established the air ambulance fee schedule in 2002 and it has not been updated since, despite significant increases in operating costs due to safety and clinical investments, inflationary costs, and regulatory requirements. Today, we estimate that the average Medicare reimbursement only covers 50% of actual trans-

port costs. At the same time the percentage of Medicare patients transported has increased to almost 40% of all transports, and the percentage of Medicaid patients transported has increased to about 28%, putting a huge strain on the ability of air medical providers to continue operations in many parts of the country. This has been compounded by the recent tremendous inflationary and economic pressures on the health care system. This has resulted in bases closures, with more expected unless the Medicare reimbursement is fixed.

Fortunately, bipartisan, bicameral legislation has been introduced by Senators Michael Bennet and Marsha Blackburn, and Representatives Ron Estes and Suzan DelBene that would preserve emergency air medical services. To ensure seniors, Americans living in rural areas, and patients in need of emergency care have access to air medical services, the Protecting Air Ambulance Services for Americans Act (S. 1803/H.R. 3691) would create the path to updating the Medicare fee schedule for these critical services. Specifically, the bill authorizes CMS to update the Medicare Fee Schedule using data collected through the No Surprises Act passed in 2020. Additionally, the bill requires air ambulance providers to submit additional data on the operational costs of air medical services and requires the Government Accountability Office to issue a report on the costs associated with providing air ambulance services for Medicare beneficiaries.

In conclusion, air medical services are often the difference between life and death for rural Americans. We urge Congress to pass The Protecting Air Ambulance Services for Americans Act to ensure that people in rural and remote communities are not left behind and will continue to have access to critical care.

ALLIANCE FOR HOME DIALYSIS
750 9th Street, NW, Suite 650
Washington, DC 20001
(202) 466–8700

The Alliance for Home Dialysis (Alliance) appreciates the opportunity to offer comments specifically regarding home dialysis in rural settings. We, a coalition of kidney dialysis stakeholders representing individuals with kidney failure, clinicians, and providers, have united to advocate for policies that promote and advance treatment choices in dialysis care while addressing systemic barriers limiting access to the numerous benefits of home dialysis.

Home dialysis primarily utilizes two modalities: peritoneal dialysis (PD) and home hemodialysis (HHD). Recognized as a vital treatment option, home dialysis provides individuals with kidney failure significant quality of life advantages, including meaningful improvements in physical and mental health. Moreover, it offers lifestyle benefits such as increased time for family, hobbies, and work, as patients are freed from the necessity of traveling to a clinic—the average end-stage kidney disease (ESKD) patient spends as much as 5 hours per session, with three sessions each week.

This freedom home dialysis offers is particularly advantageous for rural patients who often face lengthy journeys to dialysis centers. Telehealth is especially important for these patients; home dialysis patients are able to do their monthly visit with their nephrologist from home, thereby avoiding additional travel to doctors' offices. And, most home dialysis machines are equipped with software to remotely monitor the patient, feeding information to their clinical team in real-time. Moreover, for many patients, regardless of their location, home dialysis can lead to reduced medication requirements, improvements in neuropathy, better sleep, increased energy levels, and the ability to resume traveling or take vacations with family while bringing along dialysis supplies. Given the substantial benefit of home dialysis, we urge Members of Congress to address barriers that hinder access to home training and therapy.

Kidney Disease Education

It is crucial that chronic kidney disease (CKD) patients have access to the information they need to make informed decisions regarding their kidney care journey. Currently, Medicare covers up to 6 sessions of kidney disease education services for Stage 4 CKD patients. The benefit is currently underutilized, and we believe that policy changes could help to increase access to this important benefit. First, the Alli-

ance supports eliminating patient cost-sharing [1] in an effort to make KDE more affordable. We also support expanding eligibility [2] through CKD Stages 3b and 5 so that more of the applicable patient population will be able to take advantage KDE. Finally, we support allowing dialysis facilities to provide KDE, with appropriate guardrails. Guardrails must be deployed to prevent patient steering and marketing, the substance of the education should just be clinical education, not information specific to a certain provider or advertising information. CMS should also play a role in approving educational materials or modules before they are deployed. We believe that all of these changes will increase the number of patients able to access KDE, which will then increase patient choice—including the choice to elect home dialysis.

Strengthen the Workforce

Especially impactful in rural communities, labor shortages persist in the dialysis workforce; inadequate payment updates worsen the problem. Labor shortages affect patient care across the health care system. A survey conducted by a leading ESRD patient advocacy organization found nearly two-thirds of patients reported the recent labor shortage had impacted their care, with many experiencing treatment delays.[3] Providers are grappling with higher labor expenses to attract, retain, and train caregivers with the necessary skills for dialysis treatments. The inadequate increase in the ESRD PPS base rate exacerbates this issue. We urge CMS to bolster payments and request Congressional attention to this matter. Additionally, we support the development of a legislative proposal to allow reimbursement for staff-assisted home dialysis, provided healthcare workforce shortages are addressed.

Remove Barriers to Home Dialysis for AKI Patients

The Alliance has a long track record of advocating for access to home dialysis for acute kidney injury (AKI) patients, including comments to CMS' proposed ESRD Prospective Payment System (PPS) Rules. Given the clinical and quality of life benefits associated with home dialysis, mentioned above—exponentially impactful for rural patients—the Alliance urges lawmakers to ensure that home modalities be enabled for AKI patients after hospital discharge when their providers agree that the modality is the best treatment option for the patient's case. While not every AKI patient is an appropriate candidate for home therapy, *all* patients deserve the opportunity to work with their doctor to determine a treatment path that is not limited by payment restrictions on certain modalities.

Stabilize PD Catheter Insertion Procedures

Timely placement of PD catheters faces systemic barriers, including inadequate physician training and operating room availability. We believe Congress should direct CMS to provide stronger incentives for PD catheter placement, potentially through reimbursement adjustments. Equalizing reimbursement for PD catheters and vascular access procedures could increase home dialysis uptake, and we encourage CMS and Congress to explore this concept.

In conclusion, we are prepared to actively engage with lawmakers on efforts to enhance the lives of CKD and ESKD patients in rural and underserved areas. We encourage you to see the Alliance and our members as eager partners, ready to bring our expertise and resources to the table for these crucial initiatives. Thank you for your attention to the unique needs of rural Americans.

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[1] Currently, Medicare beneficiaries are responsible for the 20% copay associated with KDE as a Part B benefit. For some beneficiaries, the 20% coinsurance is prohibitive to accessing these important educational services.

[2] Eligible providers of care are limited to physicians, nurse practitioners, physician assistants, clinical nurse specialists, and "other providers" (defined as hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies or hospices).

[3] Williams, Jackson. (2023). Contributor: Medicare's Leadership Needs to Confront Our Shrinking US Workforce. *American Journal of Managed Care. https://www.ajmc.com/view/contributor-medicare-s-leadership-needs-to-confront-our-shrinking-us-workforce.*

ALLIANCE FOR RURAL HOSPITAL ACCESS
The McDermott Building
500 North Capitol Street, NW
Washington, DC 20001
https://ruralhospitalaccess.org/

May 20, 2024

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden:

The Alliance for Rural Hospital Access (ARHA, or the Alliance) thanks you for your commitment to improving rural health care and is pleased to submit this statement for the record following the committee's May 16, 2024 hearing titled *Rural Health Care: Supporting Lives and Improving Communities.*

The Alliance is comprised of hospitals designated as Medicare-Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs) and Rural Referral Centers (RRCs) under the Medicare program. MDHs, SCHs and RRCs provide rural populations with local access to a wide range of health care services. In doing so, they localize care, minimize the need for further referrals and travel, and provide services at costs lower than their urban counterparts. These hospitals also commonly establish satellite sites and outreach clinics to provide primary and emergency care services to surrounding underserved communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close.

Background on Rural Hospital Designations

Medicare Dependent Hospitals: The MDH program was established by Congress with the intent of supporting small rural hospitals for which Medicare patients make up a significant percentage of inpatient days and discharges. Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare reimbursement to sustain hospital operations. Consequently, these hospitals are more vulnerable to inadequate Medicare payments than other hospitals because they are less able to cross-subsidize inadequate Medicare payments with more generous payments from private payers. As such, Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment protections to buttress these hospitals. Congress recognized that if these hospitals were not financially viable and failed, Medicare beneficiaries would lose an important point of access to hospital services. To qualify as an MDH, a hospital must be (1) located in a rural area, (2) have no more than 100 beds, and (3) demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges.

Sole Community Hospitals: Congress created the SCH program to maintain access to needed health services for Medicare beneficiaries in isolated communities. The SCH program ensures the viability of hospitals that are geographically isolated and thus play a critical role in providing access to care. Hospitals qualify for SCH status by demonstrating that because of distance or geographic boundaries between hospitals they are the sole source of hospital services available in a wide geographic area. There are a variety of ways in which hospitals can qualify for SCH status, but the majority qualify by being more than 35 miles from another provider.

Rural Referral Centers: Congress established the RRC program to support rural hospitals that treat a large number of complicated cases and function as regional referral centers. Generally, to be classified as an RRC, a hospital has to be physically located outside a Metropolitan Statistical Area (indicating an urban area) and either have at least 275 beds or meet certain case-mix or discharge criteria.

Challenges Facing MDHs, SCHs and RRCs

MDHs, SCHs and RRCs are often the sole source of care within and around a community. Many patients who live in rural communities depend on these facilities for a full complement of health care services, from primary care to sophisticated inpatient treatment. More and more rural hospitals are struggling and closing, causing access problems for residents of rural communities. When an MDH, SCH or RRC closes, the consequences for the community may be graver than otherwise.

According to data on rural hospital closures [1] compiled by the Cecil G. Sheps Center for Health Services Research (or Sheps Center), there have been 199 rural hospital closures and conversions since January 2005. This number includes 101 complete closures, 10 rural emergency hospital (REH) conversions, and 88 converted closures (defined as facilities no longer providing inpatient services but continuing to provide some health care services such as primary care or long-term care). Many more are paring unsustainable service lines, like obstetrics. The U.S. Government Accountability Office (GAO) found [2] that when rural hospitals close, people living in areas who receive care from them must travel farther to get the same services—about 20 miles farther for common services like inpatient care, and about 40 miles for less common services like alcohol or drug abuse treatment. Further, according to 2023 data [3] from the Center for Healthcare Quality & Payment reform, more than 600 rural hospitals—nearly 30% of all rural hospitals in the country—are at risk of closing because of the serious financial problems they are experiencing.

Hospitals in rural communities often confront extremely difficult financial circumstances and tend to have negative or very small operating margins, making them increasingly vulnerable. Additional Medicare reimbursement reductions impose further financial strain, compromising rural hospitals' ability to serve their communities. These hospitals also often do not have the same flexibility as other hospitals to discontinue lower margin or unprofitable services, like mental health services. As mission driven organizations, and the only source of hospital services for their community, rural hospitals often will continue to offer services, even at great financial loss, because there are no other providers offering those services.

Recommendations for Committee Action

Congress has repeatedly reconfirmed its commitment to MDHs, SCHs and RRCs over the years by providing new protections to ensure their viability in rural communities. ARHA and its members share this goal of ensuring that federal hospital payment policies recognize the unique role and contributions these hospitals bring to the Medicare program and its beneficiaries.

As part of your efforts to support and improve rural health, the Alliance requests that the Committee on Finance consider and advance legislation that would:

- Permanently extend the MDH program and low-volume hospital payment adjustment
- Update the base years for SCHs and MDHs paid on the basis of their hospital-specific rate
- Address rural health care workforce shortages by ensuring SCHs and MDHs paid using their hospital-specific rate receive indirect medical education (IME) adjustments, to encourage these hospitals to localize resident training in rural areas
- Reimburse rural hospitals fairly for uncompensated care by ensuring SCHs and MDHs paid on the basis of their hospital-specific receive a Medicare disproportionate share hospital (DSH) payment adjustment and an uncompensated care pool allocation
- Direct the Centers for Medicare and Medicaid Services (CMS) to extend rural SCH site-neutral exemptions to urban SCHs and MDHs
- Direct CMS to extend the rural SCH 7.1% payment adjustment to urban SCHs, and to study the appropriateness of making a similar payment adjustment for MDHs
- Ensure that any congressional efforts to enact additional site-neutral payment policies include appropriate exceptions that protect financially-vulnerable SCHs and MDHs, recognizing the unique role these facilities have in their communities

Permanently Extend the MDH Program and Low-Volume Adjustment

The MDH program and the low-volume hospital payment adjustment are support mechanisms that were created by Congress decades ago, and have traditionally been reauthorized together for limited periods. The current authorization runs through December 31, 2024, requiring Congress to enact another extension before the end of the 118th Congress.

A permanent extension of these critical programs would bring more predictability and consistency to the rural hospitals that rely upon these payments to remain fi-

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[1] *https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.*
[2] *https://www.gao.gov/assets/gao-21-93.pdf.*
[3] *https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.*

nancially viable. This stability is often lacking with short-term extensions, given that hospitals cannot factor these payments into their budgets for the years in which they are due to expire. This concern was raised by Senator Chuck Grassley (R–IA) during the hearing, and Dr. Keith Mueller agreed, stressing that rural hospitals should not have to expend limited time and resources working through the budgetary implications of the potential expiration of these programs and worrying about what will happen if the funding runs out.

The Alliance strongly supports the Rural Hospital Support Act (S. 1110), legislation reintroduced earlier this year by Senators Bob Casey (D–PA) and Grassley that would *permanently* extend the MDH program and low-volume adjustment.

Enacting the provisions of S. 1110 well in advance of the December 31, 2024, deadline would provide vulnerable hospitals with more predictable Medicare reimbursements and greater financial stability, and we urge the committee to take up these provisions at its earliest convenience.

Update the Base Years for SCHs and MDHs

S. 1110 contains additional provisions that would better enable SCHs and MDHs to continue to provide high quality, cost-efficient care to the rural populations they serve.

Under Medicare's Inpatient Prospective Payment System (IPPS), SCHs and MDHs are paid the greater of the federal rate (*i.e.,* the payment that the hospital would otherwise receive under the IPPS) or a cost-based payment, which is determined by adding together the federal payment rate applicable to the hospital and the amount that the federal payment rate is exceeded by a hospital-specific rate (in the case of MDHs, the hospital receives 75% of that difference).

Hospital-specific rates are tied to a hospital's costs in a specified year. For SCHs, the years are 1982, 1987, 1996 or 2006, and for MDHs, the years are 1982, 1987 or 2002. These years are overdue to be updated, and S. 1110 would provide for a more recent base year for both SCHs and MDHs. We encourage the committee to advance these provisions as well.

Advance Workforce Legislation that Provides Fair IME Adjustments to SCHs and MDHs

Rural health care workforce shortages are well-documented, and Alliance hospitals can help alleviate physician shortages if they have adequate resources. Specifically, SCHs and MDHs are well-situated to host residency programs, but SCHs and MDHs paid on the basis of their hospital-specific rate (as detailed above) are financially disincentivized to establish such programs.

If a hospital paid on the basis of the federal (or IPPS) rate initiates a teaching program, it receives both Direct Medical Education (DME) and IME payments. While SCHs and MDHs paid on the basis of their hospital-specific rate *do* qualify to receive DME payments, they do *not* receive IME payments.

SCHs and MDHs—which comprise nearly 80% of hospitals eligible to establish training programs in rural communities—should receive the same incentives and financial buffer as hospitals paid under the federal rate. Based on CMS cost report data, 58% of SCHs and 46% of MDHs are paid on the basis of their hospital-specific rate. This formula for SCHs and MDHs should not disqualify the hospital from receiving full IME payments as they would under the federal rate formula. This full federal funding of DME and IME payments is necessary to establish and operate rural-based residency training programs.

During the hearing, Senator Catherine Cortez Masto (D–NV) raised the issue of ensuring that SCHs and MDHs paid on the basis of their hospital-specific rate receive IME adjustments, and Dr. Mueller agreed that SCHs and MDHs that train residents should receive fair incentives, and that addressing this gap in Medicare payment is one policy lever that would help address rural workforce shortages.

The Alliance has repeatedly asked CMS to use its authority to make this adjustment, but CMS has declined to take action. As such, in order for this policy to be advanced, the Alliance encourages the committee to include it in any rural health/workforce package it considers this Congress.

Advance Legislation to Equitably Reimburse SCHs and MDHs for Uncompensated Care

Similarly, if a hospital paid on the basis of the federal rate serves a disproportionate number of low-income patients, it receives an increased payment under the Medicare DSH payment adjustment, along with an uncompensated care pool allocation.

However, DSH-eligible SCHs and MDHs that are paid under the hospital-specific rate do not receive hospital-specific payment adjustments to compensate them for uncompensated care.

This highlights another inequity that exists between the two payment mechanisms, and this discrepancy continues to undermine the viability of rural safety net hospitals. SCHs and MDHs that are paid under the hospital-specific rate should receive the *same* financial protections if they have high rates of uncompensated care, through the receipt of a DSH payment adjustment and an uncompensated care pool allocation.

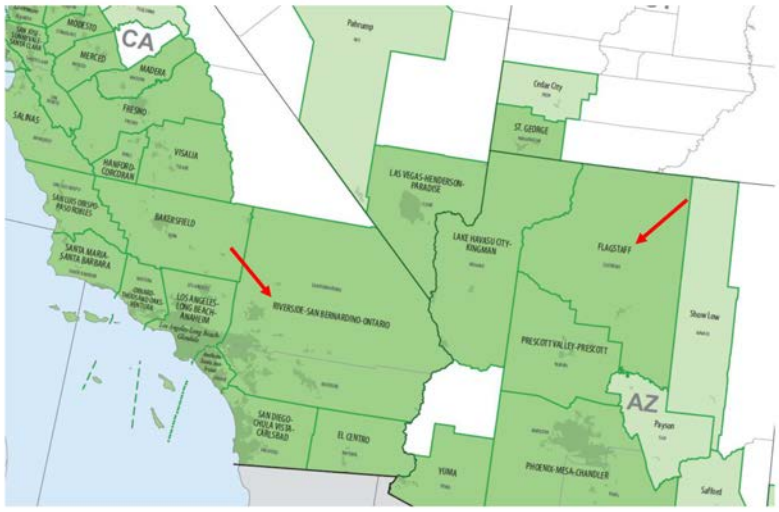
Providing SCHs and MDHs with equitable and appropriate compensation will allow for greater financial stability for these important safety net hospitals, so they can continue sustaining their communities. Again, the Alliance has repeatedly asked CMS to use its authority to fix this inequity, but CMS has declined to act. The Alliance therefore urges the committee to consider this inequity when crafting legislation to protect and sustain access to rural health care.

Direct CMS to Extend Rural SCH Site-Neutral Exemptions to Urban SCHs and MDHs

Under the Medicare outpatient prospective payment system (OPPS), CMS pays a "PFS-equivalent" rate of 40 percent of the OPPS payment rate for hospital outpatient clinic visits coded under HCPCS G0463 when delivered by a previously excepted off-campus provider-based department. Beginning in CY 2023, CMS now exempts from this payment reduction services furnished by excepted off-campus provider-based departments of *rural* SCHs.

For years, the Alliance has been urging CMS to reconsider the site neutral policy, and to exempt SCHs and MDHs from it. While we were pleased that CMS determined to exempt *rural* SCHs, we were dismayed that the agency did not extend the same relief to *urban* SCHs and MDHs. These hospitals are similarly disadvantaged by the site neutral policy; Congress should direct CMS to provide a similar exemption.

CMS uses Metropolitan Statistical Areas (MSAs) to delineate between urban and rural areas. While the Alliance appreciates the need to distinguish urban and rural for a number of payment and policy mechanisms, MSAs are an imprecise tool for differentiating urban and rural areas. Given that MSAs use counties as building blocks, many areas are designated as "urban" because they have a single urbanized area. But if the county is unusually large, significant portions of that county may be as rural as the most isolated frontier area. Using MSAs to identify urban and rural areas is particularly problematic in the western United States where there are many very large counties that comprise MSAs (see, for example, San Bernardino County in California and Flagstaff and Pima Counties in Arizona).



There are instances where an SCH is designated urban by CMS, but the hospital is actually a considerable distance from the nearest urbanized area. Verde Valley Medical Center (Provider Number 03–0007), for example, is located in Prescott, AZ and is considered an urban SCH. However, the closest urbanized area with more than 40,000 people is Flagstaff, AZ, which is nearly 100 miles away.[4] Verde Valley has undergone an urban-to-rural reclassification, so it is eligible for these protections. Hospitals like Methodist Hospital South (45–0165) in Jourdanton, Texas have not undergone urban-to-rural reclassification, and so are not eligible for these protections. These are not urban areas by most reasonable standards, except the MSA standard.

For these reasons, CMS should extend this exemption to urban SCHs because using MSAs to determine urban and rural areas is imprecise, and distinguishing between urban and rural SCHs when applying payment policy unfairly disadvantages urban SCHs that are the sole source of hospital services in their communities, like their rural counterparts. Urban SCHs are serving communities that are truly rural in character. In fact, as CMS knows, to be an *urban* SCH, a hospital has to be even further (35 miles) from another hospital to qualify than if it were a *rural* hospital. CMS also can reduce incentives to undergo urban-to-rural reclassification to take advantage of these protections.

Regarding MDHs, GAO data shows that Medicare profit margins and total hospital profit margins declined for MDHs from fiscal year 2011 through 2017, from −6.9 percent to −12.9 percent and 1.6 percent to −0.2 percent, respectively.[5] The degree to which Medicare margins declined for MDHs during this time period (6 percentage points) was greater than the degree to which they declined for rural hospitals (3.8 percentage points) and all hospitals (2.5 percentage points). The number of MDHs declined 28 percent from 193 hospitals in fiscal year 2011 to 128 hospitals in 2017 as hospitals became ineligible for MDH status, and 16 closed between 2013 and 2017, or experienced other changes.[6]

Taken together, supporting SCHs and MDHs by ensuring they receive the site neutral exemption would help secure access to care in rural and underserved communities. Rural SCHs, urban SCHs and MDHs are often the sole health care providers in isolated areas where health care access is lacking. Our analysis shows that 56 percent of rural SCHs, 73 percent of urban SCHs, and 60 percent of MDHs are located in at least one type of medically underserved area as defined by Health Resources and Services Administration (HRSA) Medically Underserved Area designations.

Hospital Type	Hospital Count	Hospitals in MUA	Percent
Rural Sole Community Hospital	448	251	56%
Urban Sole Community Hospitals redesignated as rural under § 412.103	77	33	43%
Urban Sole Community Hospitals (*not* redesignated as rural)	15	11	73%
Medicare Dependent Hospital	169	102	60%

M+ Analysis of Medically Underserved Area (MUA)[7] designations from HRSA.

The Alliance shared this analysis and recommendations with CMS in the 2023 rulemaking cycle. CMS declined to make the recommended changes, relying on a 2005

[4] Metropolitan and Micropolitan Statistical Areas of the United States and Puerto Rico, US Census Bureau. July 2015. *https://www2.census.gov/geo/maps/metroarea/us_wall/Jul2015/cbsa_us_0715.pdf.*

[5] GAO, Information on Medicare-Dependent Hospitals, GAO–20–300 (Washington, DC: February, 2020). *https://www.gao.gov/assets/gao-20-300.pdf.*

[6] GAO, Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors, GAO–18–634 (Washington, DC: Aug. 29, 2018). *https://www.gao.gov/products/gao-18-634.*

[7] A hospital is determined to be in a Medically Underserved Area (MUA) if the hospital's main address meets the requirement of at least one MUA designation type based on either geographic area, specific population characteristics of that geographic area (*i.e.,* homeless population), or a governor's designation. For detail, please refer to the Health Resources and Services Administration website: *https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.*

study of resource costs that found higher resource costs in *rural* SCHs, and noting that the 2003 legislation that required that 2005 study demonstrated that "Congress did not determine that any of these hospital types required additional payments for outpatient services."

For these reasons, the Alliance encourages the committee to direct CMS to extend rural SCH site-neutral exemptions to urban SCHs and MDHs.

Direct CMS to Extend the Rural SCH 7.1% Payment Adjustment to Urban SCHs, and Study the Appropriateness of Making a Similar Payment Adjustment for MDHs

Under current CMS policy, Medicare payments to rural SCHs for outpatient services are increased by 7.1 percent. CMS makes this adjustment because it found that, pursuant to a study required by Congress,[8] compared to urban hospitals, rural SCHs have substantially higher costs, and need a payment adjustment to be comparably treated under the OPPS.

For the reasons set forth in the previous section, the Alliance has continually urged CMS to extend the rural SCH 7.1% payment adjustment to urban SCHs as well, and to study the appropriateness of making a similar payment adjustment for MDHs. CMS has not made these changes, and has stated that it does not have the authority to do so because Congress specified that the policy apply to rural hospitals.

As noted above, CMS uses MSAs to delineate between urban and rural areas, though MSAs are not the most precise tool for actually characterizing urban and rural areas. As a result, there are instances where an SCH is designated urban by CMS, but the hospital is actually a considerable distance from the nearest urbanized area.

By specifying that the 7.1% adjustment applies to all SCHs, as well as MDHs, Congress can provide another mechanism to contribute to increased financial stability for rural hospitals. As such, we urge the committee to clarify Congress' intent with respect to these adjustments.

Protect MDHs and SCHs from Site-Neutral Payment Reductions

As noted throughout these comments, MDHs and SCHs are in dire financial straits. More cuts will force further closures. The Alliance concurs that payment policies could be refined to better align payment incentives and protect beneficiaries, but we also encourage Congress to balance beneficiary financial protection with beneficiary access to care.

Site neutral payment reforms would be in part intended to motivate provider behavioral changes—*i.e.,* services previously provided in hospital outpatient departments (HOPDs) that can be safely performed in ambulatory surgical centers (ASCs) or physician offices would migrate to those settings when payments are aligned. However, lawmakers should not expect providers in rural areas to be able to respond as intended, as ASCs are largely located in urban areas. Rural areas typically lack the surgical specialists needed for ASCs, and the lower population density in rural areas makes them less attractive locations for ASCs. The Medicare Payment Advisory Commission (MedPAC) notes that, of ASCs that were open in 2021, 93.4% were located in urban areas, compared to just 6.6% in rural areas. As a result, beneficiaries who do not live near an ASC usually obtain ambulatory surgical services in HOPDs. Further, physician offices in rural areas are less likely to be built and equipped with the capacity to perform outpatient services likely to be subject to site neutral payment reforms.

If rural hospitals cannot migrate surgical procedures and other sophisticated services to ASCs or physician offices, they will endure payment cuts without being able to respond to the intended behavioral stimuli. SCHs and MDHs are particularly vulnerable to site neutral payment changes. These hospitals are often the sole source of care in their communities, and so cannot expect other hospitals to pick up unprofitable services.

Payment policy changes that cause beneficiaries to lose access to hospital services will not serve beneficiary or taxpayer interests. To prevent such consequences, Congress should exempt SCHs and MDHs from proposed site neutral policy changes.

Thank you for your consideration of the proposals set forth in this statement. The Alliance appreciates your commitment to improving rural health care, and we look

[8] § 411(b), Pub. L. No. 108–173.

forward to continuing to serve as a resource to your committee staff on these efforts. Please contact me at 202–204–1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman

ALZHEIMER'S ASSOCIATION AND ALZHEIMER'S IMPACT MOVEMENT
655 15th St., NW, Suite 500
Washington, DC 20005

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the United States Senate Committee on Finance hearing on Rural Health Care: Supporting Lives and Improving Communities. The Association and AIM thank the Committee for holding this hearing to discuss the importance of ensuring access to life-changing therapies for the millions of people living with rare, progressive, and serious diseases, such as Alzheimer's and other dementia, and ensuring that access to those treatments reaches rural communities.

Great progress has been made in advancing Alzheimer's and dementia research, providing hope to families in the midst of a terrible, fatal disease. Now that the Food and Drug Administration (FDA) has approved Alzheimer's treatments to slow progression at an early stage, it's lifted that hope higher. However, people living with Alzheimer's and other dementia face unique health care challenges, and often primary care providers are the first clinicians with whom individuals discuss cognition concerns.

Nearly 7 million Americans are living with Alzheimer's, and by 2050 this number is expected to rise to nearly 14 million. Alzheimer's is one of the costliest conditions in the U.S. In 2024, Alzheimer's and other dementia are projected to cost the nation $360 billion. By 2050, these costs could rise to nearly $1 trillion. Only half of those living with Alzheimer's disease are diagnosed and, of those, only half are told of their diagnosis. The value of an accurate and early diagnosis cannot be ignored; it can significantly improve an individual's quality of life and could save up to $231 billion in 2050 in medical and care costs.

Rural communities often report higher prevalence rates of dementia compared to urban counterparts, despite multiple studies indicating Alzheimer's and related dementias are undersigns in rural communities. Higher prevalence may be due to elevated exposure to potential risk factors like obesity/smoking, older average populations, limited access to health care services (*e.g.,* distance to hospitals, number of ambulances), and socioeconomic challenges such as a lack of healthy, affordable food options. Timely detection and accurate diagnosis of Alzheimer's or another dementia allows people to access medical, social, emotional, financial, and legal benefits sooner, and for patient and family preferences to drive health care decisions. Even though the vast majority (85 percent) of initial diagnoses are made by primary care physicians, nearly 40 percent reported that they were "never" or "only sometimes" comfortable making a diagnosis of Alzheimer's or another dementia. Seventy-one percent of rural primary care providers reported that there were not enough geriatricians and other specialists in their area, compared to 44 percent of primary care providers in large cities and 54 percent in urban areas. Project ECHO, discussed below, can equip primary care providers to effectively diagnose patients and provide needed care based on the results.

Healthy People 2020 has stated that Alzheimer's and other dementia are more often undiagnosed in rural and minority populations, and studies suggest that dementia is diagnosed less frequently in rural areas than in metropolitan areas. Studies also suggest that individuals with Alzheimer's and related dementia have a higher mortality rate in these areas and that individuals living with dementia in rural areas receive suboptimal care.

Quality care delivered by trained providers leads to better health outcomes for individuals and caregivers and puts less strain on health systems. Yet, too often overburdened primary care providers are unable to access the latest patient-centered dementia training. There is a need to fill the gaps being felt by primary care providers, and Project ECHO and the Accelerating Access to Dementia and Alzheimer's Provider Training (AADAPT) Act can help fill that gap.

Project ECHO

Project ECHO, a video-conference-based continuing education program, improves health outcomes while reducing geographic barriers and the cost of care through a team-based approach. Project ECHO is a global movement with over 900 ECHO programs across 193 countries to improve access to high quality care for over 74 health conditions and other categories (Project ECHO 2022 Annual Report). It has been widely studied and shown to be an effective educational tool and practice improvement initiative that can improve provider skills, knowledge, and confidence to better manage common, complex disease conditions in the primary care environment. Evidence also suggests that Project ECHO can improve patient outcomes, reduce costs of care, and save patients the burden and cost of traveling to seek out specialty care. Alzheimer's and dementia Project ECHO programs have successfully provided continuing education through interactive, case-based video sessions, and have brought this training to rural and medically underserved areas where primary care providers are especially strained. We are longtime advocates and supporters of Project ECHO, including endorsing the ECHO Act (Pub. L. 114–270), and supporting $15 million in appropriations funding for project ECHO in FY25.

The Accelerating Access to Dementia and Alzheimer's Provider Training (AADAPT) Act

The AADAPT Act (H.R. 7688/S. 4276), introduced by Senators Klobuchar (D–MN) and Capito (R–WV) would provide virtual dementia education and training to empower primary care providers to better diagnose Alzheimer's and other dementia and deliver high-quality, person-centered care in community-based settings. The bill would build upon the current Project ECHO program to provide grants specifically for Alzheimer's and dementia Project ECHOs to address the knowledge gaps and workforce capacity issues primary care providers face given the increasing population living with Alzheimer's disease and other dementia. This increases access to specialty care for all while decreasing disparities in access to treatment. It also increases consistency in care across providers, the knowledge of providers, and the confidence primary care providers have to treat patients with Alzheimer's and other dementias. This bill expands access to ensure that more people in underserved and rural areas are able to access treatment from providers they trust in their own communities.

Conclusion

Quality care from providers leads to better health care outcomes, but there are currently many disparities among who receives this care. Project ECHO and the AADAPT Act work to close those gaps and provide life changing treatment, detection, and diagnosis training to primary care providers so they can better serve their communities—especially in rural and frontier areas. This bill is essential to work to close the treatment access gap felt in rural communities across the country. The Alzheimer's Association and AIM appreciate the steadfast support of the Committee and its continued commitment to issues important to the millions of families affected by Alzheimer's disease and other dementia. We look forward to working with you in a bipartisan way to ensure that rural communities are able to have access to prevention methods, detection, diagnosis, and treatment for Alzheimer's and other dementia.

AMERICAN ACADEMY OF FAMILY PHYSICIANS
1133 Connecticut Avenue, NW, Suite 1100
Washington, DC 20036–1011
202–232–9033
Fax: 202–232–9044
https://www.aafp.org/

Statement of Tochi Iroku-Malize, M.D., MPH, MBA, FAAFP, Board Chair

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership to address issues impacting family physicians and their patients through this hearing entitled "Rural Health Care: Supporting Lives and Improving Communities."

The AAFP strongly agrees with Chairman Wyden's assessment in his opening statement that the United States must boost up primary care, which is "the backbone

and front line of American health care and often experiences the greatest shortage of'' clinicians. Senator Lankford also acknowledged in his opening statement that rural health care is not just delivered in hospitals, but in a variety of settings—including independent family physician practices, which he explicitly mentioned.

Rural Americans often face greater socioeconomic barriers, such as higher poverty rates and lack of reliable transportation, than their average urban counterparts. They tend to be older and sicker, have a higher incidence of poor health outcomes, and are more likely to engage in risky behaviors such as substance use and smoking. Individuals in rural areas are also more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke as well as COVID–19.[1, 2]

They also face significant barriers and challenges to accessing high-quality, comprehensive health care. Rural residents are more likely to be uninsured and are more likely to report difficulty obtaining needed health care than their urban counterparts, largely due to the limited number of clinicians and facilities in their area.[3, 4] Rural hospitals have closed at an alarming rate over the last 10 years, and many rural populations face long travel times for primary and emergency care. Additionally, while many patients benefited from new telehealth flexibilities due to the COVID–19 public health emergency (PHE), rural individuals were less likely to have broadband access and therefore less likely to connect via video for virtual visits.[5]

The AAFP has long advocated to improve access to high-quality care in rural communities. Seventeen percent of our members live and work in rural areas, the highest percentage of any medical specialty, and they are often the only physician embedded in the community. Family physicians are uniquely trained to provide a broad scope of health care services to patients across the lifespan. This enables them to tailor their practice location and individual scope of practice to the needs of their communities. As a result, family physicians are an essential source of emergency services, maternity care, hospital outpatient services, and primary care in rural areas. It is with these considerations in mind that we offer the following policy recommendations to improve health care access in rural communities.

Appropriately Paying for Primary Care in Medicare and Medicaid

Payment for primary care is undeniably a workforce issue. The amount of money that we invest into primary care is a determining factor in whether or not we have a sufficient workforce in place to meet the needs of our population. However, despite spending more on health care than any of our peer nations, only a fraction of those dollars are spent on primary care and prevention. Specifically, only 5 to 7 percent of our total national health care spending is on primary care.[6] The consequences of this underinvestment are particularly pronounced in rural communities, which represent nearly two-thirds of primary care health professional shortage areas (HPSAs) in the country.[7]

Lower compensation dissuades prospective physicians from pursuing primary care specialties and is one of the key drivers of financial instability for family medicine practices across the country. As a result, more independent primary care practices

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[1] U.S. Centers for Disease Control and Prevention, "About Rural Health." Updated May 9, 2023. Accessed September 21, 2023. Available online at: *https://www.cdc.gov/ruralhealth/about.html*.

[2] National Institute for Health Care Management, "Rural Health During the Pandemic: Challenges and Solutions to Accessing Care." February 24, 2022. Accessed September 21, 2023. Available online at: *https://nihcm.org/publications/rural-health-during-the-pandemic*.

[3] Day JC, "Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties," United States Census Bureau. April 9, 2019. Available online at: *https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html*.

[4] Shirey L, "Challenges for the 21st Century: Chronic and Disabling Conditions—Rural and Urban Health," Georgetown University. Accessed September 21, 2023. Available online at: *https://hpi.georgetown.edu/rural/#:~:text=Rural%20residents%20are%20also%20more,tests%20for%20various%20chronic%20conditions*.

[5] Federal Communications Commission, "2019 Broadband Deployment Report," May 2019. Available at: *https://www.fcc.gov/reports-research/reports/broadband-progress-reports*.

[6] Centers for Disease Control and Prevention. National Center for Health Statistics. Ambulatory Health Care Data. National Ambulatory Medical Care Survey (NAMCS). 2016. *https://www.cdc.gov/nchs/ahcd/index.htm*. Accessed February 9, 2023.

[7] U.S. Department of Agriculture, "Rural America At A Glance: 2019 Edition" (Washington: 2019), available at *https://www.ers.usda.gov/webdocs/publications/95341/eib-212.pdf;* CAP analysis of data from U.S. Department of Health and Human Services Health Resources and Services Administration, "HPSA Find," available at *https://data.hrsa.gov/tools/shortage-area/hpsa-find.*

are acquiescing to consolidation—either selling to health systems, plans, or corporate entities for what is effectively pennies or closing their doors entirely—while too few new physicians are entering the field to take their place. Between 2021 and 2022, family medicine and internal medicine physicians accounted for more than 16,000 of the 71,309 doctors who left the workforce between 2021 and 2022.[8]

In particular, the piecemeal approach fee-for-service (FFS) payment takes to financing primary care undervalues the whole-person approach integral to primary care and hinders the ability of family physicians to provide care in a way that is organic and responsive to our community. Primary care services are relatively undervalued in the Medicare Physician Fee Schedule, which leads to further devaluation across virtually all other payers who peg their payment rates to Medicare's or use Medicare's relative values to set their rates.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs.

Rural communities are disproportionately impacted by insufficient FFS payments and the other pressure points fueling consolidation. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. They see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Because of the less-profitable patient population, studies have indicated that market concentration is higher in low-income areas.[9] For some small rural practices and hospitals, the effects of consolidation may be different. Mergers and acquisition can play an important role in preserving existing sites of care (and oftentimes, the only site) with insufficient margins. However, it also often results in the closure of service lines not deemed highly profitable—including primary care—and may worsen access to care in these communities.[10]

For these reasons, **the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care.** We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome FFS payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways. Unfortunately, a dearth of primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' transition into value-based care.

Physician practices that struggle to keep their doors open cannot possibly transition into APMs or hire care managers and behavioral health professionals. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows. Therefore, **the Academy continues to urge the Committee to advance legislative solutions, including reforms to the Medicare Access and CHIP Reauthorization Act (MACRA), that would address unsustainable FFS payment rates for physicians and alleviate some of the associated administrative burden for practices, while promoting patients' access to continuous, comprehensive primary care.** This includes providing an annual inflationary update for physician payment tied to the Medicare Economic Index and greatly needed reforms to existing budget neutrality requirements, which pit physician specialties against one another in a fight for scarce resources and hinder CMS' ability to appropriately pay for all the services a beneficiary needs.

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[8] Primary care, mental health clinician shortage jeopardizes access, Modern Healthcare. *https://www.modernhealthcare.com/labor/primary-care-mental-health-shortage-definitive-healthcare?utm_source=modern-healthcare-alert&utm_medium=email&utm_campaign=20231016&utm_content=hero-readmore*.

[9] Yerramilli P, May FP, Kerry VB. Reducing Health Disparities Requires Financing People-Centered Primary Care. JAMA Health Forum. 2021;2(2):e201573. doi:10.1001/jamahealthforum.2020.1573.

[10] O'Hanlon CE et al. "Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation," Health Affairs. December 2019. *https://doi.org/10.1377/hlthaff.2019.00918.*

Furthermore, Medicaid payment rates have a direct impact on patient access to primary care. Medicaid payment is on average 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent in some states.[11] These low rates have historically been a barrier to physicians accepting more Medicaid patients. Reports from the Medicaid and CHIP Payment and Access Commission (MACPAC) show that physician acceptance of new Medicaid patients worsens as the ratio of Medicaid payment rates to Medicare allowances decreases.[12] Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients.[13] Managed care plans report caps on clinicians' Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care.[14] Medicaid enrollees experience longer office wait times, more difficulty scheduling visits, and both low-income patients and their physicians report low payment rates lead to shorter, inadequate visit times.[15, 16, 17]

Meanwhile, evidence indicates patient access improved when Congress raised Medicaid primary care payment rates to Medicare levels in 2013–2014. One study found that appointment availability increased during the "primary care fee bump" and decreased after it expired.[18] Other studies found the fee bump did not significantly increase physicians' participation in the Medicaid program, likely due to the temporary nature of the payment increase.[19] Raising Medicaid payment for primary care services can improve access to care for Medicaid beneficiaries and in turn mitigate health disparities.

Therefore, **the Academy continues to urge Congress to pass legislation that applies a Medicare payment rate floor to Medicaid primary care services** as a necessary step toward addressing the unsustainably low payment rates that are exacerbating existing health disparities and undermining patient access to essential care. However, the AAFP also continues to emphasize that Medicare payment rates have failed to keep up with inflation and should not be considered adequate. While Medicare is not a perfect comparator, we believe that it is a useful starting place because states continue to pay even lower Medicaid rates and Medicare rates are publicly available on a national basis.

Maternal Health and Obstetric Unit Closures

The United States has one of the highest maternal mortality rates in the developed world. Recent studies have shown that U.S. maternal mortality rates have stagnated or even worsened over time, while rates around the globe continue to fall.[20]

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[11] Zuckerman, S., Skopec, L., Aarons, J. (2021, February 01). Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611.*

[12] Medicaid and CHIP Payment and Access Commission, "Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey." June 2021. Accessed online at: *https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf.*

[13] Decker SL. In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Aff (Millwood). 2012 Aug;31(8):1673–9. doi: 10.1377/hlthaff.2012.0294. PMID: 22869644; PMCID: PMC6292513.

[14] Garfield R, Hinton E, Cornachione E, Hall C. Medicaid Managed Care Plans and Access to Care. Kaiser Family Foundation. 2018. Retrieved from: *http://files.kff.org/attachment/Report-Medicaid-Managed-Care-March-Plans-and-Access-to-Care.*

[15] Oostrom, T., Einav, L., & Finkelstein, A. (2017). Outpatient Office Wait Times and Quality of Care for Medicaid Patients. Health Affairs, 36(5), 826–832. doi:10.1377/hlthaff.2016.1478. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812017/.*

[16] Hsiang WR, Lukasiewicz A, Gentry M, Kim CY, Leslie MP, Pelker R, Forman HP, Wiznia DH. Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis. Inquiry. 2019 Jan-Dec;56:469580198 38118. doi: 10.1177/0046958019838118. PMID: 30947608; PMCID: PMC6452575.

[17] Lewis C, Zephyrin L, Abrams MK, Seervai S. (2019). Listening to Low-Income Patients and Their Physicians: Solutions for Improving Access and Quality in Primary Care. The Commonwealth Fund. *https://www.commonwealthfund.org/blog/2019/listening-low-income-patients-and-their-physicians--improving-access-and-quality.*

[18] Candon M, Zuckerman S, Wissoker D, et al. Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients. JAMA Intern Med. 2018;178(1):145–146. doi:10.1001/jamainternmed.2017.63022.

[19] Decker S. (2018). No Association Found Between the Medicaid Primary Care Fee Bump and Physician Reported Participation in Medicaid. Health Affairs. *https://doi.org/10.1377/hlthaff.2018.0078.*

[20] Fleszar LG, Bryant AS, Johnson CO, et al. Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States. JAMA. 2023;330(1):52–61. doi:10.1001/jama.2023.9043.

According to the World Health Organization, maternal mortality globally declined nearly 38 percent between 2000 and 2017.[21] During roughly the same period, maternal mortality in the United States increased by over 26 percent. In the U.S., approximately 700 women a year die as a result of pregnancy or related complications, yet the vast majority (84 percent) are preventable.[22] Significant disparities exist when these rates are broken down across demographic groups, with higher rates of mortality occurring among Black women, low-income women, and those living in rural areas.[23]

The factors driving these disparities are complex and multi-faceted. They include but are not limited to access to and affordability of care, the intersection of demographic factors, and structural and systemic bias and discrimination. For example, the closure of rural hospitals and obstetrics programs has led to enormous gaps in access to prenatal and perinatal services for pregnant people living in rural communities. In addition to the loss of facilities, there are compounding factors such as lack of transportation, increased poverty, increased rate of chronic diseases, and difficulty recruiting and retaining physicians to live and work in rural communities.

Between 2011 and early 2023, 217 hospital obstetric units closed, creating many maternity care deserts across the nation.[24] As of 2018, over half of all rural counties lack a hospital providing obstetric services. Closures have been particularly focused in rural communities that are sparsely populated, have mostly Black residents, and were considered low income.[25] Family physicians were found to deliver babies more commonly in rural areas than in urban as many lack a dedicated obstetrician-gynecologist (OB/GYN).

The AAFP believes family physicians can play a significant part in addressing the disparities in maternal morbidity and mortality because they are trained to provide comprehensive care across the life course, including prenatal, perinatal, and postpartum care for people in the communities where they live. More than 1 in 10 family physicians (13 percent) reported they delivered babies in 2022. A 2019 study found that in rural counties overall, there were about equal numbers of family physicians and OB/GYNs, but in urban counties there was about one family physician for every six OB/GYNs.[26]

The AAFP has two courses to provide education and build skills focused on recognizing obstetrical emergencies. Advanced Life Support in Obstetrics (ALSO®) is a program that equips the entire maternity care team with skills to effectively manage obstetrical emergencies. Basic Life Support in Obstetrics (BLSO®) is designed to improve the management of normal deliveries, as well as obstetrical emergencies, by standardizing the skills of first responders, emergency personnel, and maternity care providers.

To further address this issue, the AAFP recommends that Congress pass the Rural Obstetrics Readiness Act (S. 4079), which would establish training programs to help non-specialists respond to obstetric emergencies. The bill would also provide grants for rural facilities to provide better equipment to train for and handle these emergencies and develop a pilot program for teleconsultation services so a maternal care expert can provide consulting services in an emergency.

However, training clinicians on how to deliver care during an obstetric emergency does not solve the problem. The fact remains that Americans living in rural areas are much less likely to have access to an obstetric unit than those living in urban and suburban areas. According to the Government Accountability Office (GAO) there are two main factors that affect the availability of hospital-based obstetric

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[21] World Health Organization. "Maternal mortality." World Health Organization (WHO), 26 April 2024, *https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.* Accessed 30 April 2024.

[22] Hill, Latoya, et al. "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them." KFF, 1 November 2022, *https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/*. Accessed 30 April 2024.

[23] Hill, Latoya, et al.

[24] Roeder, Amy. "Maternity ward closures exacerbate health inequity | News." Harvard T.H. Chan School of Public Health, 13 December 2023, *https://www.hsph.harvard.edu/news/features/maternity-obstetric-closure-health-disparities/*. Accessed 30 April 2024.

[25] Government Accountability Office. "Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas." Government Accountability Office, 19 October 2022, *https://www.gao.gov/assets/gao-23-105515.pdf*. Accessed 14 May 2024.

[26] Government Accountability Office.

care in rural areas: Medicaid reimbursement rates and recruiting and retaining providers.

Fifty percent of births in rural areas are covered by Medicaid compared to 43 percent in the U.S. as a whole making Medicaid reimbursement rates vital to the operation of rural obstetric units. However, the reimbursement rate set by states does not cover the full cost of providing obstetric services.[27] Medicaid only pays about half of what private insurers pay for childbirth-related services. Since hospital-based obstetric services can be costly to operate, it is essential to provide fair reimbursement for all births. Hospitals often rely on private insurance payments, non-obstetrical surgical care, and other supporting services to subsidize their losses from obstetric services, which leaves rural hospitals in a vulnerable financial position.

Rural hospitals also face challenges in recruiting and retaining providers. While there is a shortage of physicians and other clinicians, it is even more pronounced in rural areas. The Health Resources and Services Administration (HRSA) estimates that the anticipated supply of OB/GYNs is expected to meet only 50 percent of the demand in rural areas.

Gaps in insurance coverage and availability of affordable care also increase the risk of morbidity and mortality, particularly during the postpartum period. We appreciate that Congress permanently extended the voluntary option for states to provide postpartum Medicaid coverage for up to a year in the Consolidated Appropriations Act of 2022. However, a permanent solution across all states is needed to ensure access to continuous care for pregnant people throughout the full, 1-year postpartum period.

Current law only requires states to provide Medicaid coverage based on pregnancy status up to 60 days postpartum. As the largest single payer of maternity care in the U.S., Medicaid has a critical role to play in ensuring healthy moms and babies.[28] According to the Centers for Disease Control and Prevention, more than half (53 percent) of pregnancy-related deaths occur between 1 week and 1 year postpartum, during which time many postpartum individuals lose Medicaid coverage.[29] The AAFP therefore continues to advocate for requiring one year of postpartum Medicaid coverage as an important way to address the disparities in maternal health and improve outcomes. Specifically, **Congress should pass the Healthy Maternal and Obstetric Medicine (Healthy MOM) Act (S. 3509/H.R. 6716) to create a special enrollment period for marketplace plans for pregnant people and require states to offer Medicaid coverage to pregnant people up to 12-months postpartum.**

Further, the AAFP recognizes that the root causes of racial and ethnic disparities in maternal morbidity and mortality include institutional racism in the health care and social service delivery system and social and economic inequities. Implicit bias is pervasive among all health care professionals and has deleterious effects on patient health.[30] It reduces trust, self-efficacy, understanding, and satisfaction between a patient and their physician, affecting a patient's ability to manage their health and adhere to treatment. For physicians, implicit bias limits their level of cultural proficiency, patient-centeredness, and job satisfaction.

Formal medical education and training curricula often lack content that provides a framework for identifying and mitigating implicit biases in clinical practice. Faculty who seek to incorporate this topic in training are often faced with barriers, such as the limited number of subject matter experts who can provide instruction, a lack of opportunities for participants to observe and demonstrate mitigation strategies in practice, and a lack of opportunities to engage with patients who can share experiences of encountering implicit bias in the delivery of prenatal care.

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[27] Government Accountability Office.

[28] Valenzuela, Claudia P., and Michelle JK Osterman. "Characteristics of Mothers by Source of Payment for the Delivery: United States, 2021." Centers for Disease Control and Prevention, 25 May 2023, *https://www.cdc.gov/nchs/products/databriefs/db468.htm*. Accessed 30 April 2024.

[29] Centers for Disease Control and Prevention. "Four in 5 pregnancy-related deaths in the U.S. are preventable | CDC Online Newsroom | CDC." Centers for Disease Control and Prevention, 19 September 2022, *https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html*. Accessed 30 April 2024.

[30] Peek, Monica E et al. "Development of a Conceptual Framework for Understanding Shared Decision making Among African-American LGBT Patients and their Clinicians." Journal of General Internal Medicine vol. 31,6 (2016): 677–87. doi:10.1007/s11606–016–3616–3.

The implicit biases of health care professionals toward people of color, particularly Black women, have been shown to be a contributing factor to racial and ethnic disparities in adverse maternal health outcomes. For example, studies have demonstrated that implicit bias of health care professionals affects rates of racial and ethnic disparities in contraception use,[31] access to and quality of prenatal care,[32, 33] and clinical decision-making[34] in the intrapartum and postpartum periods.

Strengthen and Target Graduate Medical Education Programs

As acknowledged previously, the U.S. faces a critical family physician workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate care access for patients nationwide. Though the current system excels at educating skilled physicians and physician researchers, the primary care physician shortage prevents the U.S. from taking advantage of the better outcomes and lower per capita costs associated with robust primary care systems in other countries.

Most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[35] As a result, the current distribution of trainees leads to physician shortages that are particularly dire in medically underserved and rural areas. While 20 percent of the U.S. population lives in rural communities, only 12 percent of primary care physicians and 8 percent of subspecialists practice in these areas.

The Academy encourages Congress to consider ways to reimagine our country's graduate medical education (GME) system so that it better supports and invests in primary care, including an expansion of training in community-based settings. This will bolster our primary care workforce for the future and allow us to realize the true value of primary care for generations to come, including significant cost savings and improved patient outcomes as we shift toward a system that prioritizes health care, rather than sick care.

The AAFP supports consistent funding for GME for family medicine to ensure that new residency slots are allocated to address rural and urban imbalances, reduce physician shortages, and focus on medically underserved areas, including funding for programs such as the federal Teaching Health Center GME (THCGME) program.

Teaching Health Centers (THCs) play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the THCGME program has trained more than 2,027 primary care physicians and dentists, 61 percent of whom are family physicians. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities. This demonstrates that the program is successful in tackling the issue of physician maldistribution and helps address the need to attract and retain physicians in rural areas and medically underserved communities.

However, the THCGME program's authorization expires at the end of this year, which further jeopardizes the stability of this program for its current and future residents as well as the patients they serve. Historically, the program has received piece-meal, short-term reauthorizations from Congress. This fails to consider the fact that family medicine residencies are 3-year programs, meaning many medical students are dissuaded from applying to THC residencies because they have no certainty that the program will even be around long enough for them to complete their

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[31] Jackson, Andrea V et al. "Racial and ethnic differences in contraception use and obstetric outcomes: A review." Seminars in perinatology vol. 41,5 (2017): 273–277. doi:10.1053/j.semperi.2017.04.003.

[32] Kogan, M D et al. "Racial disparities in reported prenatal care advice from health care providers." American Journal of Public Health vol. 84,1 (1994): 82–8. doi:10.2105/ajph.84.1.82.

[33] Slaughter-Acey, Jaime C et al. "Personal Versus Group Experiences of Racism and Risk of Delivering a Small-for-Gestational Age Infant in African American Women: A Life Course Perspective." Journal of Urban Health: bulletin of the New York Academy of Medicine vol. 96,2 (2019): 181–192. doi:10.1007/s11524–018–0291–1.

[34] Bryant, Allison S et al. "Racial/ethnic disparities in obstetric outcomes and care: prevalence and determinants." American Journal of Obstetrics and Gynecology vol. 202,4 (2010): 335-43. doi:10.1016/j.ajog.2009.10.864.

[35] Fagan BE, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training—Graham Center Policy One-Pagers—American Family Physician.

training. We have unfortunately seen this instability result in some THCGME programs accepting fewer or no new residents for next year or closing their program entirely.

For these reasons, the AAFP strongly cautions against a short-term extension. Instead, **the AAFP recommends that Congress pass the Doctors of Community (DOC) Act (H.R. 2569) to permanently authorize the THCGME program.** Absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program.

We also strongly urge Congress to pass the Rural Physician Workforce Production Act (S. 230/H.R. 834), which would provide invaluable new federal support for rural residency training to help alleviate physician shortages in rural communities. Specifically, the bill would remove caps for rural training and provide new robust financial incentives for rural hospitals, including critical access and sole community hospitals, to provide the training opportunities that the communities they serve need.

While the new Medicare GME residency slots approved in the previous Congress were very much appreciated, additional action is needed to address disparate access to care in rural and other medically underserved areas. **Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians.** Any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare is the largest single payer of GME, spending about $16 billion annually, but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[36] CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect, analyze data on how Medicare GME positions are aligned with national workforce needs, and publish an annual report.

Thank you to the Committee for its continued bipartisan leadership to improve access to rural health care. The AAFP looks forward to continuing to work with you to advance policies that will best support family physicians and the patients they serve in these communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Tochi Iroku-Malize, M.D., MPH, MBA, FAAFP
Board Chair

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits—that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit *www.aafp.org*. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, *https://familydoctor.org/*.

Links

https://www.aafp.org/about/policies/all/rural-practice-keeping-physicians.html

https://www.aafp.org/about/policies/all/maternal-child.html

https://www.aafp.org/cme/programs/also.html

https://www.aafp.org/cme/programs/blso.html

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[36] Congressional Research Service. Federal Support for Graduate Medical Education: An Overview. *https://fas.org/sgp/crs/misc/R44376.pdf*. Published December 27, 2018. Accessed February 9, 2023.

https://www.aafp.org/about/policies/all/birth-equity-pos-paper.html

https://www.aafp.org/about/policies/all/graduate-medical-education-financing.html

https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/gme/LT-Congress-RuralWorkforceProductionAct-021423.pdf

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AMERICAN ACADEMY OF PHYSICIAN ASSOCIATES
2318 Mill Road, Suite 1300
Alexandria, VA 22314
P 703–836–2272
F 703–684–1924
https://www.aapa.org/

Dear Chairman Wyden, Ranking Member Crapo and members of the committee:

On behalf of the more than 168,000 physician associates/physician assistants (PAs) throughout the United States, the American Academy of Physician Associates (AAPA) thanks the committee for your ongoing commitment to ensuring all Americans have access to high-quality healthcare. AAPA appreciates the opportunity to submit comments for the record with respect to the committee's May 16, 2024, Hearing "Rural Health Care: Supporting Lives and Improving Communities."

AAPA recognizes the complex and multifaceted issues and challenges facing the healthcare workforce in the United States, especially on the heels of a global pandemic and record levels of burnout. As our nation's population continues to age and additional factors, such as rising chronic disease, increase demand for healthcare services, we are confident that PAs are an integral part of the solution. The PA profession was established in the 1960s at a time when the nation was facing a primary care shortage and was founded to improve access, especially in rural and underserved communities.[1] Today, PAs remain ready to respond to the national demand for greater access to high-quality healthcare services. PAs already possess the medical education, training, and experience to do so.

As Congress considers policies to ensure timely access to high-quality care for all patients, AAPA encourages the committee to embrace opportunities to reduce provider barriers and burdens wherever they interfere with optimizing patient care and access. AAPA also encourages the Congress to reauthorize current programs to address workforce challenges and enact legislation to ensure all providers can practice to the top of their license and education. Although PAs are already providing high-quality care across the nation and in all medical specialties, outdated barriers to practice remain. AAPA stands ready to work with the committee as you consider new ideas to ensure quality care is available to all Americans, particularly those in rural and underserved communities.

Background: What is a PA?

PAs are medical professionals who diagnose illness, develop, and manage treatment plans, prescribe medications, and are often a patient's primary healthcare provider. PAs are highly trained professionals with thousands of hours of medical education and training who practice in all medical and surgical specialties in all 50 states, the District of Columbia, U.S. territories, and in the uniformed services. Additionally, PAs are one of three healthcare professions, including physicians and advanced practice registered nurses (APRN), who are recognized in Medicare to provide both primary and mental health medical care in the United States. The typical PA education program provides students with an intensive, master's degree level, medical education over approximately three academic years, or 27 continuous months.[2] However, PA education does not end with graduation. To practice, PAs must pass the PA National Certifying Examination and obtain state licensure. To maintain certification, PAs must also complete 100 hours of continuing medical education (CME) every two years and pass a comprehensive examination every ten years.[3] Many PAs seek additional educational opportunities following graduation and throughout the duration of their careers.

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[1] Cawley JF, Cawthon E, Hooker RS. Origins of the physician assistant movement in the United States. JAAPA. 2012 Dec;25(12):36-40, 42.

[2] PAEA. Program report 35, Table 6, page 7.

[3] NCCPA. Certified PAs: Improving health, saving lives, making a difference. *https://prodcmsstoragesa.blob.core.windows.net/uploads/files/PatientBrochure.pdf.*

For more than 50 years, PAs have provided high-quality, cost-effective healthcare services to patients across the nation. However, several barriers remain at the state and federal levels that prevent PAs from practicing to the full extent of their education, training, and license. These barriers diminish the value PAs can bring to rural communities suffering from ongoing shortages of qualified healthcare providers.

According to the Health Resources and Services Administration (HRSA), more than 15% of Americans live in rural areas, but only 10% of physicians practice in those communities.[4] About 16% of all clinically practicing PAs are located in a rural county, with more than 1 in 3 practicing much needed primary care in rural locations. Removing barriers to ensure PAs can practice to the top of their license should be viewed as an important solution to the shortage of providers along with adequate access to primary care in rural and underserved areas.

Diabetic Shoes

PAs diagnose and treat illnesses, manage complex conditions, prescribe medications in all 50 states, and assist in surgery—but the current statute governing Medicare does not authorize PAs to complete the simple task of ordering diabetic shoes. With the aging U.S. population and increasing prevalence of diabetes, it is absurd that a PA can manage a patient's diabetes and other complex chronic conditions but is not authorized to order diabetic shoes. *The Promoting Access to Diabetic Shoes Act (S. 131/H.R. 618)* will modernize current Medicare policy and authorize PAs to certify a patient's need for diabetic shoes.

A study published in the American Journal of Medicine in 2018 found that PAs perform as well as physicians in the management of diabetes at diagnosis and during 4 years of follow-up care. PAs are federally recognized primary care providers and frequently manage care for diabetics who may have multiple comorbidities. Outside of the Medicare program, PAs can certify the need for diabetic shoes for their patients. This is an example of the Medicare statute not making common sense or keeping up with how medicine is practiced today.

Diabetic foot complications are directly related to poor clinical outcomes and substantial cost, especially among rural Medicare patients. Compared to urban populations, rural populations have a 16 percent higher prevalence of type 2 diabetes, a 20 percent higher type 2 diabetes-related hospital mortality, and smaller improvements in overall mortality rates in the past 2 decades.[5] It is further estimated that rural patients face a nearly 35 percent increase in major amputation following diabetic foot ulcers as compared to patients living in urban areas.[6]

Often referred to among providers as the "diabetic amputation loop," 19 percent of diabetic patients will then face a second amputation within 1 year and more than 37 percent within the first 5 years.[7] The cost of a lower extremity amputation (LEA) among Medicare beneficiaries is substantial and growing. It has been estimated that the mean annual reimbursement of all services for diabetic Medicare patients with an LEA was more than $49,000 in 2006, more than $51,000 in 2007, and more than $54,000 in 2008.[8]

Modernizing Medicare to authorize PAs to certify a patient's need for diabetic shoes, consistent with state law, will improve the quality and continuity of care available to diabetic patients, especially for those living in rural and medically underserved areas experiencing critical access issues and physician shortages.

Mental and Behavioral Healthcare Access

Our nation is currently facing a significant shortage of mental healthcare providers, and unfortunately this shortage is only projected to grow in the coming years. As

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[4] HRSA. Designated HPSAs as of March 31, 2024. *file:///C:/Users/DP953PR/Downloads/BCD—HPSA—SCR50—Qtr—Smry.pdf.*

[5] Dugani, Sagar et al. Diabetes Metab Res Rev. Burden and Management of Type 2 Diabetes Mellitus in Rural United States.

[6] Krepnek GH, Mills JL, Armstrong DG. A diabetic emergency one million feet long: Disparities and burdens of illness among diabetic foot ulcer cases within emergency departments in the United States, 2006–2010.

[7] Liu R, Petersen BJ, Rothenberg GM, et al. Lower extremity reamputation in people with diabetes: A systematic review and meta-analysis. BMJ Open Diab Res Care 2021;9:e002325. doi:10.1136/ bmjdrc–2021–002325.

[8] Margolis DJ, Malay DS, Hoffstad OJ, et al. Economic burden of diabetic foot ulcers and amputations: Data Points #3. 2011 Mar 8. In: Data Points Publication Series [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2011–. Available from: *https://www.ncbi.nlm.nih.gov/books/NBK65152/*.

front-line providers, PAs are recognized across the nation as high-need providers in mental health who play a critical role in expanding psychiatric care.[9] While some PAs practice in mental and behavioral health specialties including psychiatry, currently more than 30,000 PAs practice in primary care and *routinely provide mental healthcare to their patients*.[10] PAs in emergency and hospital medicine also treat patients with psychiatric symptoms and are often a first line provider for patients to access mental or behavioral health services. PAs also serve an essential role providing high-quality mental health services to veterans across the Department of Veterans Affairs (VA) system. It is imperative that PAs are authorized to practice to the full extent of their education, training, and experience to confront the growing need for behavioral and mental healthcare services.

As highly educated and qualified medical professionals, PAs practice in behavioral health facilities, hospitals, private practice, rural health clinics, community health centers, and prisons across the United States. With clinical expertise, medical training, and the initiative to help, PAs are on the ground in local communities. In 2018, the PA Foundation launched an inaugural *Mental Health Outreach Fellowship.*[11] This profession-driven initiative was the first phase of a wider mental health outreach effort that sought to connect PAs with community mental health needs.[12] In 2019, the first PA fellows reported training more than 1,500 people across the United States to recognize and respond to mental health needs in their communities.

Recognized in federal law as providers in opioid treatment programs, PAs are also instrumental in providing care for patients with substance use disorder (SUD) and surrounding mental, physical, and behavioral health concerns. Effective treatments for substance use disorders are available, but few patients receive the treatment they need. In 2019, only 12.1% of individuals with a SUD received treatment.[13]

While rural and urban areas alike are dealing with an overdose crisis, 56 percent of rural counties lack access to a provider who can prescribe treatment.[14] PAs are authorized to prescribe controlled medications in all 50 states. Once granted, no state has ever rescinded PA authority to prescribe controlled medications. There has been no record of increased liability or malpractice claims due to PA prescribing of scheduled drugs, and professional liability insurers have not increased premiums when PAs have been granted authority to prescribe controlled medications.

Healthcare in the United States continues to evolve from a traditional, physician-centric model to a more streamlined, efficient, and patient-centric model and PAs are evolving with it. As our nation faces a severe shortage of behavioral health providers, including physicians, it is imperative that PAs and other qualified mental health providers are appropriately utilized to provide this necessary care. The COVID–19 pandemic and public health emergency (PHE) highlight just how critical a robust and secure healthcare workforce is to our nation's security and overall well-being. Access to high-quality, evidence-based healthcare is critical for positive patient outcomes and healthy communities. PAs and other providers throughout the United States have faced increased stress, high rates of burnout and challenges to their own mental health. PAs must also confront an increasing demand to provide critical healthcare services while physician shortages, especially in rural and low-income areas, continue to grow.[15]

Medicare Shared Savings Accountable Care Organization (ACO)

PAs are recognized in the Medicare Shared Savings Program (MSSP) as "ACO professionals," yet their patients cannot be assigned as beneficiaries in that program. Under current law, Medicare fee-for-service beneficiaries are assigned to an ACO based on their utilization of primary care services furnished by a physician. However, individuals in rural and underserved communities often rely on PAs and other

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[9] Medical Director Institute. The psychiatric shortage: Causes and solutions. National Council for Behavioral Health. March 28, 2017. Washington, DC. *https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_NationalCouncil-.pdf.*

[10] AAPA. 2020 PA Data Book.

[11] *https://pa-foundation.org/mental-health-outreach-reflecting-and-forging-ahead/.*

[12] *https://pa-foundation.org/our-programs/mental-health-outreach-fellowship/.*

[13] *https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/increase-proportion-people-substance-use-disorder-who-got-treatment-past-year-su-01/data.*

[14] AIR, Exploring Urban-Rural Disparities in Accessing Treatment for Opioid Use Disorder, November 19, 2021. *https://www.air.org/resource/equity-focus/exploring-urban-rural-disparities-accessing-treatment-opioid-use-disorder#:~:text=Rural%20and%20urban%20communities%20alike,treatment%20for%20opioid%20use%20disorder.*

[15] *https://www.aamc.org/media/45976/download?attachment.*

advanced practitioners. As a result, the physician requirement prevents Medicare fee-for-service beneficiaries in these communities from accessing the coordinated care provided by ACOs. It is essential that primary care services furnished by PAs and other advanced care providers count for purposes of ACO assignment. This encourages ACO formation in rural and underserved areas and allows healthcare providers to attain enough ACO beneficiaries to participate in the Medicare Shared Savings Program. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages and encourage the adoption of value-based care principles such as care coordination and population health.

The ACO Assignment Improvement Act (S. 3939/H.R. 7665) will improve the way beneficiaries are assigned under the MSSP by also basing such assignment on primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists.

Cardiac and Pulmonary Rehabilitation (CR/PR)

Current law arbitrarily restricts the ordering and supervision of cardiac and pulmonary rehabilitation in Medicare. In 2018, Congress rightfully authorized PAs and other advanced practice providers to **supervise** cardiac and pulmonary (CR/PR) services but with a delayed implementation until 2024. However, PAs are still not authorized to **order** this critical service for their patients.

CR/PR services are an essential and proven tool in the management of patients with chronic respiratory conditions, those who have survived myocardial infarction (heart attack) as well as patients fighting chronic obstructive pulmonary disease (COPD.) CR/PR services have also been used to treat patients recovering from an active SARS–COV–2 infection. Despite the clinical implications and critical importance of this treatment, CR/PR services remain severely underutilized, especially among high-risk populations in rural areas.[16]

CR/PR services are offered through medically directed and supervised programs designed to improve a patient's physical, psychological, and social functioning. Both programs utilize supervised exercise, risk factor modification, education, counseling, behavioral modification, psychosocial assessment, and outcomes assessment.

PAs are routinely on the front line in critical care environments, such as in hospitals, clinics, emergency rooms, and intensive care units. They are highly trained providers, qualified to order and supervise critical medical services. However, under current law only physicians may order and supervise CR/PR programs in Medicare. CR/PR services are proven to improve health outcomes for patients who have survived a heart attack and/or have chronic obstructive pulmonary disease (COPD) and can treat patients recovering from other chronic diseases, including COVID–19. However, this life-saving treatment is underutilized, especially in rural and medically underserved areas, because qualified providers such as PAs are unnecessarily and arbitrarily prevented from ordering and supervising CR/PR. Patients deserve the highest-care available; outdated restrictions like this only compound the challenge in areas where access issues and care disparities are particularly acute. The *Increasing Access to Quality Cardiac Rehabilitation Care Act (S. 3481/H.R. 2583)* would authorize PAs to order this critical service for Medicare patients, especially those in rural areas.

Hospice and Palliative Care

In 2018, the *Medicare Patient Access to Hospice Act* was included in the *Bipartisan Budget Act of 2018* and broadened the Medicare definition of hospice "attending physician" to include PAs. This inclusion took effect in January of 2019 and was a necessary step in ensuring adequate access to hospice care for Medicare patients, especially those in rural and underserved areas.

PAs regularly function as a patient's primary healthcare provider. Frequently, it is the primary provider, acting in the role of a Medicare hospice attending physician, who helps with a patient's transition to hospice and subsequently assists in facilitating care received. However, PAs may not certify or re-certify terminal illness. PAs are highly qualified health professionals and should be authorized to perform these functions, consistent with state law, under Medicare. Further, PAs need to be authorized to perform the face-to-face encounter that is required prior to recertifi-

[16] Fleg JL, Keteyian SJ, et al. Increasing Use of Cardiac and Pulmonary Rehabilitation in Traditional and Community Settings: Opportunities to Reduce Health Care Disparities. J Cardiopulm Rehabil Prev. 2020 Nov;40(6):350–355. doi: 10.1097/HCR.0000000000000527. PMID: 33074849; PMCID: PMC7644593.

cation after a patient has been under the hospice benefit for 180 days. NPs, however, *are* authorized to perform this face-to-face visit that is then used by a physician to determine a patient's eligibility for recertification. These arbitrary restrictions on PAs remain a significant barrier to care for patients needing hospice services and are amplified in their detrimental effects by ongoing provider shortages. Our rural communities are facing a significant hospice workforce shortage that Congress could help alleviate. Authorizing PAs to certify and recertify terminal illness, in addition to perform face-to-face visits required for recertifications, something well within their scope and education, would significantly increase the number of highly qualified providers in the hospice workforce.

AAPA requests that Congress 1) modify 42 U.S.C. 1395f(a)(7)(A) to authorize PAs to certify and recertify terminal illness, and 2) modify 42 U.S.C. 1395f(a)(7)(D)(il) to authorize PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days.

Federal Workers Compensation

Currently, all U.S. federal and postal employees receive workers compensation coverage for employment-related injuries and disease through the Federal Employees Compensation Act (FECA). However, FECA does not cover medical care provided by PAs (or nurse practitioners [NPs]) within the current definition of *"medical, surgical, and hospital services. . . ,"* meaning once a federal or postal employee is injured on the job, they can no longer receive healthcare from a PA, even if that PA is their primary care provider (PCP) through their federal health insurance program. This undue and unnecessary restriction negatively impacts our federal workforce, especially those in rural areas where access to any provider, not just physicians, can be challenging.

PAs provide high-quality healthcare and are recognized providers in Medicare, Medicaid, and nearly every state and federal healthcare program, including state workers' compensation programs. PAs are included in the definition of an *"acceptable medical source"* by the Social Security Administration and thousands of PAs are federal employees themselves and practice within the Department of Veterans Affairs, the Department of Defense, the Public Health Service, and Indian Health Services. FECA is the outlying federal program that does not recognize the critical role PAs play in our healthcare system. The *Improving Access to Workers' Compensation for Injured Federal Workers Act (S. 260/H.R. 704)* would authorize PAs to treat their federally employed patients in accordance with state law.

Conclusion

In 2021, an AAPA Practice Survey [17] found that approximately half of the PAs who responded were already working in or interested in moving to practice in, a rural location, health professional shortage area, or medically underserved area. PAs are practicing in rural areas across the nation and while interest remains high, barriers and recruitment challenges remain. While PAs increase access to healthcare in rural areas, they also increase economic benefits in the same communities.[18] AAPA urges the committee to consider the vital role that PAs and other providers play in communities across the nation, specifically in rural and underserved areas, and ensure that they can provide the care that is so critically needed.

AAPA thanks the committee for the opportunity to submit these recommendations and for your ongoing dedication to our nation's healthcare systems. We are committed to working with Congress to advance our shared mission of improving access to healthcare in the United States. If we can be of assistance on this or any issue, please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at theuer@aapa.org.

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[17] *https://www.aapa.org/download/103451/*.

[18] Eilrich FC. The economic effect of a physician assistant or nurse practitioner in rural America. JAAPA. 2016;29(10):44–48. doi:10.1097/01.JAA.0000496956.02958.dd.

AMERICAN ASSOCIATION OF NURSE ANESTHESIOLOGY
25 Massachusetts Ave., NW, Suite 320
Washington, DC 20001

Statement of Dru Riddle, Ph.D., DNP, CRNA, FAAN, President

Background on AANA and CRNAs

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthesiology (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 61,000 CRNAs and student nurse anesthetists representing over 85 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who provide anesthesia, as well as acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

AANA applauds the Committee's decision to hold this hearing, as it is of the utmost importance that our nation's healthcare systems that we ensure rural communities have access to high quality, timely healthcare. This hearing is an important opportunity to address the unique healthcare challenges that rural communities face. CRNAs and other advance practice registered nurses (APRNs) have consistently answered the call to help ensure these communities have access to care. To better help these communities, Congress should remove costly, unnecessary barriers to care and mobilize resources already available to them. **We strongly urge Congress to pass the *Improving Care and Access to Nurses (ICAN) Act* (S. 2418/H.R. 2713) that would make much needed updates to Medicare and Medicaid that would help rural and nonrural communities alike.**

CRNAs are highly trained and skilled anesthesia providers who have full practice authority in the Army, the Navy, and the Air Force, as well as the Indian Health Service. CRNAs are the primary provider of anesthesia on the battlefield, including in forward surgical hospitals. CRNAs possess all the necessary skills and training to be autonomous providers of anesthesia, particularly in rural and underserved communities where they predominate. This is why states have continued to remove barriers to CRNA practice to allow CRNAs to practice to the top of their education and skills. This increases access, lowers costs, increases efficiency in the healthcare system, and improves competition in a healthcare system that is plagued by consolidation and monopoly.

Rural Healthcare: How CRNAs Can Fill the Gaps

Rural communities tend to have higher rates of poverty, more elderly residents, poorer overall levels of health, and have fewer physician practices, hospitals, and other health care facilities. Ongoing provider shortages are felt even more acutely in rural areas. These disparities are critical when it comes to the anesthesia workforce. In rural areas, unnecessary supervision requirements can have a disastrous impact on a patient's ability to access healthcare in a timely manner and delayed delivery of healthcare can lead to dangerous, even deadly, complications. According to the *Journal of Rural Health,* 81.2% of rural counties lack a physician anesthesiologist.[1] Data from the VA shows that full practice authority for other APRNs has increased access to care and decreased wait times, and Congress should work to remove barriers that inhibit CRNAs and other APRNs from providing this care.[2]

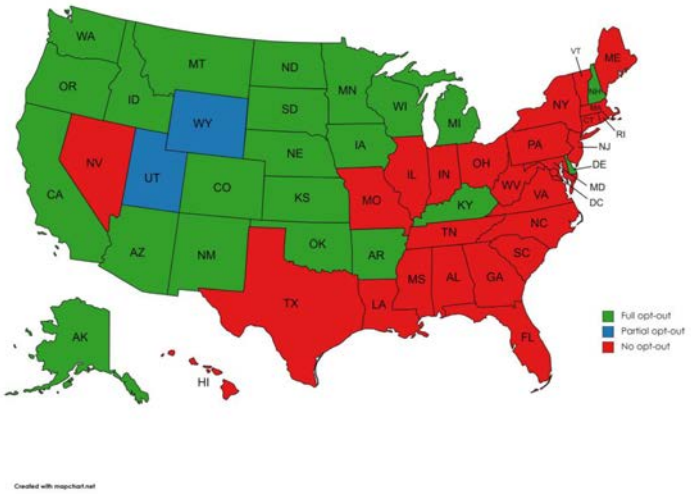
While physician anesthesiologists are a rarity in rural communities, the same cannot be said of CRNAs who are much more prevalent in rural communities. Unlike our physician peers, who are more likely to care for higher-income populations, CRNAs are disproportionately the anesthesia provider for rural and low-income communities.[3] Given the reality that healthcare outcomes are identical between

[1] "The Surgical and Anesthesia Workforce and Provision of Surgical Services in Rural Communities: A Mixed-Methods Examination" (Cohen, et al., 2020). *https://doi.org/10.1111/jrh.12417.*

[2] Rugs, D., Toyinbo, P., Barrett, B., Melillo, C., Chavez, M., Cowan, L., Jensen, P. K., Engstrom, C., Battaglia, C., Thorne-Odem, S., Sullivan, S. C., & Powell-Cope, G. (2021). A preliminary evaluation of full practice authority of advance practice registered nurses in the Veterans Health Administration. Nursing outlook, 69(2), 147–158. *https://doi.org/10.1016/j.outlook.2020.11.005.*

[3] "Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations" (Liao, et al. 2015). *https://pubmed.ncbi.nlm.nih.gov/26625579/.*

physician anesthesiologists and CRNAs, as well as the potential cost-savings, we urge Congress to remove barriers to care and allow a well-trained workforce to fill gaps in communities across the country. Since states have had the option to opt-out of Medicare's unnecessary supervision requirements for CRNAs, 24 states have opted out, and no opt-out has ever been reversed.

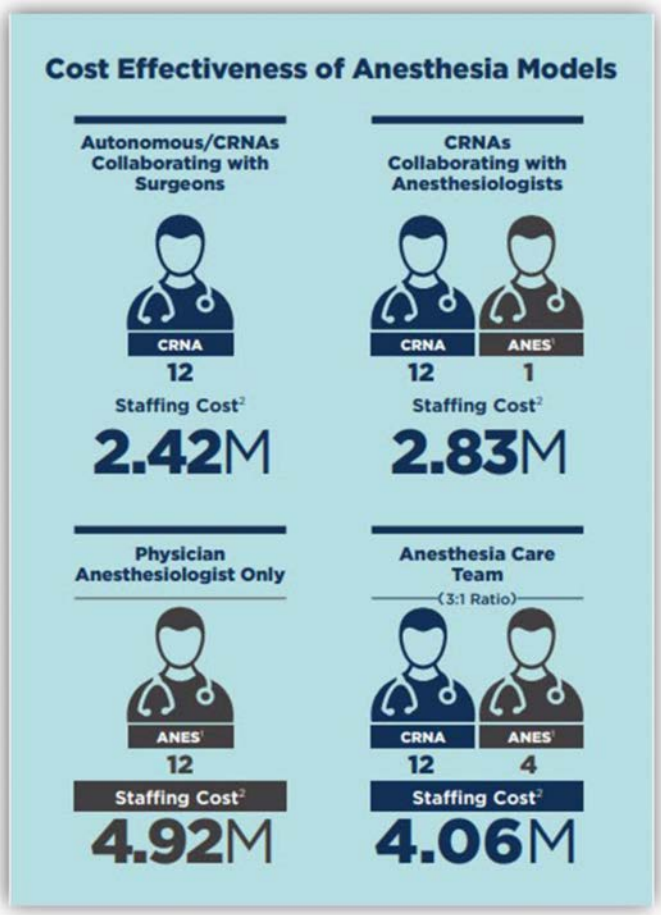


Map of states that have opted out of Medicare's supervision requirement for CRNAs

CRNA Supervision: At What Cost?

Currently, only seven states have rules in their Nurse Practice Acts or the State Boards of Nursing that require physician supervision of CRNA services. Twenty-four states have already opted out of Medicare's supervision requirement for CRNAs as well. Only one state requires the involvement of a physician anesthesiologist when a CRNA is providing care, and only at ambulatory surgical centers. Every branch of the military allows for CRNAs to practice autonomously. Supervision has no proven benefits to patients but has proven costs and detriments.

Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most cost-effective model for anesthesia delivery. Current trends in the QZ modifier, which is utilized when a CRNA is billing for anesthesia without supervision, have shown a steady increase in the utilization of this billing modifier, implying an increase in CRNA autonomous practice. The anesthesia care team model, of 1:3 supervision is one of the most expensive anesthesia delivery models possible. Allowing for autonomous practice by CRNAs allows facilities the flexibility to choose a model that meets their needs and helps to keep costs down.



CRNA Safety and Outcomes

The evidence is overwhelming that CRNA independent practice is just as safe as the anesthesia care provided under supervision or by our physician anesthesiologists colleagues. In a study that the VA commissioned from Temple University, it was found that "studies have found that CRNAs who had an expanded scope of practice did not have worse patient outcomes, complications, or mortality when compared to anesthesiologists."[4] A peer reviewed study published in the *Journal of Medicare Care* in 2016 looked at anesthesia related complications for CRNA only, anesthesiologist only, and a team-based approach and found there were no differences in complication rates based on delivery model.[5] This corroborates an earlier peer reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs were no different than outcomes in states that maintained supervision.[6] A comprehensive review completed by the Cochrane Library in 2014 further reinforced these finding,

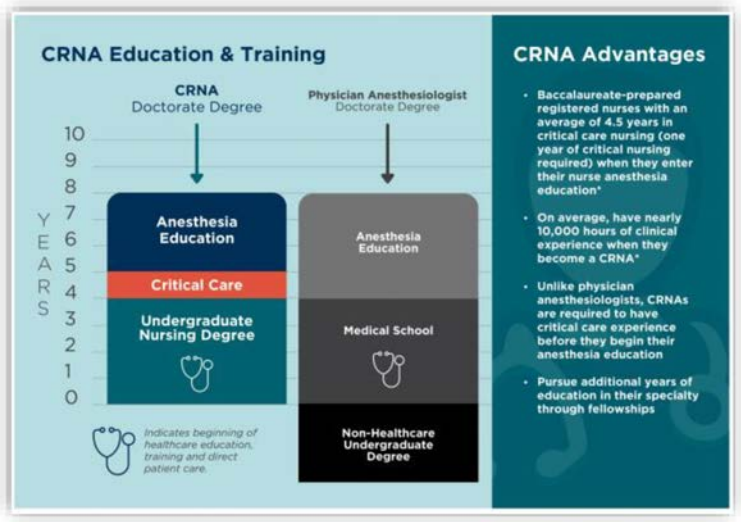
[4] Baumle, *op. cit*.

[5] "Scope of Practice Laws and Anesthesia Complications" (Negrusa, Hogan, Warner, Schroeder, and Pang, 2016). *https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx.*

[6] "No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians" (Dulisse and Cromwell, 2010). *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff.*

when it reviewed the literature on anesthesia staffing and found that there could be no definitive statement can be made about the superiority of anesthesia delivery models.

Some low-quality studies have purported to claim that CRNAs providing anesthesia without supervision negatively affects outcomes. A 25-year-old study that was not published in an outside peer-reviewed Journal, but rather in the Journal run by the American Society of Anesthesiologists, has major methodological issues that lead the Centers for Medicare and Medicaid to dismiss the study as too flawed to be used, stating, "One cannot use this analysis (Silber) to make conclusions about CRNA performance with or without physician supervision." This study looked at outcomes for 30-days post operative period, which is well outside the 48-hour period for anesthesia related complications. Only the ASA and the American Medical Association (AMA) continue to push a false narrative that CRNA care is unsafe to protect their turf.



Independent Recommendations

The removal of barriers to care and efforts to modernize Medicare and Medicaid to meet the needs of patients today is critical. Unfortunately, the AMA, ASA, and others in organized medicine have continued to misrepresent the skills and education of CRNAs and APRNs, relied on misleading information and scare tactics to continue to eliminate competition in ways that inevitably hurts patients. The AMA has even touted that they have spent millions of dollars to limit the ability of other providers to practice to the full extent of their education and training and turned our healthcare system into an unnecessary and highly political turf battle, that does not serve the interest of our nation's patients.[7]

This is why the Federal Trade Commission supported removing unnecessary barriers to competition for APRNs in a 2014 report, writing, "Physician supervision requirements may raise competition concerns because they effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition. In addition, APRNs play a critical role in alleviating provider shortages and expanding access to health care services for medically underserved populations."[8]

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[7] American Medical Association. May 15, 2023. AMA Successfully fights scope of practice expansions that threaten patient safety. *https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten.*

[8] Federal Trade Commission. March 2014. Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses. *https://www.ftc.gov/system/files/documents/re-*

Outside of the sphere of healthcare providers, there are numerous independent groups who have weighed in supporting the removal of restrictions on CRNAs and other APRNs. Across the ideological spectrum, groups have weighed in with support for removing barriers in order to increase access to care and to reduce costs. Among the groups that have supported the removal of restrictions are the Bipartisan Policy Center, Americans for Prosperity, The Progressive Policy Institute, the Trump Administration, the National Rural Health Association, AARP, and LeadingAge among others.

Critical Provider Nondiscrimination Protections Needed

In addition to efforts by medical associations to reduce competition and limit availability of high-quality care from APRNs, CRNAs and other non-MD/DO providers face pressures from insurance companies that also limit availability of care. Despite Congressional action in the *No Surprises Act* requiring the Department of Health & Human Services, Treasury and Labor to work together to promulgate rulemaking on provider nondiscrimination, the agencies have continually kicked the can. **We are almost two and a half years past the statutory deadline, and the agencies have still not done their work to promulgate this critical rulemaking.** Without rulemaking an enforcement, insurers like Cigna have announced across the board cuts to CRNA reimbursement, effectively discriminating solely based on licensure and hurting the rural communities that rely on their services, while at the same time, Cigna announces record profits, made on the backs of providers and patients.

Recently, the American Bar Association highlighted how the lack of rulemaking has allowed insurers to break the law. They have called for enforcement of the nondiscrimination provision to protect from the actions of Cigna and other payors, writing, "such practices have no sound basis, particularly in light of the recent shift toward quality and performance based reimbursement."[9] Congress needs to hold the agencies accountable for promulgating rulemaking promptly.

Conclusion

Everyone deserves access to timely, high-quality healthcare no matter where they live. In rural settings, where healthcare delivery is already complex, CRNAs can fill critical gaps in the existing care matrix and help our nation deliver on its promise to those who have served. **To fully remove barriers to care for rural communities, we call on Congress to pass the Improving Care and Access to Nurses Act (S. 2418/H.R. 2713) and to hold the agencies accountable for promulgating provider nondiscrimination rulemaking that is over two years passed due.**

AMERICAN ASSOCIATION OF NURSE PRACTITIONERS
Government Affairs
1400 Crystal Drive, Suite 540
Arlington, VA 22202
Website: *https://www.aanp.org/*

The American Association of Nurse Practitioners (AANP), representing the 385,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide a statement for the record for the Senate Committee on Finance hearing entitled "Rural Health Care: Supporting Lives and Improving Communities." AANP is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).[1] We appreciate the Committee's focus on the challenges facing patients and providers who live and provide care in rural communities. We thank Chairman Wyden and Ranking Member Crapo for holding this hearing which highlighted the importance of access to high-quality health care to rural communities. Nurse practitioners are working to meet the health care needs of rural communities across the country. We look forward to working with the Committee on proactive

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ports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicy paper.pdf.

[9] American Bar Association. March 29, 2024. Opinion: Provider Non-Discrimination Law Continues to be Violated by Insurance Companies. *https://www.americanbar.org/groups/health law/section-news/2024/march/opinion-provider-non-discrimination-law-continues-to-be-violated-by-insurance-companies/*.

[1] *https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19 https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/strategic-focus.*

policy solutions which will improve access to care for rural communities and address the challenges faced by rural health care providers.

As Chairman Wyden accurately stated, "without rural health care, you cannot have rural life."[2] Rural health care is an issue of particular importance to nurse practitioners, who provide a significant portion of health care in rural areas and areas of lower socioeconomic and health status. The Medicare Payment Advisory Commission (MedPAC) has found that NPs and PAs comprise approximately one-third of the primary care workforce, and up to half in rural areas.[3] When rural communities experience hospital closures, it is often NPs who are filling the gaps and providing critical care to these communities. According to the Government Accountability Office (GAO), an exception to the pattern of clinicians leaving rural areas after rural hospital closures were APRNs, finding that "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[4]

Along with primary care, MedPAC has also published data on the importance of NPs providing mental and behavioral health care.[5] NPs are also the second largest provider group in the National Health Services Corps.[6] As such, they understand the barriers to care that face vulnerable populations on a daily basis.[7, 8, 9] They are also "significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[10]

NPs provide a substantial portion of the high-quality,[11] cost-effective [12] care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[13] Approximately 42% of Medicare patients receive billable services from a nurse practitioner,[14] and approximately 80% of NPs are seeing Medicare and Medicaid patients.[15]

We agree with the opening statement by Chairman Wyden, which noted the unique challenges facing rural health care providers, including reimbursement, workforce, and barriers; all of which contribute to providers in rural areas operating on a "knife's edge."[16] Ranking Member Crapo noted that "Federal health programs, including Medicare and Medicaid, have an obligation to serve the unique needs of rural communities"[17] and the need to address "the challenges facing rural hospitals and providers as they deliver high-quality medical care to families in environments with more limited resources."[18]

Despite the importance of NPs to the nation's rural health care system, our members continue to face antiquated statutory barriers which prevent them from meet-

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[2] *https://www.finance.senate.gov/imo/media/doc/05162024_wyden_statement.pdf.*
[3] *https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf* (see Chapter 2).
[4] *https://www.gao.gov/assets/gao-21-93.pdf.*
[5] *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.*
[6] *https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.*
[7] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine,* 4–6. *https://doi.org/10.1007/s11606-017-4287-4.*
[8] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010–2016. Journal of the American Medical Association, 321(1), 102–105.
[9] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. *https://doi.org/10.1177/1077558718793070.*
[10] *https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/.*
[11] *https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.*
[12] *https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.*
[13] *https://data.cms.gov/,* MDCR Providers 6 Calendar Years 2017–2021.
[14] *Ibid.*
[15] NP Fact Sheet, *https://www.aanp.org/about/all-about-nps/np-fact-sheet.*
[16] *https://www.finance.senate.gov/imo/media/doc/05162024_wyden_statement.pdf.*
[17] *https://www.finance.senate.gov/imo/media/doc/05162024_crapo_statement.pdf.*
[18] *Ibid.*

ing the needs of their communities. NPs receive a 15 percent reduction in reimbursement within the Medicare program and are ineligible for the 10 percent Health Professional Shortage Area (HPSA) bonus.[19] For NPs in rural HPSAs, this equates to a 25-percent reimbursement differential from their physician colleagues. Further, Medicare statutes currently prohibit NPs from referring their patients for therapeutic diabetic shoes, restrict NPs from ordering cardiac and pulmonary rehabilitation services, and prevent them from performing all of the mandatory visits in skilled nursing facilities, among other barriers. All of these policies restrict patient access to care and prevent the full utilization of an already limited workforce in rural communities.

It is critical that federal government policies are updated to reflect the modern delivery of healthcare. Included below are our suggested proactive policy solutions to help achieve the important goals identified by the Committee members including increasing access to care for rural patients and removing barriers for rural providers. These bipartisan solutions will equitably reimburse rural providers and remove anachronistic barriers which inhibit NP's authority to provide care to their patients. We greatly appreciate your consideration of this statement and look forward to working with the Committee on these issues.

Equitable Reimbursement for Nurse Practitioners

As NPs continue to provide increasing amounts of care for Medicare patients, it is important to understand the significant evolution of the role of NPs in Medicare. In 1977, Congress first formally recognized care delivered by nurse practitioners in the Medicare program in rural health clinics.[20] In 1989, Congress authorized direct reimbursement under the Medicare program for services rendered by nurse practitioners in rural areas, and indirect reimbursement for NPs rendering services in skilled nursing facilities.[21] Since 1997, Congress has authorized reimbursement under the Medicare program to NPs regardless of setting or geographic area, for any services that would be covered when provided by a physician, in accordance with State law, at 85% of the fee schedule rates.[22]

Since this policy was implemented in 1997, despite the increasing importance of NPs in Medicare, the reimbursement structure has not changed in over 26 years. NPs are still reimbursed at 85% of the fee schedule for the services they provide, in contrast to the 100% reimbursement rate for their physician colleagues. This 15% differential is for services which require the same amount of work, time and intensity regardless of the clinician who is providing them. NPs are required to meet the same standards for billing, include the same documentation, and provide the same care to patients. This 15% differential is significant and is in addition to other factors which impact reimbursement rates, including statutory reductions and corresponding adjustments to the conversion factor.[23] This inequitable reimbursement structure is an anachronism, and does not reflect the modern health care system.

Therefore, we respectfully request that the Committee address the inequitable reimbursement structure for NPs within the Medicare program, and ensure any legislation includes equitable reimbursement for nurse practitioners. This is directly aligned with National Academy of Medicine *Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity* report which states, "Payment reform can help improve population health, address social needs and [social determinants of health], reduce health disparities, supporting the provision of effective, efficient, equitable, and accessible care for all across the care continuum instead of incentivizing the volume of care or low value procedures and practices."[24]

Medicare Payment in Rural Communities

Nurse practitioners are a critical and growing portion of the rural health care workforce. While reimbursement equity is an important principle regardless of geographic location, we recognize the unique challenge of rural communities in address-

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[19] Physician Bonuses | CMS. *https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas.*

[20] *https://www.govinfo.gov/content/pkg/STATUTE-91/pdf/STATUTE-91-Pg1485.pdf.*

[21] *https://www.govinfo.gov/content/pkg/STATUTE-103/pdf/STATUTE-103-Pg2106.pdf.*

[22] 63 FR 30862. *https://www.govinfo.gov/content/pkg/FR-1998-06-05/pdf/98-14650.pdf.*

[23] CY 2024 Medicare Physician Fee Schedule Final Rule. *https://www.cms.gov/newsroom/press-releases/cms-finalizes-physician-payment-rule-advances-health-equity.*

[24] The Future of Nursing 2020–2030—National Academy of Medicine. *https://nam.edu/publications/the-future-of-nursing-2020-2030/*.

ing clinician shortages. As previously stated, in the June 2022 report to the Congress, MedPAC found that NPs and PAs comprise approximately one-third of the primary care workforce, and up to half in rural areas.[25]

However, despite the importance of NPs to the health care workforce in rural and underserved communities, NPs are not eligible for the 10% Medicare bonus available to their physician colleagues in HPSAs.[26] According to the Health Resources and Services Administration (HRSA), there are currently 4,985 rural primary care HPSAs,[27] and 293 partially rural crime care HPSAs.[28] There are 3,859 rural mental health HPSAs, and 378 partially rural mental health HPSAs. For NPs in all of these HPSAs, ineligibility for the bonus means there can be up to a 25% difference in reimbursement rates between rural NPs and their physician colleagues.[29] This differential is substantial, and impacts both primary care and mental health HPSAs.

As the Committee considers policy options to better support rural providers, ensuring NPs practicing in rural and underserved communities have equitable access to the HPSA Medicare Bonus Program is critical. **Therefore, we respectfully request the Committee update the Medicare HPSA incentive bonus program to include NPs.** This is aligned with the FY 2025 Department of Health and Human Services (HHS) Budget in Brief[30] which included a legislative proposal to broaden the HPSA incentive program to include NPs. In the request, HHS notes that "This proposal responds to the evolving delivery of healthcare in the United States. Academic research found that the share of medical visits delivered by nurse practitioners or physician assistants increased from 14 percent to 26 percent among Medicare beneficiaries between 2013 and 2019. Research also found that nurse practitioners make up a larger share of the primary care workforce in lower income and rural areas."[31]

Additionally, the confluence of the COVID–19 PHE, opioid epidemic and behavioral health workforce shortages have led to an ongoing behavioral health crisis in the United States. According to HRSA, more than one-third of Americans live within mental health professional shortage areas.[32] Data demonstrates that nurse practitioners have been critical in filling access gaps and providing mental and behavioral health care to Medicare beneficiaries. A recent study published in *Health Affairs* found that from 2011–2019 the number of psychiatric-mental health NPs (PMHNPs) treating Medicare beneficiaries grew by 162%, compared to a 6% drop in psychiatrists during that same period.[33] The study also found that the proportion of all mental health prescriber visits provided by PMHNPs to Medicare beneficiaries increased from 12.5% to 29.8% during that same period, exceeding 50% in rural, full practice authority regions.[34]

In addition, MedPAC found "large shifts in the behavioral health workforce over time: Between 2016 and 2021, substantial growth in behavioral health services provided by nurse practitioners occurred, while volume by psychiatrists declined."[35] The report also states that "we found shifts over time in the specialty of the clinicians who provide Part B behavioral health services. Most notably, between 2016 and 2021, the volume of these services provided by psychiatrists declined (5 percent average annual decrease) and rose for nurse practitioners (12 percent average annual increase)."[36] **Accordingly, we also support section 101 of the *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act* which would expand the HPSA bonuses to 15% for mental health and substance use disorder**

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[25] *https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf* (see Chapter 2).
[26] Physician Bonuses | CMS. *https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas.*
[27] Shortage Areas. *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*
[28] *Ibid.*
[29] Health Professional Shortage Area Physician Bonus Program. *https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/HPSAfctshtTextOnly.pdf.*
[30] *https://www.hhs.gov/sites/default/files/fy-2025-budget-in-brief.pdf* (P. 79).
[31] *Ibid.*
[32] 88 FR 52366.
[33] Trends in Mental Health Care Delivery by Psychiatrists and Nurse Practitioners in Medicare, 2011–19 | Health Affairs. *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00289?journalCode=hlthaff.*
[34] *Ibid.*
[35] *https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.*
[36] *Ibid.*

services provided in mental health HPSAs by a broader group of clinicians, including NPs.

Increase Access by Removing Barriers

In the hearing, many Committee members identified the need to remove administrative barriers which prevent clinicians from practicing to the full extent of their education and clinical training to fully empower the rural health care workforce. We strongly agree there is a critical need to update outdated federal statutes which do not reflect the modern provision of health care and prevent NPs from fully meeting the health care needs of their communities. Reports issued by the National Academies of Medicine,[37] American Enterprise Institute,[38] the Brookings Institution,[39] the Federal Trade Commission,[40] the Bipartisan Policy Center[41] and the U.S. Department of Health and Human Services under multiple administrations[42, 43, 44] have all highlighted the positive impact of removing barriers confronted by NPs and their patients. The World Health Organization's *State of the World's Nursing 2020* report also recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, and noted the positive impact this would have on addressing health care disparities and improving health care access within vulnerable communities.[45] As noted by MedPAC data, the number of encounters per FFS beneficiary with APRNs and PAs increased by 10.4 percent from 2021–2022.[46] This underscores the urgent need for Congressional action to remove these barriers to care.

As the Committee works on legislation to enhance access to care in rural communities, we strongly encourage inclusion of the following bipartisan legislation: the *Improving Care and Access to Nurses Act* (S. 2418), the *Promoting Access to Diabetic Shoes Act* (S. 260), the *Increasing Access to Quality Cardiac Rehabilitation Care Act of 2023* (S. 3481), the *ACO Assignment Improvement Act* (S. 3939), and the *Rural Health Clinic Burden Reduction Act* (S. 198). These bipartisan bills will reduce the administrative burden for NPs and rural communities and increase needed access to care for patients. This is especially true in rural communities, where requiring unnecessary visits, referrals or certifications presents immense challenges for patients.

Improving Care and Access to Nurses (ICAN) Act (S. 2418)

S. 2418 would update the Medicare and Medicaid programs to ensure that NPs and other APRNs are authorized to provide care as effectively and efficiently as possible, consistent with state law. This includes updating Medicare and Medicaid to remove barriers to evidence-based preventive services such as authorizing NPs to order cardiac and pulmonary rehabilitation, referring patients for medical nutrition therapy, certifying patients' needs for diabetic shoes, establishing home infusion plans of care, and performing mandatory visits in skilled nursing facilities. This bill does not supersede any state laws, it simply modernizes these provisions within Medicare and Medicaid to make them consistent with state law to ensure that beneficiaries have access to these health care services, from their provider of choice, without undue burden. This legislation is supported by over 240 national, state, and local organizations[47] including the National Rural Health Association, National Association of Rural Health Clinics, American Health Care Association, LeadingAge, Americans for Prosperity, and AARP.[48] Patients who choose NPs as their health care pro-

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[37] The Future of Nursing 2020–2030—National Academy of Medicine. *https://nam.edu/publications/the-future-of-nursing-2020-2030/*.

[38] *https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf*.

[39] *https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf*.

[40] *https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy*.

[41] Strengthening the Health Professional Workforce | Bipartisan Policy Center. *https://bipartisanpolicy.org/blog/strengthening-health-professional-workforce/*.

[42] *https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf*.

[43] *https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners*.

[44] *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf*.

[45] *https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf*.

[46] *https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf*.

[47] *https://www.aanp.org/news-feed/more-than-235-organizations-show-their-support-for-the-ican-act*.

[48] *https://www.aana.com/comment-letter/aarp-endorsement-of-i-can-act-hr-2713*.

viders should not face increased burdens and decreased access to medically necessary treatment that are covered by Medicare and Medicaid.

Promoting Access to Diabetic Shoes Act (S. 260)

S. 260 would authorize NPs to satisfy the documentation requirement for coverage of therapeutic shoes for individuals with diabetes. NPs provide the full range of care to patients with diabetes, but federal law requires that an NP must send a patient who needs therapeutic shoes to a physician to certify that need. Additionally, according to current statute, the certifying physician must take over the treatment of the patient's diabetic condition going forward. These barriers often lead to delays in accessing needed items and undermine care continuity. The estimated total annual cost of an individual patient with diabetes is $17,000.[49] However, if left untreated, patients with diabetes may face serious complications including foot ulcers or amputations, driving up the estimated annual individual costs to $52,000.[50] By removing this outdated and unnecessary barrier, NPs would be authorized to certify the need for therapeutic shoes for patients with diabetes, and ensure they get the care they need in a timely fashion.

For patients in rural communities, this barrier leads to delays in care. If a patient is seeing an NP for their care, they would then have to schedule a visit with a physician for the certification of the need for therapeutic shoes. If the physician is not located within their community, they would have to drive to that additional certification appointment. There have been cases where our members are the only available provider in a community, and a patient has had to drive a significant distance to receive their certification, which can be made even more difficult by unreliable transportation options. This barrier has an acute impact on patients in rural communities, and removal will result in better access to care and outcomes.

Passage of this legislation will also eliminate duplicative services, potentially saving the Medicare program $12 million annually.[51] Data also demonstrates that NPs manage the care for patients with diabetes in a cost-effective manner that results in health care savings. A recent study utilizing Veterans Affairs (VA) data from FY 2013 found significant savings, 6–7% lower costs, for highly complex diabetic patients who had an NP as their primary provider compared to those with a physician.[52] Other researchers found even greater savings, 12–13% lower costs when examining patients with diabetes with varying degrees of complexity served by the VA. For a single VA medical center, this equated to an annual savings of just over $14 million, exemplifying the efficiency and effectiveness of NP delivered care in the VA.[53] Patients who choose nurse practitioners as their health care providers deserve equitable access to care from their chosen health care provider.

Increasing Access to Quality Cardiac Rehabilitation Care Act (S. 3481)

S. 3481 would authorize NPs to order cardiac and pulmonary rehabilitation for Medicare patients. In 2018, Congress passed legislation which authorized NPs, clinical nurse specialists (CNSs) and physician assistants (PAs) to supervise cardiac and pulmonary rehabilitation starting in 2024. However, these clinicians are still not authorized to order cardiac and pulmonary rehabilitation for Medicare patients.

Cardiac rehabilitation and pulmonary rehabilitation are programs designed to improve a patient's physical, psychological, and social functioning after a qualifying diagnosis or procedure, such as a heart attack or coronary artery bypass surgery or after a diagnosis of chronic obstructive pulmonary disease (COPD). Heart disease remains the leading cause of death in the United States with nearly 700,000 deaths per year.[54] Not only does heart disease have a tremendous impact on the lives of patients and their families, but managing and treating heart disease and related

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[49] American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care, 41, 917–928. *http://care.diabetesjournals.org/content/diacare/early/2018/03/20/dci18-0007.full.pdf.*

[50] Agency for Healthcare Research and Quality (2011). Data points #3: Economic burden of diabetic foot ulcers and amputations. *https://effectivehealthcare.ahrq.gov/topics/diabetes-foot-ulcer-amputation-economics/research.*

[51] Analysis based on author calculations. Approximately 134,000 Medicare patient visits billed using an established patient level 3 E/M code (CPT 99213).

[52] Morgan, et al. (2019). Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients. *Health Affairs*, 38(6), 1028–1036. *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014.*

[53] Rajan, et al. (2021) "Health care costs associated with primary care physicians versus nurse practitioners and physician assistants." *https://pubmed.ncbi.nlm.nih.gov/34074952/.*

[54] *https://www.cdc.gov/heartdisease/about.htm.*

risk factors is estimated to cost the United States over $320 billion annually.[55] Chronic obstructive pulmonary disease (COPD) is the sixth leading cause of death in the United States, with nearly 150,000 deaths per year.[56] COPD is estimated to cost the United States nearly $50 billion annually in related health care expenditures and indirect mortality and morbidity costs.[57]

Yet, while studies show that these programs can reduce hospitalizations, decrease heart attack recurrence, increase adherence to preventive medication, improve overall health and reduce the need for costly care, less than 25 percent of qualifying patients receive cardiac rehabilitation and only 3 percent of Medicare patients with COPD receive pulmonary rehabilitation.[58, 59, 60] Participation rates are even lower for female and minority patients and those who live outside metropolitan areas or in lower income urban areas.[61, 62] Research also indicates that cardiac rehabilitation is associated with lower all-cause mortality rates in patients with diabetes, however patients with diabetes have lower participation rates than the non-diabetes population.[63] It is essential that Congress increase access to these vital services.

Rural Health Clinic Burden Reduction Act (S. 198)

NPs are essential providers in the over 5,300 federally certified rural health clinics that provide primary care services to more than 37.7 million people in 45 states.[64] Despite the importance of NPs in RHCs, outdated statutory requirements exist which prevent RHCs from utilizing the full extent of NPs education and clinical training. Therefore, we strongly support the inclusion of the *Rural Health Clinic Burden Reduction Act* (S. 198) in any legislation released by the Committee pursuant to this hearing. This important legislation increases operational flexibility for RHCs by expanding NPs authority to provide care in these settings. This bill also provides broader modernization for RHCs by updating the RHC statutes, some of which have not been updated since the RHC program was established in 1977.

ACO Assignment Improvement Act (S. 3939)

The Medicare Shared Savings Program (MSSP) is an important component of Medicare, which saved more than 1.8 billion dollars in 2022.[65] Over 140,000 NPs are participating in MSSP ACOs, providing critical services to millions of Medicare beneficiaries within the program.[66] However, statutory requirements[67] still exist which require a beneficiary to receive a primary care service from a physician as a prestep before they can be assigned to a MSSP accountable care organization (ACO). This requirement inhibits the ability of Medicare to equitably provide accountable care and limits the participation of patients who see NPs as their primary care providers. Therefore, we strongly support the passage of the *ACO Assignment Improvement Act* (S. 3939) which would address this barrier and fully include NPs and their patients in the MSSP.

In the 2024 PFS final rule, the Centers for Medicare and Medicaid Services (CMS) finalized updates to better include patients seen by NPs into the MSSP, and better

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[55] Birger M, Kaldjian AS, Roth GA, Moran AE, Dieleman JL, Bellows BK. Spending on Cardiovascular Disease and Cardiovascular Risk Factors in the United States: 1996 to 2016. Circulation. 2021 Jul 27;144(4):271-282. doi: 10.1161/CIRCULATIONAHA.120.053216. Epub 2021 Apr 30. PMID: 33926203; PMCID: PMC8316421.

[56] *https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-mortality.*

[57] *https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-burden.*

[58] *https://millionhearts.hhs.gov/data-reports/factsheets/cardiac.html.*

[59] *https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.119.005902.*

[60] *https://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OC.*

[61] Li S, Fonarow GC, Mukamal K, Xu H, Matsouaka RA, Devore AD, Bhatt DL. Sex and Racial Disparities in Cardiac Rehabilitation Referral at Hospital Discharge and Gaps in Long-Term Mortality. *J Am Heart Assoc.* 2018 Apr 6;7(8):e008088. doi: 10.1161/JAHA.117.008088. PMID: 29626153; PMCID: PMC6015394.

[62] Castellanos LR, Viramontes O, Bains NK, Zepeda IA. Disparities in Cardiac Rehabilitation Among Individuals from Racial and Ethnic Groups and Rural Communities—A Systematic Review. *J Racial Ethn Health Disparities.* 2019 Feb;6(1):1–11. doi: 10.1007/s40615–018–0478–x. Epub 2018 Mar 13. PMID: 29536369.

[63] *https://www.ahajournals.org/doi/10.1161/JAHA.117.006404.*

[64] NARHC—National Association of Rural Health Clinics. *https://www.narhc.org/narhc/ESX_About_Us.asp.*

[65] Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care | CMS. *https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high.*

[66] *https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results/data.* (January 2022 Performance Year Financial and Quality Results.)

[67] Social Security Act Section 1899(c)(1).

align beneficiaries with the clinician who is providing their care.[68] The CMS analysis of the expansion of the assignment methodology to better account for NPs' patients notes that the changes would add a population of patients who have been historically underrepresented in the MSSP.[69] This includes those with a disabled Medicare enrollment type, those residing in areas with a slightly higher average ADI national percentile rank, and a larger share of Medicare Part D LIS enrollment. This is consistent with the June 2022 MedPAC report which found that, among all clinician types, NPs on average had the highest share of allowed charges associated with low-income subsidy (LIS) beneficiaries. "In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs."[70]

In its FY 2021 Budget in Brief, HHS stated that basing ACO-assignment on a broader set of primary care providers, including NPs, better reflects our current primary care workforce and would lead to $80 million in savings for the Medicare program over 10 years.[71] However, statutory barriers still need to be fixed to fully include NPs and their patients in the program. Therefore, we respectfully request the Committee include S. 3939 in any legislative efforts pursuant to this hearing to fully include NPs and their patients in the MSSP.

Permanent Medicare Coverage of Increased Telehealth Access

Telehealth has been a vital lifeline throughout the COVID–19 PHE to reach patients who otherwise would not be able to receive care and it will continue to be an essential access tool moving forward. We thank Congress for extending the Medicare telehealth flexibilities through the end of 2024 and urge the permanent adoption of those policies. In a 2020 AANP member survey on the impacts of COVID–19, 76% of nurse practitioners identified federal telehealth waivers as some of the most beneficial flexibilities throughout the COVID–19 PHE.[72] NPs have made a rapid transition to telehealth, with over half of AANP members reporting their practices have adopted, or increased the use of, telehealth and virtual platforms. According to the United States Health Resources and Services Administration (HRSA), there are 4,986 rural primary care HPSAs and 2,157 non-rural primary care HPSAs.[73] Adequate access to providers impacts patients in both rural and non-rural geographic settings. Permanently removing the restrictions that prevent Medicare patients in certain geographic areas from accessing telehealth is increasingly important.

The expanded coverage of certain services throughout the PHE, including audio-only care, have also enabled NPs and other clinicians to reach patients who otherwise may have been unable to receive medically necessary healthcare, particularly in rural and underserved communities and for patients with behavioral health needs. Coverage of audio-only telehealth has been critical for NPs and patients who do not have access to adequate broadband or technological devices capable of synchronous two-way audio video technology. In the survey previously noted, AANP members reported that the three most significant barriers to telehealth adoptions were patient connectivity issues, patient access to technology and the internet and patient comfort with technology.[74] For patients experiencing issues that prohibit them from utilizing synchronous two-way technology, the permanent coverage of audio-only visits will be an important component of telehealth moving forward.

As Congress further considers telehealth legislation, we respectfully request that increased coverage of telehealth removes barriers to care, and that policies intended to maintain program integrity are flexible and do not inadvertently inhibit patient access to care. Important policy changes include the permanent coverage of audio-

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[68] P. 961 2024 PFS Final Rule. *https://public-inspection.federalregister.gov/2023-24184.pdf.*

[69] 88 FR 52440. *https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.*

[70] *https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf* (Page 135).

[71] HHS, *https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf* (page 84).

[72] Nurse Practitioner COVID–19 Survey. *https://www.aanp.org/practice/practice-related-research/research-reports/nurse-practitioner-covid-19-survey-2.*

[73] Shortage Areas. *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*

[74] Nurse Practitioner COVID–19 Survey. *https://www.aanp.org/practice/practice-related-research/research-reports/nurse-practitioner-covid-19-survey-2.*

only services, and removal of geographic and site restrictions for telehealth services for Medicare beneficiaries.

Support Robust Nursing Education Programs

In addition to supporting the current healthcare workforce, it is important for the Committee to support the future healthcare workforce and ensure that we have a strong pipeline of clinicians to address healthcare workforce shortages. AANP supports the *Educating Future Nurses Act* (S. 1586) which would establish a permanent National Graduate Nurse Education (GNE) Program to provide clinical training to APRNs, particularly with respect to services for Medicare beneficiaries. This builds off a successful temporary GNE program which "led to 54 and 67 percent increases in APRN student enrollment and graduations, respectively."[75] Establishing a permanent program will help ensure that our healthcare system continues to have a robust network of APRNs to meet our nation's healthcare needs.

Conclusion

We are deeply appreciative of the Committee's recognition of the need to enhance access to care in rural and underserved communities. We thank the Committee for focusing on improving our nation's health care system and look forward to working with the Committee on solutions that will expand access to care for patients.

AMERICAN HOSPITAL ASSOCIATION
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001–4956
(202) 638–1100
https://www.aha.org/

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; 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) welcomes the opportunity to comment on policies to ensure rural patients continue to receive access to high-quality care.

Hospitals and health systems are the lifeblood of their communities and committed to ensuring local access to health care. At the same time, many hospitals, including those in rural areas, continue to experience unprecedented challenges that jeopardize access and services. These include workforce shortages, high costs of prescription drugs, and continued severe underpayment by Medicare and Medicaid.

Rural hospitals make up about 35% of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby. As a result, in rural hospitals, the acute care occupancy rate (37%) is less than two thirds of their urban counterparts (62%).

Below are a series of proposals and suggestions for the Finance Committee to consider as it seeks to ensure financial stability of providers, maintain critical flexibility to protect access and services, build the workforce of tomorrow and improve infant and maternal care in rural communities.

FLEXIBLE PAYMENT OPTIONS

To improve health care in rural communities, sustainable financing for rural hospitals and health systems is imperative. As a result, rural hospitals require flexible payment options to address barriers and invest in new resources in rural communities.

Providing certainty and stability in rural Medicare hospital payments is essential. Low reimbursement, low patient volume, sicker patients and challenging payer mix, common at many rural hospitals, puts added financial pressure on those facilities. **The AHA supports policies that promote flexible payment options and address financial challenges faced by the full spectrum of rural hospitals, which will allow them to continue providing high-quality care for their patients.**

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[75] *https://www.cms.gov/priorities/innovation/files/reports/gne-final-eval-rpt-fg.pdf.*

- **Making Permanent the Medicare-dependent Hospital (MDH) and Low-volume Adjustment (LVA).** MDHs are small, rural hospitals where at least 60% of admissions or patient days are from Medicare patients. MDHs receive the inpatient prospective payment system (IPPS) rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. AHA supports making the MDH program permanent and adding an additional base year that hospitals may choose for calculating payments. The LVA provides increased payments to isolated, rural hospitals with a low number of discharges. AHA also supports making the LVA permanent. The MDH designation and LVA protect the financial viability of these hospitals to ensure they can continue providing access to care and AHA supports the **Rural Hospital Support Act (S. 1110)** and the **Assistance for Rural Community Hospitals Act (H.R. 6430)** to extend those important designations.
- **Extend Telehealth Flexibilities.** The expansion of telehealth services has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients, especially those with transportation or mobility limitations. Given current health care challenges, including major clinician shortages nationwide, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. AHA supports the **CONNECT for Health Act (S. 2016/H.R. 4189)** to make permanent coverage of certain telehealth services made possible during the pandemic, including lifting geographic and originating site restrictions, allowing Rural Health Clinics and Federally Qualified Health Centers to serve as distant sites, expanding practitioners who can provide telehealth, and allowing the continuation of audio-only telehealth services, among others.
- **Reopen the Necessary Provider Designation for Critical Access Hospitals (CAHs).** The CAH designation allows small rural hospitals to receive cost-based Medicare reimbursement, which can help sustain services in the community. Hospitals must meet several criteria, including a mileage requirement, to be eligible. A hospital can be exempt from the mileage requirement if the state certified the hospital as a necessary provider, but only hospitals designated before Jan. 1, 2006, are eligible. **AHA urges Congress to reopen the necessary provider CAH program to further support local access to care in rural areas.**
- **Strengthen the Rural Emergency Hospital (REH) Model.** REHs are a new Medicare provider type to which small rural and critical access hospitals can convert to provide emergency and outpatient services without needing to provide inpatient care. **AHA supports strengthening and refining the REH model to ensure sustainable care delivery and financing.**
- **Rebase Sole Community Hospitals (SCHs).** SCHs must show they are the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible. **AHA supports the Rural Hospital Support Act (S. 1110) to add an additional base year that SCHs may choose for calculating their payments.**
- **Improve Access to Capital.** Access to capital is important to stabilize a vulnerable hospital or advance innovations in others. **AHA supports expanding the USDA Community Facilities Direct Loan & Grant Program and creating a new Hill-Burton like program to update rural hospitals to ensure continued access in rural communities.**

FINANCIAL STABILTY—FAIR, TIMELY AND ADEQUATE REIMBURSEMENT

Medicare and Medicaid each pay less than 90 cents for every dollar spent caring for patients—with Medicare hitting a historic low of 82 cents for every dollar—according to the latest AHA data. Given the unique financial challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of care.

AHA supports the following policies to ensure fair, timely and adequate reimbursement.

- **Medicare Advantage Payment Parity for CAHs.** The Medicare Advantage (MA) program has grown significantly in the past decade. MA enrollment, which traditionally has grown slower in rural areas, is now surpassing the growth rate in urban areas. For example, MA enrollment quadrupled between 2010 to 2023 in rural counties, compared to metropolitan areas which doubled in enrollment during the same period. Yet, MA plans are not required to pay

CAHs at the same cost basis as fee-for-service Medicare; and they are increasingly paying below costs, straining the financial viability of many rural providers. Further, MA plans have the additional burden of prior authorization and other health plan requirements with which rural providers must increasingly contend—requirements that do not exist to nearly the same extent in fee-for-service Medicare and add additional costs for rural providers to comply. **We support legislation to ensure CAHs receive cost-based reimbursement for MA patients.**

- **Prompt Pay.** Ensuring prompt payment from insurers for medically necessary, covered health care services is important for ensuring financial stability of rural hospitals and health systems. Delayed payments are particularly problematic for rural hospitals given their low patient volume and often challenging financial position. **We support policies to increase oversight and accountability of health plans including establishing more stringent standards for timely payment to address certain commercial insurer tactics to delay and deny payment to health care providers.**
- **Make the Ambulance Add-on Payments Permanent.** Rural ambulance service providers ensure timely access to emergency medical care but face higher costs than other areas due to lower patient volume. We support, permanently extending the existing rural, "super-rural" and urban ambulance add-on payments to protect access to these essential services. **AHA asks Congress to pass the Protecting Access to Ground Ambulance Medical Services Act of 2023 (S. 1673/H.R. 1666) to maintain those enhanced ambulance payments.**
- **Commercial Insurer Accountability.** Systematic and inappropriate delays of prior authorization decisions and payment denials by commercial insurers for medically necessary care are putting patient access to care at risk. **We support regulations and legislative solutions that streamline and improve prior authorization processes, including the Improving Seniors' Timely Access to Care Act, which would codify many of the reforms in the Interoperability and Prior Authorization Final Rule. In addition, we support policies that ensure patients can rely on their coverage by disallowing health plans from inappropriately delaying and denying care, including by making unilateral mid-year coverage changes.**
- **Wage Index Floor. AHA supports the Save Rural Hospitals Act (S. 803) to place a floor on the area wage index, effectively raising the area wage index with new money for hospitals below that threshold.**
- **Behavioral Health.** Implementing policies to better integrate and coordinate behavioral health services will improve care in rural communities. We urge Congress to:
    - Fully fund authorized programs to treat substance use disorders, including expanding access to medication assisted treatment.
    - Implement policies to better integrate and coordinate behavioral health services with physical health services.
    - Enact measures to ensure vigorous enforcement of mental health and substance use disorder parity laws.
    - Permanently extend flexibilities under scope of practice and telehealth services granted during the COVID–19 public health emergency.
    - Increase access to care in underserved communities by investing in supports for virtual care and specialized workforce.

BOLSTERING THE WORKFORCE

Recruitment and retention of health care professionals is an ongoing challenge and expense for many hospitals. Nearly 70% of the primary health professional shortage areas are in rural or partially rural areas. Hospitals and health systems need a robust and highly qualified staff to handle medical care in emergency situations. To achieve this goal, targeted programs that help address workforce shortages in rural communities should be supported and expanded. Workforce policies and programs also should encourage nurses and other allied professionals to practice at the top of their licenses. Below are listed a variety of different proposals and pieces of legislation Congress should consider enacting to tackle the workforce shortage crisis.

- **Graduate Medical Education.** We urge Congress to pass the **Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389),** legislation to increase the number of Medicare-funded residency slots, which would expand

training opportunities in all areas including rural settings to help address health professional shortages.

- **Conrad State 30 Program.** We urge Congress to pass the **Conrad State 30 and Physician Access Reauthorization Act (S. 665/H.R. 4942)** to extend and expand the Conrad State 30 J–1 visa waiver program, which waives the requirement to return home for a period if physicians holding J–1 visas agree to stay in the U.S. for 3 years to practice in federally-designated underserved areas.
- **International Workforce.** The AHA urges Congress to pass the **Healthcare Workforce Resilience Act (S. 3211/H.R. 6205),** bipartisan legislation that would recapture 25,000 unused employment-based visas for foreign-born nurses and 15,000 for foreign-born physicians to help address staffing shortages.
- **Loan Repayment Programs.** We urge Congress to pass the **Restoring America's Health Care Workforce and Readiness Act (S. 862)** to significantly expand National Health Service Corps funding to provide incentives for clinicians to practice in underserved areas, including rural communities. AHA also supports the **Rural America Health Corps Act (S. 940/H.R. 1711)** to directly target rural workforce shortages by establishing a Rural America Health Corps to provide loan repayment programs focused on underserved rural communities.
- **Boost Nursing Education.** We urge Congress to invest significant resources to support nursing education and provide resources to boost student, faculty and preceptor populations, modernize infrastructure and support partnerships and research at schools of nursing. AHA also supports expanding the National Nurse Corps.
- **Health Care Workers Protection.** We urge Congress to enact the **Safety from Violence for Healthcare Employees Act (S. 2768/H.R. 2584)** to provide federal protections for health care workers against violence and intimidation.

IMPROVING MATERNAL HEALTH IN RURAL COMMUNITIES

The AHA and its hospitals and health systems are dedicated to eliminating maternal mortality and reducing maternal morbidity to provide mothers and babies with the opportunity to lead healthy and productive lives. Last year, we released a comprehensive set of federal public policy and legislative solutions for improving maternal health. In addition, the AHA has shared tools and resources and promoted the fields' efforts through case studies, webinars and podcasts.

Over the last decade, more than 200 rural hospitals have closed obstetric (OB) units. The decision to close an OB unit is not made lightly. Hospitals and health systems consider various factors, including patient care, staffing challenges, declining patient volume and inadequate reimbursement, in addition to the important role they play in their communities and the lives of their patients. A recent Government Accountability Office study [1] estimated that half of all rural counties lack access to this essential care.

As Congress examines this issue more closely, we would encourage legislative approaches that focus on:

- **Increasing reimbursement for obstetric services.** For example, some states have implemented add-on payments for labor and delivery—paid directly to the hospital—by their state Medicaid programs; a federal match could be helpful in maintaining and expanding the use of these payments.
- **Reducing regulatory barriers to encourage partnerships and innovative approaches to delivering care.** Partnerships between smaller rural hospitals and larger health systems can allow systems to share staff, connect patients with complex health needs to specialists, and in some cases, transfer high-risk pregnant women to other facilities.
- **Encouraging state Medicaid graduate medical education (GME) programs to support expanding capacity of existing workforce.** States have broad authority to create Medicaid GME programs that meet the needs of their state, including through fee-for-service and Medicaid managed care programs. In some states, primary care or family practitioners have received training in labor and delivery, including performing cesarean sections, to offer care as part of a broader clinical team that includes obstetricians and gynecologists. CMS

[1] *https://www.gao.gov/products/gao-23-105515.*

could assist with guidance and encourage state Medicaid agencies to develop Medicaid GME programs focused on rural hospitals that provide maternity care.

- **Requiring state Medicaid programs to cover telemedicine for maternal care.** Telehealth can provide support throughout the perinatal period as well to allow for consultations with specialists and access to care for rural areas that do not have obstetric providers.[2] A study by the CDC examined work done by 13 state maternal mortality review committees to identify contributing factors and strategies to prevent future pregnancy-related deaths, which included addressing personnel issues at hospitals by providing telemedicine for facilities with no obstetric provider on-site.[3] In addition, the use of remote patient monitoring, such as with blood pressure cuffs weekly glucose review, both lowered pregnancy-related stress and improved patient satisfaction with their treatment. While the use of telemedicine for obstetric services has increased over the last few years, not all states may be requiring Medicaid to reimburse for these services.

CONCLUSION

We thank you for the opportunity to comment on ways to improve rural health care and strengthen the communities that rely on the services provided by their local hospitals and health systems. We look forward to continuing to work with you on this important issue.

Links:

https://www.aha.org/system/files/media/file/2023/09/Federal-Public-Policy-Legislative-Solutions-Improving-Maternal%20Health_August%202023_Final.pdf

https://www.aha.org/advocacy/maternal-and-child-health

AMERICAN MEDICAL ASSOCIATION
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611–5885
(312) 464–4782
https://www.ama.assn.org

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. Senate Committee on Finance as part of the hearing entitled, "Rural Health Care: Supporting Lives and Improving Communities." This hearing is critically important as it focuses on the ability of rural communities to access quality health care and highlights innovative solutions that these communities need to overcome persistent health care challenges.

The AMA commends the Committee for its consideration of this important issue aimed at, among other things, ensuring the continuation of certain programs and policy flexibilities granted as part of the response to the COVID–19 pandemic that help ensure patients retain access to at-home care. The COVID–19 pandemic made clear that rural and underserved areas that have historically lacked adequate access to health care services can greatly benefit from permanent legislative and regulatory flexibilities. As a result, we applaud the Committee for recognizing the importance of promoting health equity as it considers which COVID–19 policies to retain to facilitate continued access to home-based care. In addition, we urge Congress to consider how making many of these existing flexibilities permanent will provide the necessary assurances that physicians, health care organizations, and patients may need before investing additional resources into policies such as telehealth and the Hospital at Home program.

INNOVATION MODELS AND TECHNOLOGY

The AMA strongly recommends that Congress permanently lift the restrictions on access to telehealth services for Medicare patients by passing the "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act" (S. 2016/H.R. 4189), and the "Telehealth Modernization Act" (S. 3967/H.R. 7623). Given that we are in the middle of a national physician workforce crisis, telehealth continues to provide critical access for patients across the country in various settings.

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[2] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9639859/#bib5.*

[3] *https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w&T3_down.*

The AMA Supports the CONNECT for Health Act and the Telehealth Modernization Act (S. 3967/H.R. 7623)

The CONNECT for Health Act is bipartisan legislation that would permanently extend many important COVID–19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. More specifically, the bill repeals the existing Medicare geographic site restrictions and permanently modifies the originating site requirements to allow patients to receive telehealth services wherever the patient can access a telecommunications system, including, but not limited, to the home. These COVID–19 policies have allowed patients to obtain telehealth services at home instead of having to travel to a medical facility to receive virtual care from a distant site. They have also allowed Medicare patients located in urban and suburban areas to have access to telehealth services for the first time. The CONNECT for Health Act currently has 65 cosponsors, an overwhelming majority of supporters in the Senate and, as a result, should be passed expeditiously.

COVID–19 flexibilities also enabled patients to access health care services through audio-only visits when they do not have reliable access to two-way audio-video telecommunications technology. Therefore, passage of the Telehealth Modernization Act is crucial because, in addition to eliminating the geographic and originating site restrictions, thus allowing rural, urban, and suburban patients to receive telehealth services wherever they can access a telecommunications system, the legislation permanently continues the ability to use audio-only telehealth services beyond the current statutory deadline of December 31, 2024. Access to two-way audio-visual telehealth and audio-only services has lowered or eliminated barriers that many patients in rural and underserved areas face when trying to obtain in-person care, such as functional limitations that make it difficult to travel to physician offices, long travel times, workforce shortages, the need for a caregiver to accompany the patient, and patients experiencing unstable housing and lack of transportation and childcare. Also, in an effort to boost access to virtual mental health services, both the CONNECT for Health Act and the Telehealth Modernization Act repeal the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within 6 months of an initial telehealth visit for a mental health condition. Federal lawmakers have also introduced stand-alone bills, specifically S. 3651/H.R. 3432, the "Telemental Health Care Access Act," to remove these in-person visit requirements that will only stifle access to mental health services. While federal lawmakers have, thus far, passed legislation delaying the mandate for patients to receive an in-person visit within 6 months of receiving an initial telemental health service from taking effect, it is crucial this policy is permanently removed to ensure patients retain ample access to virtual mental health services. Absent Congressional intervention, the in-person telemental health requirements will go into effect on January 1, 2025, so it is crucial legislative action occurs expeditiously.

The AMA Supports H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act"

As an interim step, the AMA also recommends that Congress pass H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act." This important legislation will extend through 2026 many of the above telehealth provisions we strongly support including audio-only telehealth services, exemptions to geographic and originating site restrictions, and delaying the in-person requirements for telemental health services.

This bill also extends the Acute Hospital at Home Waiver Flexibilities through 2029. On March 11, 2023, the AMA along with other organizations, including medical groups participating in the Acute Hospital Care at Home (AHCaH) waiver program, submitted a request to Congress asking for at least a 5-year extension of AHCaH before its expiration at the end of 2024. Without an extension, Medicare beneficiaries will lose access to AHCaH programs that have demonstrated excellent clinical outcomes and lower the costs of care. With an expiration set for the end of this year, medical groups, and health systems nationwide need assurance that this waiver program will be extended if they are going to invest their resources into logistics, supply chain, and workforce for AHCaH.

Although our ultimate goal is that these flexibilities are made permanent to facilitate greater long-term investment in virtual care for the betterment of patients, we are glad Congress is prioritizing legislative action to extend the telehealth services currently scheduled to lapse at the end of the year and we urge that this extension be kept clean of guardrails that will serve to limit patient access to care.

The AMA Opposes H.R. 1746, the Preventing Medicare Telefraud Act

The AMA strongly opposes any efforts to impose other types of antiquated "guardrails" pertaining to telehealth services. The AMA views telehealth as a method to deliver care, and creating significant burdens to access these services in the name of program integrity requires substantial justification. As a result, the AMA strongly opposes H.R. 1746, the "Preventing Medicare Telefraud Act," or any other legislation that promotes similar policies.

This legislation requires a patient to receive an in-person visit within 6 months of receiving "high-cost" durable medical equipment (DME) and laboratory tests ordered via telehealth. This provision makes little sense as it is impossible clinically for a physician to know if the patient will need high-cost DME or laboratory tests prior to receiving a telehealth visit. Under this legislation, "high cost" DME and laboratory tests would also be defined by the Centers for Medicare & Medicaid Services (CMS) Administrator, which the AMA believes to be an excessive expansion of executive authority.

In addition, H.R. 1746 stipulates that, beginning 6 months after the effective date of the high-cost DME/lab clause, Medicare Administrative Contractors (MACs) shall conduct reviews on a schedule determined by the HHS Secretary of all claims of high cost DME/lab tests ordered over the preceding 12 months when at least 90 percent of these services are prescribed by a physician/provider via telehealth. Again, since telehealth is simply a modality, the AMA believes such audits are not appropriate or necessary because it provides no consideration of medical necessity.

In general, the AMA urges members of the Senate Finance Committee to reject any inclination to establish additional guardrails, including in-person visits or mandatory audits, in the name of rooting out fraud, waste, and abuse. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication of services are of particular concern for telehealth services.

The AMA believes existing HHS and OIG fraud capabilities and authorities are more than adequate to police telehealth services in the same way they oversee in-person Medicare services. A February 2024 HHS OIG report confirms this reality.[1] For 105 out of the 110 sampled Evaluation and Management (E/M) services provided via telehealth during the early parts of the pandemic, physicians appropriately complied with Medicare requirements. As a result, OIG did not provide any policy recommendations to CMS because, ". . . providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records." Medicare fraud is still Medicare fraud, irrespective of whether it involved telehealth services.

In February 2021, HHS's Principal Deputy Inspector General (OIG) released a statement dispelling any concerns with OIG's authority or ability to address concerns of fraud and abuse. Instead, HHS OIG's statement highlights that concerns stem from "telefraud" schemes, rather than "telehealth fraud," in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the telehealth visit but instead use the sham telehealth visit to induce a patient to agree to receive unneeded items and gather their info.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. CMS has also implemented Place of Service (POS) indicators for this purpose, including POS 02 when the originating site is someplace other than the patient's home and POS 10 when the patient is in their home. Additional indicators may be used for asynchronous services and home health services provided via telehealth. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via Modifier 95 and other CMS indicators.

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[1] *https://oig.hhs.gov/oas/reports/region1/12100501.asp.*

The State of Health at Home Models: Key Considerations and Opportunities

Building on existing playbooks and resources supporting digitally enabled care, the AMA conducted research to explore the different ways health care is and can be provided in the home. The AMA report titled, "The State of Health at Home Models: Key Considerations and Opportunities" offers a comprehensive guide that outlines the concept and benefits of delivering care to patients in their home environments.[2] These include recommendations for physicians to: Determine whether your practice or organization should build your health at home program internally or partner with another organization; consider required training to strengthen your mobile workforce, which is a core component of health at home programs; ensure you understand the unique and varied circumstances of each home environment and plan for the patient and caregiver experience in detail; develop the infrastructure up front that will provide the necessary tools to appropriately handle the flow of resources and information to provide patient care as required by your specific program.

Future of Health Case Study: Atrium Health

This case study highlights how this vision is being accomplished through a strategic partnership between a traditional brick-and-mortar health system and a technology company, with a common goal to build and scale a program that enables patients to continue their care and recovery at home. Each organization brings its expertise to the partnership, enabling thoughtful development and implementation of a complex, digitally enabled clinical initiative.

Payment and Delivery in Rural Hospitals

In this issue brief, the AMA reports on background, challenges, costs, and strategies related to the delivery of care in rural hospitals. Additionally, this includes strategies to improve rural health and hospital viability.

ASPE Report—Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019–2021

This report by the Assistant Secretary for Planning and Evaluation (ASPE) reveals sustained above-pre-pandemic levels of telehealth utilization among Medicare beneficiaries, notably for behavioral health and primary care visits. This sustained utilization highlights the importance of telehealth in bridging access gaps, particularly for vulnerable populations due to the severity and complexity of their illnesses. The findings from ASPE highlight the critical role of telehealth in maintaining continuity of care and suggest a pressing need for policies that support the permanent integration of telehealth services within the Medicare program.

AHRQ Study—The Impact of Expanded Telehealth Availability on Primary Care Utilization

An Agency for Health Care Research and Quality (AHRQ) funded study analyzing over 4 million primary care encounters highlights telehealth's role in maintaining health care utilization levels without contributing to overutilization. This study's results challenge concerns about potential increased health care utilization due to telehealth expansion, reinforcing telehealth's value as a viable alternative to in-person encounters when deemed appropriate. Given these insights, it is important for legislation like the CONNECT for Health Act and the Telehealth Modernization Act to pass, ensuring telehealth's role as a cornerstone of accessible, efficient health care delivery.

Change Healthcare and Cybersecurity

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians, hospitals and pharmacies, and delays in patient care.

In fact, on March 19th, Representatives Mariannette Miller-Meeks (R–IA) and Robin Kelly (D–IL), along with 96 bipartisan members of the House of Representatives, sent a letter to HHS Secretary Becerra alerting the administration of the ongoing challenges physicians and patients are continuing to experience as part of the

[2] *https://www.ama-assn.org/system/files/health-at-home-models.pdf.*

Change Healthcare cyberattack. In addition to highlighting the inability of physician practices to file claims and receive prompt payment, the letter urges CMS to clarify why they issued such stringent repayment terms as part of their March 9th announcement permitting advance payments for Part B physicians and other providers. The letter also highlights how individuals are being forced to pay out-of-pocket for pharmaceuticals and health care services due to the cyberattack, as well as pressed the Department for answers as to how it proposes to safeguard patients from the negative impact of their private health care information being inappropriately disclosed to malicious actors.

Overall, the attack demonstrates the vulnerability of our health care sector's infrastructure to cyber threats and the cascading effects these breaches can have on patient safety, privacy, and the overall delivery of care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

This incident is especially concerning for rural, remote, and underserved communities, where access to health care services is already limited. The reliance on digital platforms for telehealth and at-home care programs has been a lifeline for these communities, offering a measure of parity in access to essential health care services. However, the cybersecurity vulnerabilities exposed by the attack on Change Healthcare reveal a potential gap in our efforts to extend health care equity through digital means. As noted in the March 21st letter led by Vice Chairman Vern Buchanan and 19 Ways and Means members, a 2022 AMA study found that nearly 75 percent of patients expressed concern about protecting their personal health data.

The technical and financial burden of implementing cybersecurity should not be placed solely on physicians or the hospitals. Congress must provide important financial resources to assist physician practices with the challenge of protecting health care data. Ensuring the security of digital health care services is not merely about protecting data but about safeguarding the continuity of care for the most vulnerable populations in our society.

ELECTRONIC FUND TRANSFER (EFT) FEES AND REDUCING ADMINISTRATIVE BURDENS IN HEALTH CARE

The AMA recognizes the critical need to address financial and administrative inefficiencies that detract from our health care system's ability to serve rural and underserved communities effectively. A pressing issue in this context is the undue financial strain imposed on physicians and health care providers by unnecessary fees for Electronic Fund Transfers (EFTs).

The burden of EFT fees, as outlined in our support for S. 3805, the "No Fees for EFTs Act" in the Senate, and support for H.R. 6487, the corresponding House bill, highlights a significant barrier to the efficient operation of health care practices. These fees, which can range from 2 percent to 5 percent of the claim payment, are levied by some health plans and their vendors without explicit agreement from practices, thereby exacerbating the financial and administrative burdens on physicians. This issue is especially significant for health care providers in rural and underserved areas, where financial resources are already stretched thin, and administrative burdens can significantly impact the quality and accessibility of patient care.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

Need for an Inflation Based Update to Physician Payment

The physician payment system is on an unsustainable path that threatens patients' access to physician services. This year, physicians faced yet another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed Medicare budget neutrality rules. Congress acted last March to partially mitigate the 3.37 percent reduction that was imposed in January but did not stop the cuts completely. These cuts come on the heels of 2 decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates fell 29 percent from 2001 to 2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

In its 2023 annual report, the Medicare Trustees "expect access to Medicare-participating physicians to become a significant issue in the long term" unless Congress takes steps to bolster the system. The Trustees noted, for example, that "the law specifies the physician payment updates for all years in the future, and these up-

dates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."

The current Medicare physician payment system—with its lack of an adequate annual physician payment update—is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent this year.

We appreciate that Congress passed legislation that, again, mitigated severe Medicare payment cuts. However, this pattern of last-minute stop gap measures must end. As the Committee looks to provide adequate payments to physicians, particularly those in rural and underserved areas, annual Medicare physician payments equal to the full MEI should be enacted to provide an annual update that reflects practice cost inflation. Specifically, we ask Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care and enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care.

Improvements to Budget Neutrality

Another way to help ensure physicians have ample resources to provide more care in the home is via reforms to statutory budget neutrality requirements within the Medicare Physician Fee Schedule. The AMA urges Congress to pass H.R. 6371, the "Provider Reimbursement Stability Act." In fact, the Energy and Commerce Committee already took action on a portion of this legislation when it passed H.R. 6545, the Physician Fee Schedule Update and Improvement Act, out of committee in December 2023.

The reality is that physician payments are further eroded by frequent and large payment redistributions caused by these budget neutrality adjustments. CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule. When these misestimates are not adjusted in a timely way, it results in permanent removal of billions of dollars from the payment pool. Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS to account for past overestimates of spending when applying budget neutrality. Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for misestimates and adjust the conversion factor to reflect actual claims data. In addition, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—3 years before the current physician payment system took effect. There have been no adjustments for inflation. As a result, the amount should be increased to $53 million to best account for past inflation.

Merit-based Incentive Payment System (MIPS)

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID–19 pandemic. Further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. In particular, the 2022 Quality Payment Program Experience Report shows that 27 percent of small practices, nearly 50 percent of solo practitioners, and 18 percent of rural practices received a MIPS penalty. Yet, a 2022 study found MIPS scores were inconsistently related to performance, "which suggests that the MIPS program is approximately as effective as chance at identifying high vs low performance." This program is driving up burden, penalizing physician practices with fewer resources, and devoid of meaning for patients.

Last year, the AMA responded to a Congressional RFI request from the House Committee on Ways and Means on ways to improve health care in rural and underserved areas. In our comments, we highlight the difficulties experienced by health care providers, particularly small, rural, independent, and safety net practices, in adapting to the MIPS framework, especially in the context of the disruptions caused by the COVID–19 pandemic. We also proposed three key legislative changes aimed at mitigating the negative impacts of MIPS penalties, improving the timeliness and relevance of performance feedback and claims data provided by CMS, and making the program more clinically relevant while reducing the administrative burden on practices. We urge the Senate Finance Committee and Congress, in general, to continue considering these same recommendations and look forward to collaborating closely on these critical issues to ensure that health care providers, especially those in rural and underserved areas, are supported effectively through the MIPS framework.

Private Equity and Health Care

The increasing presence of private equity in the health care sector raises important considerations for the sustainability and accessibility of health care services. With a notable shift in physician practice ownership from independent practices to those owned by hospitals, health systems, and private equity groups, there is an urgent need to examine the implications of these changes, especially in rural and underserved areas where health care options are already limited. Rural and underserved communities stand to be significantly impacted by the growing influence of private equity in health care. These areas, already grappling with a shortage of health care providers and limited access to medical services, may find themselves further marginalized by health care consolidation and the business-driven approaches of private equity-owned practices. The AMA's observation of a decline in the percentage of physicians working in private practices highlights the potential for decreased health care autonomy and personalized patient care, aspects crucial for addressing the unique health challenges of these rural communities. The AMA supports legislation which creates a more equitable and transparent health care system that prioritizes patient care over profit. H.R. 2474 is one such proposal that seeks to ensure sustainable Medicare physician payment rates, a crucial factor in maintaining the viability of independent practices and, by extension, preserving access to high-quality health care in rural and underserved areas.

HEALTH CARE WORKFORCE AND GRADUATE MEDICAL EDUCATION (GME)

Rural hospitals play a very important role within communities. For example, in "2020, rural hospitals supported one in every 12 rural jobs in the U.S. as well as $220 billion in economic activity in rural communities." However, between 2010 and 2021, 136 rural hospitals closed. These closures only compound the problems experienced by the current Health Workforce Shortage Areas (HPSAs). According to the Health Resources and Services Administration over 19,000 providers are currently needed just to eliminated our primary care and mental HPSAs. Moreover, these closures have contributed to unequal access and distribution of providers since about 20 percent of the U.S. population lives in rural communities, but only 10 percent of physicians practice in such areas. On top of this, with our aging physician workforce, it is projected that there will be about a quarter fewer rural physicians practicing by 2030.

In order to increase providers in rural areas, and to combat the projected shortage of 86,000 physicians by 2036, **more residency positions should be created.** Additionally, "Cap-Flexibility," which would allow new and current GME teaching institutions to extend their cap-building window for up to an additional 5 years beyond the current window (for a total of up to 10 years), would begin to help to remedy the physician shortage we are currently experiencing. "Giving these [rural] hospitals more time to establish their caps will help them start more programs and attract more residents to their communities before the Medicare-funded resident caps are set."

In order to encourage more individuals to become physicians and to practice in areas that are most in need we recommend that:

- Congress should act to allow the cap on GME slots to be increased as needed to meet the nation's changing needs rather than remain stagnant. Also, the cap building period should be increased.
- The immense debt burden experienced by America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government. Moreover, the

Teaching Health Center Graduate Medical Education, Rural Residency Planning and Development Programs, the National Health Service Corps, and the Indian Health Service should have their funding increased to bolster scholarships, loan forgiveness, and expand these programs.
- Support should be provided so that more institutions are incentivized to create rural training track programs.
- Holistic changes to how physicians are recruited need to be made. Students need to be recruited earlier in life. Additionally, communities that need health professionals should be educated about medical education and encouraged to help groom and assist local students with getting into medical school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound diverse clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural or underserved areas, support systems are needed.

Specific bills we support include: H.R. 2389/S. 1302 the "Resident Physician Shortage Reduction Act"; H.R. 4942/S. 665, the "Conrad State 30 and Physician Access Reauthorization Act"; H.R. 6205/S. 3211 the "Healthcare Workforce Resilience Act"; H.R. 6980/S. 2719, the "Directing Our Country's Transfer of Residency Slots" or the "DOCTORS Act"; H.R. 1202/S. 704, the "Resident Education Deferred Interest (REDI) Act"; H.R. 2761/S. 705, the "Specialty Physicians Advancing Rural Care Act" or the "SPARC Act"; S. 1403/H.R. 3046, the "Medical Student Education Authorization Act"; S. 3022, the "IHS Workforce Parity Act"; H.R. 7050, the "Substance Use Disorder Workforce Act"; H.R. 7258/S. 3968, the "Community Training, Education, and Access for Medical Students (Community TEAMS) Act"; H.R. 7855, the "Rural Residency Planning and Development Act of 2024"; legislation to promote pathways to practice for the medical profession by providing additional funding for the recruitment, education, and training of medical students willing to work in rural and underserved communities; and Physician Shortage GME Cap Flex legislation.

OBSTETRICS CARE IN RURAL COMMUNITIES

Access to physician practices, clinics, and hospitals that provide maternal and infant care services is critical to providing high-quality care; yet, in 2023, only about 43,500 Obstetrician-Gynecologists (OBGYNs) were in practice across the entirety of the U.S. and its territories. In order to increase the number of maternal care providers and help with the retention of physicians who provide maternal care Congress should:

- National Health Service Corps: Ensure that further information about the Maternity Care Target Area (MCTA) addition to the NHSC is provided to the public and grant more funding for the MCTA addition so that an adequate number of maternity care physicians—including OBGYNs, family physicians with an emphasis on maternal care, emergency medicine physicians, and maternal-fetal medicine specialists—can be placed in HPSAs through the NHSC.
- Indian Health Service: Additional funding should be provided for the IHS Maternal Child Health (MCH) program. The IHS MCH should ensure that the funds it receives are used to increase access to OBGYNs and maternal-fetal medicine specialists for AI/AN pregnant individuals; and the Centers for Disease Control and Prevention should increase its engagement in the following ongoing initiatives (this list is not exhaustive): develop awards to fund support for MMRCs for AI Tribes, expand materials on the Hear Her Campaign website for AI Tribes, and continued support for the Healthy Native Babies Project (HNBP) to assist local programs in addressing safe infant sleep in AI/AN communities.
- Teaching Health Center Graduate Medical Education: Increase funding for Teaching Health Center Graduate Medical Education (THCGME) Programs. Since 2010 this program has helped 21 OBGYNs complete their residency and enter the workforce. Though this is an excellent start, additional funding, and support for this program, and in particular OGBYNs in the THCGME Program, is needed.

Residency

Additional specific training tracks for maternal and infant care should be created and expanded. Rural track programs (RTP) already exist and are designed to encourage the training of residents in rural areas. Specifically, the Maternal Health and Obstetrics Pathway within the Rural Residency Planning and Development (RRPD) Program is available for both OBGYN rural residency programs and family medicine rural residency programs that have enhanced obstetrical training.

The RRPD is a vital path that helps draw more physicians into rural practice. Therefore, **the AMA supports the "Rural Residency Planning and Development Act of 2024" (H.R. 7855),** which would codify the RRPD program. This legislation is a great example of some of the permanent and meaningful fixes that Congress can make to help provide additional training pathways for physicians who want to provide much needed care in rural communities.

While the Maternal Health and Obstetrics Pathway within the RRPD is an important first step, it needs to be expanded so that additional maternal health pathways can be created. For example, additional training tracks should be created that allow for both rural and urban training for OBGYNs, maternal-fetal medicine specialists, family physicians, and other physicians who will likely have to provide maternal care. These training programs could be modeled off existing programs that are already accredited by ACGME such as the family medicine RTP programs which exist in the "1–2 format"—meaning the resident's first year is at a core family medicine program and the 2nd and 3rd years are at another site. Since there are already provisions of law and regulations that allow urban hospitals to create multiple RTPs and receive adjustments to their caps for newly established RTPs, it would be possible to create an educational format that allows for residents to train in urban and rural settings in maternal care thereby enabling physicians who will ultimately practice in rural areas to do rotations in hospitals with a high volume of deliveries so they can receive ongoing training and experience with cesarean sections and pregnancy-related complications. As such, **more funding should be provided for the Maternal Health and Obstetrics Pathway and programs with similar goals should be created. Moreover, additional funding for rural clinics and hospitals should be provided to enable them to offer rotations for medical students and residents in rural obstetric care.**

Monitoring of Hypertension During Pregnancy and Postpartum

Over the last decade, the AMA has developed and disseminated an evidence-based quality improvement program, AMA MAPTM hypertension (HTN), that has demonstrated improvement in blood pressure (BP) control for adult patients with hypertension in primary care settings. In addition the AMA has collaborated with other interested groups to increase access to tools, resources and services to improve the clinical management of hypertension, including clinical services and home devices for self-measured blood pressure (SMBP), specifically increasing Medicaid coverage. SMBP is an evidence-based strategy for BP control that is incorporated into AMA MAP HTN and other AMA solutions.

Improving Care for Patients with Hypertensive Disorders of Pregnancy

HDPs are one of the leading causes of pregnancy-related deaths that occur in the first 6 weeks postpartum. The rate of patients entering pregnancy with chronic HTN and the overall rate of HDPs have risen considerably in recent years. The use of SMBP has been shown to increase compliance with American College of Obstetricians and Gynecologists recommendations for BP monitoring, increase patient satisfaction, and decrease readmissions for HDPs. SMBP has also shown promise in reducing inequities in the monitoring and treatment of BP in postpartum patients. Multiple barriers prevent the widespread adoption and use of SMBP for which there are potential solutions. These include coverage and access, clinical infrastructure, clinical quality improvement, federal legislation related to remote patient monitoring, and teleconsultation which are discussed below.

Coverage and Access

Medicaid covers 42 percent of all births in the U.S. Unfortunately, coverage varies by state, which means that the acquisition of an extra appropriately sized cuff, often needed to ensure clinical accuracy, is not always covered. This variation and others are barriers to scaling SMBP. Even when coverage exists there are still access issues. Some states prohibit shipping a covered device directly to the patients or require patients to go to a specific durable medical equipment supplier rather than a more convenient location. For SMBP coverage to be clinically impactful it necessitates that patients have coverage and access to devices that are appropriately sized and clinically validated. **Therefore, we recommend policies that support increased coverage and access to SMBP devices clinically validated for pregnancy and appropriate cuff sizing options.**

Clinical Infrastructure

SMBP requires investments in clinical personnel and technology integration into clinical practice. Therefore, we recommend policies that support: **Improved interoperability of apps/platforms to support the transfer of BP measurement**

data from patients to clinical teams; and increased reimbursement for physician-led team-based care in order to increase patient access to programs that improve care for patients with HDP.

Clinical Quality Improvement

Clinical teams require access to data to drive and measure quality improvement programs as well as research efforts. Dedicated funding to scale promising interventions nationally and measure the impact on outcomes is also needed to identify the most effective solutions and strategies. Therefore, we recommend policies that support: **Increased availability of standardized clinical and billing data for use in quality improvement; and increased funding for clinical, dissemination and implementation research on HTN and cardiovascular diseases during pregnancy and postpartum in order to identify and measure effective interventions to improve quality of care and health outcomes.**

Federal Legislation Related to Remote Patient Monitoring

It is vital to begin improving maternal and infant health outcomes for pregnant and postpartum women with the support of telehealth and remote patient monitoring solutions. Telehealth and technology enabled devices have proven to be key assets in the physician's toolbox for prevention and improved health outcomes for a number of conditions. The AMA recognizes the same technology is critical to addressing maternal mortality and morbidity by helping screen new mothers for high blood pressure and related treatable and preventable conditions, such as preeclampsia, that lead to unnecessary and avoidable maternal deaths and adverse health outcomes.

To help improve maternal health outcomes, **the AMA strongly supports S. 712, the "Connected Maternal Online Monitoring (Connected MOM) Act."** This bill would require CMS to send a report to Congress identifying barriers to coverage of remote physiologic devices (*e.g.,* pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women. This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.

For additional information about the AMA maternal health recommendations please see these resources:

- What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?
- AMA Recommendations on Maternal Health.
- Maternal health: Expanding on the AMA's recommendations to reduce deaths and improve outcomes.
- AMA advocacy to improve maternal health.

CONCLUSION

The AMA is committed to working with the Senate Finance Committee and Congress to find permanent solutions that ensure that Medicare beneficiaries have uninterrupted continued access to high quality, affordable health care. This will require a multi-pronged approach including continued investment and stability for access to telehealth, addressing the lack of an inflationary update in the Medicare physician payment system, working to eliminate administrative burdens that make practicing medicine difficult and drive physicians out of private practice, and policies to facilitate a larger and stronger health care workforce. We must build on the gains achieved during the pandemic so that all patients have access to the care they need.

Links:

https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp?utm_source=oig-web&utm_medium=oig-covid-policies&utm_campaign=oig-grimm-letter-02262021

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https://www.acgme.org/initiatives/medically-underserved-areas-and-populations/rural-tracks/

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https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/index.html

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AMERICAN NURSES ASSOCIATION
8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

May 29, 2024

The Hon. Ron Wyden
Chairman
United States Senate
Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

The Hon. Mike Crapo
Ranking Member
United States Senate
Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Nurses Association (ANA), I would like to thank you for this opportunity to share our input on solutions Congress can implement to improve patients' access to healthcare in rural and underserved communities. We appreciate the Committee's recognition of the significant and increasingly dire challenges the nation's rural population, workforce, and health care infrastructure are facing. We have seen a disturbing number of facility and department closures in rural areas. Nurses are leaving for better work environments, causing patient access issues that will continue to worsen without meaningful policy changes. ANA is pleased to recommend solutions that Congress can implement to help optimize utilization of nurses and recognize their value and contributions to our nation's health care system, particularly in rural and underserved areas.

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs), through its constituent and state nurses associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include those practicing in the four advanced registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists. ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

Sustainable Provider and Facility Financing

Support RN Residency and Fellowship Programs and APRN Fellowship Programs

ANA encourages Congress to identify ways to establish nurse residency and fellowship programs, especially for rural and underserved communities. During his opening statement, your witness, Jeremy P. Davis, MHA, President and Chief Executive Officer of Grande Ronde Hospital, chronicled the hospital's success in establishing a nurse residency program to attract, train, and retain nurses. ANA has heard from health systems across the country, and internationally, who have nurse residency and fellowship programs and they share Mr. Davis's enthusiasm for and success with these programs.

Two programs within the American Nurses Credentialing Center (ANCC), a subsidiary of ANA, are the Practice Transition Accreditation Program® (PTAP) and the Advanced Practice Provider Fellowship Accreditation™ (APPFA). PTAP accredits transition to practice programs and prepares RNs for new practice roles, referred to as residency and fellowship programs. Whereas APPFA accredits transition to practice programs for APRNs and physician assistants/associates (PA). ANCC is the only nurse credentialing organization to successfully achieve ISO 9001: 2015 certification.

Nurse residency and fellowship programs bridge the gap between formal education and practice, or transitions between nursing roles or specialties, through hands-on mentoring and professional development. There are programs for both RNs and APRNs.

In 2023, the RN residency and fellowship programs ANCC accredits, included 224 programs at 774 individual sites, with 44,597 participants, and boasted more than an 83 percent retention rate over a 12-month period. The average cost per participant was $10,095 for residency programs and $7,424 for fellowship programs. While smaller in scale, APP fellowship programs showed similar success. In 2023, there were 31 ANCC accredited fellowship programs for APRNs across 16 states with 166 participants. They boasted a 92 percent completion rate at an average cost of $20,461 per participant. Most of the funding for these programs comes from the health systems themselves, philanthropy, and state support. Funding from the Centers for Medicare and Medicaid Services (CMS) and the Department of Labor does help these programs but is by no means a large source of revenue compared to the other funding streams. ANA strongly encourages Congress to look for ways to increase nurse residency and fellowship programs, especially for rural and underserved communities.

Educating Future Nurses Act (H.R. 3623/S. 1586)

Congress can also improve patients' access to healthcare in rural and underserved communities by expanding clinical education and training opportunities for APRNs. Medicare makes a significant investment in Graduate Medical Education, and in FY 2020 it paid an estimated $16.2 billion.[1] The entire federal investment in nursing education from the federal government in FY 2024 was only $300 million, which pales in comparison.[2] The Educating Future Nurses Act (S. 1586/H.R. 3623) would establish federal funding for hospitals to partner with schools of nursing, community-based care settings, and other hospitals to address clinical training costs for graduate nursing students. This legislation builds upon the highly successful Graduate Nurse Education Demonstration Program which evidence shows is a promising option for increasing primary care providers.[3]

Permanently establishing a national graduate nurse education program that strengthens partnerships between hospitals and nursing schools, future APRNs will be able to receive additional training and practice options while they provide high-quality care to patients, especially in rural and underserved communities. This is a critical part of a comprehensive strategy to support the nursing workforce.

Expand Home Visiting Programs

Home visits by RNs can support pregnant families, promote infant and child health, foster child development and school readiness, and help prevent child abuse and neglect. Home visiting programs, such as the Nurse Family Partnership (NFP), are voluntary and offer vital support to parents as they manage the challenges of raising babies and young children.

States are covering these evidence-based services, such as home visiting, during the perinatal period, to improve continuity of care for pregnant and postpartum people enrolled in Medicaid or the Children's Health Insurance Program (CHIP). States leverage other federal, state, local and private funding sources to finance these services and in some cases use existing Medicaid services to cover components of home visiting.

NFP is a national public health intervention that allows nurses to build relationships with new mothers. NFP provides RN care in the home during pre- and postnatal periods. The program has demonstrated multiple positive outcomes, including reduced emergency department visits for children and improved indicators for the health and well-being of mothers.[4] One example is the NFP in South Carolina, financed jointly by the state and private funders. The partnership supports lower income first-time mothers, and aims to reduce preterm births, child hospitalizations, and increasing birth spacing.[5]

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[1] *https://crsreports.congress.gov/product/pdf/IF/IF10960#:~:text=Medicare%20makes%20a%20significant%20investment,in%20FY2020%2C%20primarily%20to%20hospitals..*

[2] *https://www.thenursingcommunity.org/_files/ugd/148923_4994611787d740c9a0d9c47990db0d61.pdf.*

[3] *https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01328.*

[4] *https://nap.nationalacademies.org/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to.*

[5] *Ibid.*

Home visiting models are adaptable in rural states, as well as nonrural areas. In 2019, Kansas served an estimated 23.8 percent of children under age three in families with incomes of less than 150 percent of the Federal Poverty Level in the state's home visiting programs. As of 2021, families in the state have access to five out of a possible seven evidence-based program models that have a demonstrated impact on parenting and are designed for families with young children. In 2021, Maryland launched a maternal and child health care transformation initiative to fund the expansion of current maternal health-focused programs, which includes home visiting services. In Michigan, the statewide Maternal Infant Health Program serves over 20,000 Medicaid-eligible families, with prenatal and postnatal home visiting covered. Michigan is creating more awareness of their Home Visiting Program and other state maternal health programs by developing a mobile pregnancy app to connect users to state maternal health programs. In 2021, New Jersey joined Oregon in enacting Universal Newborn Nurse Home Visiting enabling all new moms, including those that experience a stillbirth and those that adopt, to receive up to three visits by a registered nurse in their home. Additional states with robust home visiting programs include Iowa and Maine.[6]

ANA encourages the Committee to explore and consider ways it can build on the successes of these programs as part of its efforts to increase access to care in rural and underserved areas.

Health Care Workforce

Improving Care and Access to Nurses (ICAN) Act (S. 2418/H.R. 2713)

One of the most significant ways lawmakers can increase access to health care services for patients in rural and underserved areas is to remove legislative and regulatory barriers at the federal and state levels that prevent APRNs from practicing to the top of their education and clinical training. Supported by more than 30 years of evidence of the safe and cost-effective provision of care by APRNs, there is a national call to remove all barriers to full practice authority from organizations such as the National Academies of Medicine, the National Governors Association, the Federal Trade Commission, the Bipartisan Policy Center, and the Veteran's Health Administration, and many others. Here are some examples:

"Nurse Practitioners: A Solution to America's Primary Care Crisis," published by the American Enterprise Institute in 2018 stated that, "A large and growing body of research shows that the quality of care provided by nurse practitioners is as good and, in some cases, even better than the care provided by primary care physicians. But in many states, nurse practitioners are held back by laws that restrict their scope-of-practice."[7]

In 2019, Americans for Prosperity published, "The Nurse Practitioner Solution," stating that, "Providing NPs full practice authority has also helped states reduce health care costs. States that implement these reforms spend 17 percent less per-capita on outpatient care, 11 percent less on prescription drugs, and 15 percent less on pediatric preventive care than states that restrict access to NPs."[8]

The Brookings Institute published, "Improving efficiency in the health-care system: Removing anticompetitive barriers for advanced practice registered nurses and physician assistants," in 2018. The report stated that, ". . . the research literature is consistent in finding no evidence of harm to patients associated with less-burdensome SOP requirements. For example, SOP restrictiveness for NPs appears to have no effects on a variety of outcomes, including chronic disease management, cancer screening, and ambulatory care—sensitive hospital admissions. Moreover, enhanced prescription authority for NPs has no effects on infant mortality rates. In some cases, there are benefits of less-restrictive SOP, as with infant and maternal health: independent SOP for CNMs is associated with lower probabilities of labor induction, fewer Caesarean deliveries (C-sections), and slight improvements in infant health metrics such as birth weight."[9]

There are two major barriers that patients face when trying to access care provided by APRNs: state licensure laws and the Medicare law. Currently, there are 27 states with full practice authority (FPA) for nurse practitioners and 23 states with FPA for CRNAs. To date, not one of the 27 states that expanded FPA for APRNs

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[6] *https://www.nga.org/maternal-infant-health/.*
[7] *https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/.*
[8] *https://americansforprosperity.org/the-nurse-practitioner-solution/.*
[9] *https://www.brookings.edu/wp-content/uploads/2018/06/AM_PB_0620.pdf.*

has ever reversed course. Time after time, APRNs demonstrate that granting FPA proves safe, cost effective, and increases access for patients—especially those in rural areas. Congress can use the sticks and carrots at its disposal to encourage states to adopt FPA through federal health programs.

ANA highlights and urges Congress to take up and pass a bipartisan, bicameral proposal that would remove federal practice barriers and increase access to care in rural and underserved areas. Led by Sen. Jeff Merkley (D–OR) and Cynthia Lummis (R–WY) in the Senate, the Improving Care and Access to Nurses (ICAN) Act (S. 2418/H.R. 2713) is currently endorsed by more than 240 organizations, including the National Rural Health Association and AARP. The bill would improve access to care for Medicare beneficiaries by removing numerous administrative and practice barriers for APRNs. If enacted, nurse practitioners, certified registered nurse anesthetists, certified nurse-midwives, and clinical nurse specialists will be able to treat Medicare beneficiaries without arbitrary and outdated hurdles that patients in private or other insurance models do not face.

Shortages in primary care providers affect 1 in 5 Americans. Given the shortage of primary care physicians, allowing non-physician professionals, such as APRNs, to practice to the full extent of their education and training gives patients more options and more types of services. Supporting and passing the ICAN Act would meaningfully help ensure that patients in rural and medically underserved communities have enhanced access to care.

Improving Seniors' Timely Access to Care Act

ANA strongly supports passing the soon-to-be-reintroduced Improving Seniors' Timely Access to Care Act, which unanimously passed the House and was cosponsored by a majority of members in the Senate and House last Congress. Nurses spend an inordinate amount of time on prior authorizations to the point where it has become a subspecialty in nursing practice. This is a waste of time, money, and resources. It is a contributor to burnout for every heath care provider that deals with it to get their patients the care they need—especially in commonly understaffed rural clinics and facilities. In the future, we look forward to working with the Committee to further reduce prior authorization burdens in Medicare Advantage programs and elsewhere.

Innovative Models and Technology

CONNECT for Health Act (S. 2016/H.R. 4189)

ANA is a strong, long-time supporter of using technology to bring providers and patients together. Nurses know firsthand—especially in rural and underserved areas—that many patients choose between buying gas and buying groceries. With the advancements made in telehealth, it makes sense for Congress to pass legislation that fosters the use of these technologies to better serve our patient populations. We urge Congress to pass the CONNECT for Health Act (S. 2016/H.R. 4189) to achieve these goals.

Over the past few years, many provisions of the CONNECT for Health Act have either been passed into law or put into place by regulations. The updated version of this bill will remove geographic restrictions and expand originating sites; allow health centers and rural health clinics to provide telehealth services; remove unnecessary in-person visit requirements for telemental health services; and require more data to study how telehealth is being used, impacts of quality of care, and how it can be improved to support patients and health care providers. These are all important steps to fully capitalize on the possibilities and capabilities of telemedicine.

In closing, I would like to thank you for your leadership and willingness to consider our perspective on these critical issues to ensure that we can build a robust nursing workforce that serves patients in rural and underserved communities across America. ANA stands ready to work with the Senate Finance Committee to implement policy solutions to comprehensively address the nation's health challenges. If you have any questions, please contact Tim Nanof, Vice President of Policy and Government Affairs, at (301) 628–5081 or Tim.Nanof@ana.org.

Sincerely,

Debbie Hatmaker, Ph.D., R.N., FAAN
Chief Nursing Officer/EVP

cc: Jennifer Mensik Kennedy, Ph.D., R.N., NEA–BC, FAAN, ANA President
Angela Beddoe, Interim Chief Executive Officer

AMERICAN OSTEOPATHIC ASSOCIATION
511 2nd Street, NE
Washington, DC 20002
312–202–8000
https://osteopathic.org/

On behalf of the American Osteopathic Association (AOA) and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to thank you for the opportunity to provide a statement for the record to the Senate Finance Committee on issues impacting the rural health care landscape. This is a particularly important opportunity to provide insight on matters impacting physicians and our patients. DOs represent nearly 11%[1] of physicians in the United States but comprise nearly 40% of physicians serving rural and underserved communities.[2] In fact, many osteopathic schools are in rural areas, allowing students to establish connections with these communities at an early stage in their medical education.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and high-quality care when and where they need it. Our policy proposals would provide stability in the delivery of high-quality care in rural communities and would provide lasting solutions to problems that have long plagued both patients and physicians across rural America.

Serving Patients in Rural Communities:

Providing health care services in rural communities presents unique challenges. Beyond the geographic distances rural patients must cover in order to seek care, rural populations are older and more likely to suffer from chronic diseases on average.[3] Nearly 95 percent of adults aged 60 and older have at least one chronic illness or condition, and nearly 80 percent of the same cohort have two or more chronic conditions.[4] Over the next decade, the projected number of patients with at least one chronic condition is expected to double and encompass more than 142 million Americans by 2050, placing increasing strain on the U.S. healthcare system and workforce.[5]

At the same time, the United States could see a shortage of as much as 124,000 physicians by 2034 if the current trends are not reversed.[6] The physician shortage will be even more severe in rural areas, as rural areas already comprise 60% of Health Professional Shortage Areas (HPSAs), and projections show a shortage of 20,000 primary care physicians in rural areas as soon as 2025.[7, 8] Investment in the physician workforce, especially in primary care, is needed to build capacity across the country. **To help alleviate building pressure on the physician workforce and subsequent access impacts upon patients, the AOA strongly urges the Committee to consider the *Resident Physician Shortage Reduction Act* (S.**

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[1] American Osteopathic Association. "2023 OMP Report." 2023. *https://osteopathic.org/about/aoa-statistics/#:~:text=In%202023%2C%20the%20total%20number,to%20reach%20186%2C871%20in%202023.*

[2] Senator Martin Heinrich. "Heinrich, Wicker, Lee Lead Bipartisan, Bicameral Call for Increased Access to Osteopathic Medical Research That Benefits Rural, Underserved Communities." 2022. *https://www.heinrich.senate.gov/newsroom/press-releases/heinrich-wicker-lee-lead-bipartisan-bicameral-call-for-increased-access-to-osteopathic-medical-research-that-benefits-rural-underserved-communities.*

[3] National Institute for Health Care Management Foundation. "Rural Health in America: How Shifting Populations Leave People Behind." October 20, 2022. *https://www.nihcm.org/publications/rural-health-in-america-how-shifting-populations-leave-people-behind#:~:text=In%20rural%20areas%2C%2018.4%25%20of,the%20health%20care%20they%20need.*

[4] National Council on Aging. Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. Page 5, Figure 2. April 2022. Accessed online at: *https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults.*

[5] Ansah JP, Chiu CT. Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. Front Public Health. 2023 Jan 13;10:1082183. doi: 10.3389/fpubh.2022.1082183. PMID: 36711415; PMCID: PMC9881650.

[6] Association of American Medical Colleges: Report Reinforces Mounting Physician Shortage. June 11, 2021. Accessed online at: *https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage.*

[7] AAMC. "Attracting the Next Generation of Physicians to Rural Medicine." 2022. *https://www.aamc.org/news/attracting-next-generation-physicians-rural-medicine.*

[8] Nielsen M, D'Agostino D, Gregory P. Addressing Rural Health Challenges Head On. Mo Med. 2017 Sep-Oct;114(5):363–366. PMID: 30228634; PMCID: PMC6140198.

1302). The bill would increase the number of residency positions funded by Medicare, with particular emphasis on hospitals in rural areas and Health Professional Shortage Areas (HPSAs).

Additionally, the Committee should evaluate proposals such as the bipartisan *Rural Physician Workforce Production Act* (H.R. 834), which would allow certain hospitals to receive additional payments from Medicare for employing resident physicians in rural areas. This would increase the number of physicians practicing in rural communities and would provide financial support to make these residencies more accessible.

Practice Sustainability:

Implementing policies that would reduce physician shortages in rural areas would help to alleviate the significant burdens that rural patients face, but does not guarantee easier or quicker access to care for those patients. More than 100 rural hospitals have closed over the past decade, and another 700 additional hospitals are at risk of imminent closure. Those figures do not include the substantial impact of small and independent physician practice closures. The GAO has found these closures result in an average increase of 20 miles traveled each way for patients accessing common health services, and 40 miles for more complex services such as drug or alcohol abuse treatment.[9]

Physicians across the country, but especially those in rural areas, face ongoing uncertainty regarding the payment they will receive for services rendered year after year. This year, in the Medicare Physician Fee Schedule CMS finalized a 3.37% cut to Medicare's physician payments, which was only able to be partially mitigated by Congress. This cut coincides with ongoing increases in costs to practice medicine—which CMS acknowledges, as the projected increase in the Medicare Economic Index (MEI) for 2024 will be 4.6%. **Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update.** Changing this would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), and **the AOA strongly urges the Senate Finance Committee to consider this legislation further.**

The AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians. For example, in its March 2024 report, MedPAC recommended creating an add-on payment for physicians caring for low-income patients to better support physicians working with rural and underserved populations.[10] Without predictable inflationary payment updates and additional incentives for rural and underserved areas, the physician workforce in these communities is likely to decline further.

Furthermore, Medicare's current budget neutrality obligations within the physician payment schedule exacerbate the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS due to upward payments or new procedures in one category that increase costs by $20 million or more must be offset by cuts in other areas of the fee schedule. This issue is reflected in the implementation of a new and controversial care complexity add-on code (G2211). Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of payment reductions in other specialties that would limit the benefits the new code provides.

Continued patient access to high quality care, particularly for chronic conditions, is contingent upon the confluence of all three factors: sustainable and predictable updates to physician payment under the Medicare Physician Fee Schedule, adjustments to the budget neutrality threshold, and investment in the physician workforce, particularly in rural and underserved communities.

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[9] GAO. "Why Health Care is Harder to Access in Rural America." May 16, 2023. *https://www.gao.gov/blog/why-health-care-harder-access-rural-america.*

[10] MedPAC. "March 2024 Report to Congress." April 18 2024. Accessed online at: *https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf.*

Value and Innovation:

The AOA has long advocated for expanding payment models predicated upon delivering high quality, value-based care rather than the volume-based nature of the current fee-for-service payment model. Despite that, transitions to value-based payments must account for the unique needs of different specialties, practices' current capacities, and the ways physicians deliver care—particularly in rural areas. It also must not create additional barriers to entry, result in reduced or inequitable payment, or increase administrative burden. To better promote high-value care and reduce burdens, the Committee should look at Advanced Alternative Payment Models (APMs) rather than the Merit-Based Incentive Payment System (MIPS) when building new policies.

Advanced APM pathways include Accountable Care Organizations (ACOs), including those under the Medicare Shared Savings Program (MSSP), and Centers for Medicare and Medicaid Innovation (CMMI) models. Many AAPMs are well suited for physicians helping patients manage chronic conditions, as they include added incentives for providers who take on additional risk when treating patients as they deliver high quality, coordinated, and efficient care. Ultimately, in considering any shifts towards expanding existing APMs or seeking to accelerate physician participation in such models, efforts must:

- Support practices in making the necessary infrastructure investments to succeed under such models;
- Ensure sufficient flexibility in the range of models available to account for differences across specialties and the ways different physicians deliver care;
- Minimize administrative burden to enable physicians who commit to value-based models to focus on patient care; and
- Ensure adequate payment for the range of services the particular physician provides, and in the case of primary care, support the comprehensive services that advanced primary care seeks to deliver.

Ensuring that financial support is available to incentivize this transition is essential, and the AOA applauds Congress' extension of AAPM bonuses for PY 2024, despite our disappointment at the reduced bonus rate.

When Congress passed the *Medicare Access and CHIP Reauthorization Act* (MACRA) it clearly intended to deliver an accelerated pathway for physicians to participate in APMs. The transition to value-based payment has not materialized as Congress had hoped because practices have not been paid enough to be able to reinvest to have the capacity to succeed in APMs. It is important to note that most APMs are built upon the foundation of our FFS system, and continuously declining payment rates in FFS create a vicious cycle that only makes it more challenging to transition as revenue, and funds available to make investments, declines.

Moreover, the current structure of MIPS does not effectively measure performance on meaningful outcomes or accurately predict care quality, and it is not an effective means of delivering value and penalizes small and rural practices.

In order to ensure that rural physicians can effectively participate in value-based care delivery models, the Committee should consider additional funding for the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP–SURS) program. This program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access while lowering costs. Most small and rural providers do not have access to the technical or administrative staff necessary to ensure proper participation in the MIPS, which currently disadvantages small and independent physician practices. Physicians in small and rural practices consistently receive below-average MIPS scores, demonstrating that practice size and resources are better indicators of MIPS performance than patient outcomes. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.[11] Physician-owned practices deliver high-quality, cost-effective care regardless of health system affiliation, and this research demonstrates the technical and administrative disadvantage small and independent physician practices are currently facing. Ensuring physicians at small or rural practices can participate in APMs that incentivize high-

[11] Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. JAMA Netw Open. 2020;324(10):984–992.

quality, cost-effective care is integral to improving patient access to care for chronic conditions.

Value-based payment is an important tool that can be used to enhance access to primary care, particularly for patients with chronic conditions. The AOA applauds the Committee's interest in taking steps to ensure physician payment reform drives patients access to high quality, affordable, coordinated care, and we look forward to working with the committee further.

Access Improvement Through Telehealth:

Telemedicine presents a unique opportunity to improve access for rural patients. As practice closures increase the distance patients are required to travel to access care, and decrease the number of available primary care physicians and specialists, telemedicine can allow those patients to access care from their homes. The decision to expand telehealth flexibilities during the COVID–19 public health emergency (PHE), and the subsequent extension of those flexibilities, has allowed millions of Americans to access high-quality care they otherwise would not have been able to receive. The AOA is sincerely appreciative that the Committee and Congressional leaders have extended Medicare's telehealth coverage flexibilities through CY 2024, and strongly encourage the Committee to work toward a long-term reauthorization that would provide clarity and certainty for the future of telehealth.

The expansion of telehealth coverage has allowed for patients to have better access to the care they need when they need it and supports physicians in building longitudinal relationships with their patients. Congress can improve access to care by passing the *Telehealth Modernization Act* and making permanent the flexibilities that were established during the COVID–19 public health emergency and extended via the *Consolidated Appropriations Act of 2023.* Some of these critical flexibilities to expand payment for telehealth services include allowing Medicare patients to receive telehealth services in their home, eliminating site and geographic restrictions for non-behavioral health services, permitting the delivery of telehealth via audio-only technology, and allowing federally qualified health centers and rural health clinics to serve as distant sites services other than behavioral health services.

Ensuring appropriate coverage and payment for telehealth will enable physician practices to leverage this modality in providing longitudinal care and to sustain these vital services into the future. Moreover, it will support improved access to specialists and mental health services that are otherwise inaccessible for the vast majority of patients in rural and underserved communities.

Conclusion

Again, thank you for the opportunity to submit comments for the record. The Committee's work on these important issues will support the stability of both the physician workforce and patient access to affordable, high-quality care. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Federal Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349–8748.

AMERICAN PHYSICAL THERAPY ASSOCIATION
3030 Potomac Ave., Suite 100
Alexandria, VA 22305–3085
800–999–2782
https://www.apta.org

Chairman Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association thanks the Committee for the opportunity to provide our perspectives and policy recommendations to improve health care in rural communities. APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles

are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

"The Economic Value of Physical Therapy in the United States," a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs. The committee should *consider the insights provided in this report* to support access to, coverage of, and payment for physical therapist services, and to support policies that position physical therapists as entry-point providers to ensure beneficiaries have timely access to proven, cost-effective care.

Policy Recommendations

APTA appreciates the committee holding this hearing to address health care issues in rural areas. Patients residing in rural regions often have access to far fewer health care providers and services than those in other areas, and they further face unnecessary delays and barriers to critical care. To help address the current and future challenges related to health care in rural communities, APTA endorses a series of proposals and recommends that Congress enact the following policies:

Eliminate the Outdated Direct Supervision Requirements of PTAs Under Medicare Part B to Provide Staffing Flexibility for Outpatient Therapy Clinics

Patients in rural areas, particularly those on Medicare, face limited access to a sufficient number of medical providers. In some instances, this is due to outdated Medicare rules. Medicare allows for "general supervision" of physical therapist assistants by physical therapists in all settings—except for outpatient private practice under Part B, which requires more stringent "direct supervision." (In comparison, occupational therapists in all settings are subject only to general supervision of occupational therapy assistants.) While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, 49 states call for "general supervision" of physical therapist assistants and occupational therapy assistants, making this outdated Medicare regulation, which arbitrarily applies only to physical therapists in private practice, more burdensome than most state requirements.

Standardizing the supervision requirement from direct to general for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more flexibility in meeting the needs of beneficiaries.

We urge the committee to pass S. 2459/H.R. 4878—the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation (EMPOWER) Act to eliminate these unnecessary barriers to therapy providers. According to an independent *report published by Dobson & Davanzo in September 2022,* this change in supervision rules is estimated to save Medicare $271 million over 10 years.

Eliminate Duplicative and Unnecessary Administrative Burdens to Streamline Medicare Patient Access to Care

Medicare patients in rural areas may often face delays in treatment due to needless administrative rules, such as requirements that mandate unnecessary plan of care certification approvals. At present, Medicare Part B guidelines permit Medicare beneficiaries to receive therapist evaluation and treatment services with or without a physician's order. The physical therapist or occupational therapist may evaluate that patient, formulate a plan of care, and commence treatment. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed and returned within 30 days to receive payment. The clerical signature requirement creates unnecessary paperwork and stress for therapists, as they often struggle to track down signatures before the 30 days are up.

APTA is endorsing legislation that would provide for a new streamlined model where in such cases that outpatient therapy services are provided under a physician's order, the plan of care certification requirement will be deemed satisfied if the qualified therapist simply submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. Therapists would no longer need to obtain a signed plan of care within 30 days from the physician who referred the patient. The time and resources spent by therapists and physicians in procuring a

timely signature to a plan of care adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

We urge Congress to approve H.R. 7279—the Remove Duplicative Unnecessary Clerical Exchanges (REDUCE) Act, to streamline the current plan of care certification requirement under Medicare Part B to expedite patient access to care.

Permanently Include Physical Therapists as Authorized Providers of Telehealth in the Medicare Program

The increased use of telehealth services since the pandemic has helped patients gain greater access to medical providers and maintain continuity of care, leading to improved health care outcomes for patients. The expansion of telehealth payment and practice policies under the Section 1135 waivers during the public health emergency, including permitting physical therapist services to be furnished via telehealth by PTs and PTAs across settings, has demonstrated that many health care needs can be safely and effectively met and that patients can have improved access to skilled care by leveraging these resources. This has been especially beneficial for patients residing in rural areas, who often have access to far fewer providers than other regions and may live a very considerable distance from medical facilities and other health care professionals.

Physical therapists and physical therapist assistants use telehealth as a supplement to in-person services to evaluate and treat a variety of conditions prevalent in the Medicare population, including but not limited to Alzheimer's disease, arthritis, cognitive/neurological/vestibular disorders, multiple sclerosis, musculoskeletal conditions, Parkinson disease, pelvic floor dysfunction, frailty, and sarcopenia.

APTA supports the ability of Medicare beneficiaries to maintain the option, when appropriate, to have physical therapist services provided via telehealth. Permitting services to be furnished via telehealth by PTs and PTAs has provided greater options for patients to access care. However, unless Congress acts, the current Medicare telehealth flexibilities are scheduled to expire on Dec. 31, 2024.

APTA strongly urges the Committee to consider and pass S. 2880/H.R. 3875—the Expanded Telehealth Access Act, to ensure that PTs and PTAs are permanent authorized providers of telehealth in the Medicare program.

Facilitate the Formation of Health Care Provider State Compacts to Increase Health Care Providers in Rural Areas

Rural areas unfortunately experience challenges in attracting the necessary numbers of health care providers. One solution to this issue is the use of state health care provider compacts. Professional interstate compacts are entities consisting of state licensing bodies that facilitate the ability of licensed professionals to provide their services in multiple states without having to complete the time-consuming and costly effort to become licensed in every jurisdiction.

In many professions, licensed professionals may apply to a compact where states will recognize the professional's state credentials and enable that professional to practice in additional states. Compacts often result in reducing the administrative burdens on licensed professionals while increasing services and options to consumers. Many health care disciplines, including physical therapy, have established a compact to allow providers—once they have been granted compact privileges—to work in multiple states. This is especially important in helping to address the health care provider shortage in many rural and underserved areas.

The PT Compact allows eligible PTs and PTAs to practice in states in addition to the ones where they are initially licensed. Member states recognize the state licensure and credentials of a PT or PTA and allow them to practice in other compact member states. Currently, 36 states are members of the PT Compact and other states are considering legislation to join.

However, PTs and other medical providers are experiencing delays and difficulties to participate in their respective compacts due to a lack of clarity in federal law. Before a state can become an active compact member, it must require that all applicants for initial licensure as a PT and PTA complete a criminal background check conducted by both state law enforcement and the FBI, with the results of the check delivered to the state physical therapy licensing board to be used in making a licensure determination. Since not all physical therapy licensing boards already have the FBI criminal background check requirement in place, those boards are experiencing significant delays in the FBI reviewing their application for an Originating Agency Identifier, which is needed before the board can require FBI criminal background

checks. An ORI is a federal code assigned to an agency or person enabling the entity to request and receive federal background check information.

In recent years, the FBI has delayed reviewing the ORI application, and it recently has been rejecting ORI applications, even though the statutory language is substantially similar to language adopted a few years ago by other state boards, whose ORI applications were approved in a timely manner by the FBI.

APTA is endorsing legislation to require the FBI to expeditiously process ORI applications. Once the ORI application is approved, state licensing entities would be permitted only to share with the compact that an applicant for licensure has completed the required criminal background check. No other information, including any findings in the criminal background check, would be shared with the compact. This would enable these states to become active compact members, which will expedite the ability of PTs and PTAs to provide their services to patients in need of physical rehabilitation in multiple states.

APTA and dozens of organizations are asking Congress to pass H.R. 1310—the States Handling Access to Reciprocity for Employment (SHARE) Act, to ensure that required federal background checks are completed so health care providers can participate in their respective state compacts. This legislation will enable PTs and PTAs to obtain PT Compact privileges, which will allow them to provide critical physical therapy care for patients in multiple states.

Add Physical Therapists to the National Health Service Corps Loan Repayment Program to Improve Access to Therapy Service in Rural and Underserved Areas

The National Health Service Corps addresses the *health needs of more than 21 million underserved individuals across the nation* and supports growing our nation's health care workforce in rural and underserved communities through the loan repayment program. The NHSC loan repayment program, administered by the Health Resources and Services Administration, is a federal program designed to address the nation's dire health care workforce shortage areas by recruiting certain health care providers to work in rural and underserved areas, known as health professional shortage areas, or HPSAs. The program awards scholarships and student loan repayments up to $50,000 per participant provided that the provider agrees to work in a HPSA for at least a 2-year, full-time commitment or a 4-year, part-time commitment. Based on data from the Congressional Research Service, HPSAs benefit from the NHSC program beyond the term requirements, as many providers remain in their service area. Approximately 80% continue to practice in the HPSA for a year after their service commitment, and about half remain in the HPSA for 10 years.

However, the NHSC Loan Repayment Program is missing a critical element in promoting health across the continuum of care: The program does not include a physical rehabilitation component. As experts in rehabilitation and habilitation, PTs help individuals improve overall health and prevent the need for avoidable and costly health care services.

Many of the NHSC participants often work in federal community health centers, or CHCs. However, CHCs are restricted in how physical therapist services are delivered and reimbursed under Medicare and Medicaid. Currently, a PT in a CHC can only perform services under the supervision of a primary care physician and cannot independently bill for therapy services. This restricts how CHCs may use PTs, creating a barrier to recruiting PTs to work in CHCs. Instead, many centers must refer patients out to receive physical therapy at another location, which can cause delays or impediments in care for patients in rural areas.

To address this problem, APTA urges Congress to pass H.R. 4829—the Physical Therapist Workforce and Patient Access Act, to include PTs in the NHSC Loan Repayment Program and provide federal community health centers with increased flexibilities to offer physical therapist services to their patients.

Conclusion

APTA thanks the committee for focusing attention on the importance of improving health care in rural communities. We stand ready to work with Congress on this issue and others affecting our nation's health care system. Should you have any questions regarding our comments, please contact Steve Kline with APTA Congressional Affairs at stevekline@apta.org.

Links:

https://www.valueofpt.com/

https://www.valueofpt.com/policy-and-payment/for-policymakers

https://www.dobsondavanzo.com/index.php?src=directory&view=Publications&category=Cost%20Estimation&srctype=Publications_lister_redesign

https://ptcompact.org/ptc-states

https://nhsc.hrsa.gov/sites/default/files/nhsc/about-us/nhsc-builds-healthy-communities.pdf

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AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS
4500 East-West Highway, Suite 900
Bethesda, MD 20814
301–657–3000
http://www.ashp.org

May 16, 2024

The Honorable Ron Wyden
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

The Honorable Mike Crapo
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Hearing on Rural Health and Supporting Lives and Improving Communities.

Dear Chairman Wyden and Ranking Member Crapo:

Thank you for holding this hearing on supporting lives and improving communities through access to rural health care. The American Society of Health-System Pharmacists (ASHP) is the largest association of pharmacy professionals in the United States, representing 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health system community pharmacies. Many of our members play a critical role in providing pharmacy services in rural and underserved areas.

Provider Status: Pharmacists provide accessible preventive care to many patients in rural and underserved areas. Nine in 10 Americans live within 5 miles of a pharmacy, and patients visit their community pharmacist twice as frequently as they visit primary care physicians. This is particularly true for Medicare beneficiaries, who have an average of 14 pharmacy visits per year compared to only 5 primary care encounters. Pharmacists are a significant source of care for these communities, by delivering preventive care, such as tests and immunizations, flu shots, and other vaccinations to seniors that protect them from preventable diseases and hospitalization.

To continue to protect rural and underserved seniors' access to the pharmacists' services, we call on the Committee to approve the Equitable Community Access to Pharmacist Services Act ("ECAPS") (S. 2477). ECAPS will provide the necessary payment for essential pharmacist services under Medicare Part B and ensure pharmacists can continue to protect Medicare beneficiaries in rural and underserved areas from the threat of COVID–19, influenza, RSV, strep throat, pneumococcal, and hepatitis B. Without immediate Congressional action, Medicare beneficiaries will experience difficulty obtaining essential pharmacist services for common infectious diseases that place a disproportionate burden on older Americans and can result in serious hospitalization.

Virtual Supervision: Telehealth authorities have expanded access to seniors in rural and underserved areas. One specific telehealth flexibility that must be made permanent to enable long-term success is allowing direct supervision of auxiliary personnel such as pharmacists to be provided virtually. Prior to the Public Health

Emergency ("PHE"), to be reimbursed under Medicare Part B for services provided by auxiliary personnel incident to a physician's services, a physician was required to "directly supervise" such services, which required actual physical presence by the supervising physician (42 CFR 410.32(b)(3)(ii)). During the PHE, CMS permitted direct supervision to be effectuated through the use of audio/video real-time communication, thus protecting the health and safety of providers as well as expand access to services in rural and underserved areas. This has now become the norm. Unfortunately, this flexibility is set to expire December 31, 2024. We recommend the Committee approve legislation to extend this flexibility permanently to ensure Medicare beneficiaries continue to have access to these services.

ASHP thanks you for holding this important hearing and considering our recommendations. We look forward to continuing to work with you to ensure Americans have access to the life-saving pharmacy services in rural and underserved areas. If you have questions or if ASHP can assist your office in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

Tom Kraus

BLUE CROSS BLUE SHIELD ASSOCIATION
750 9th Street, NW
Washington, DC 20001–4524
202–626–4800
https://www.bcbs.com/

The Blue Cross Blue Shield Association (BCBSA) believes everyone should have access to affordable, quality health care, no matter who you are or where you live, and we share the Committee's ongoing commitment to improving access to health care for all Americans. We thank the Chairman and Ranking Member for holding this important hearing to discuss how to improve health care access for rural communities and drive better health outcomes.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer or purchase coverage on their own. We are committed to delivering affordable and equitable access to high-quality care for every American.

BCBSA and BCBS companies are taking strong action to meaningfully address health disparities in rural areas. The two most impactful and effective ways to advance care in these communities are 1) increasing the health care workforce to better serve patients in rural communities, and 2) leveraging existing and digital health technologies to expand access to care.

BCBS Plans are partnering with and investing in innovative programs to expand workforce and drive telehealth so we can expand affordable access to quality care—no matter where the are:

- **BCBS Alabama** recently *expanded* its medical scholarship program to further address health disparities in rural and underserved areas by increasing the number of available providers. The program has graduated 29 medical professionals who now practice in rural Alabama, with that number bound to grow after the Plan renewed its initial $11 million scholarship funding and committed an additional $13 million to the program.
- **BCBS Montana** and the Caring Foundation of Montana are partnering with Montana State University (MSU) to help nursing students leverage care vans that provide requisite health screenings and assessment so that tribal communities in rural and underserved areas can *meet federal Head Start program requirements.*
- **The BCBS Louisiana Foundation** *helped fund* the Rapides Parish Public Library system to deploy telehealth kiosks in branches in rural areas of the state without existing hospitals, clinics or doctors' offices to expand community members' access to health care services.
- **Regence BlueCross BlueShield** has increased telehealth access across Washington, Idaho, Oregon and Utah, expanding access to care in largely rural areas

through strategic partnerships. With Talkspace, Regence members have access to more than 3,000 licensed mental health professionals for 24/7 support via secure messaging and live video sessions from the convenience of home. For members with substance use disorders, another partnership with Boulder Care brings in-network access to virtual addiction treatment, as well as long-term support to address social drivers of health such as stable housing and employment. Members are paired with a clinician, care advocate and peer coach for wraparound care.

- **BCBS Plans** in Illinois, Montana, New Mexico, Oklahoma and Texas have created an innovative Population Health Analytics & Research Tool (PopART) that generates insights into members' potential care needs. PopART helps clinical teams identify where care is most needed by displaying essential health and demographic features at the ZIP code-, member- and community levels in a digestible heat map.

On a national level, we continue to improve our Blue Distinction® Centers for Maternity Care program. This is especially critical for rural areas, which in too many communities across the country lack even minimal access to OB/GYNs, doulas and midwives. Our Blue Distinction Centers advance outcomes and measurement standards with the goal of recognizing higher-quality facilities that have taken action to improve maternal health outcomes while reducing health disparities. Starting this year, the Blue Distinction® Centers for Maternity Care met enhanced quality measurement standards, outperforming national averages in the following critical areas:

- 17% fewer cesarean births
- 60% fewer elective deliveries
- 26% fewer episiotomies

While BCBS companies are driving these innovations and effective programs to improve access to care and reduce costs for rural communities, more can be done. Because every community—and every patient—deserves affordable coverage, we urge Congress to:

Enact Site-Neutral Payment and Honest Billing Reforms. BCBSA encourages Congress to enact federal legislation to standardize payments for identical services provided in a physician's office and at hospital outpatient departments (HOPDs). To accomplish this, Congress should eliminate the grandfathering provision of the Bipartisan Budget Act (BBA) of 2015, which exempts certain HOPDs from site-neutral payments, and pass honest billing reform. These key reforms are included in the following bills:

- S. 1869, the *Site-based Invoicing and Transparency Enhancement Act (SITE Act),* introduced by Sens. Mike Braun (R–IN) and Maggie Hassan (D–NH), which both equalizes payment for all physician office services, regardless of ownership, and provides honest billing transparency.
- Section 204 of H.R. 5378, the *Lower Costs, More Transparency Act (LCMTA),* introduced by Rep. Cathy McMorris Rodgers (R–WA–5) and Frank Pallone (D–NJ–6), which requires HOPD owned physician offices to use a separate National Provider Identifier when billing for services provided in a physician office to ensure appropriate reimbursement. This bill passed the House by an overwhelming bipartisan majority in December 2023.

An independent analysis of the grandfathering proposal estimated federal savings of $231 billion over 10 years. The analysis also estimated $152 billion in lower out-of-pocket costs for consumers (about $470 per person in the U.S.) and spillover savings to private insurance that would reduce premiums by $117 billion. Changing payment rates in Medicare will help commercial plans negotiate more aggressively to lower costs for patients and employers. The Congressional Budget Office *estimates* Section 204 of LCMTA will reduce premiums by $1.4 billion over the 10-year budget window.[1] These policies have the potential to lower out-of-pocket costs for patients in rural areas.

Additional studies highlight the potential for significant savings and the limited impact of existing site-neutrality policies on rural outpatient providers. For example, a recent study by Avalere reports that only 2.3% of hospital outpatient revenues are subject to the site-neutral provisions of the 2015 law. An additional 10% of revenues

[1] Blue Cross Blue Shield Association. "Affordability Solutions for the Health of America." January 24, 2023, *https://www.bcbs.com/the-health-of-america/articles/affordability-solutions-white-paper,EHP_Savings_Estimates_BCBSA_01.18.2023_Final.pdf.*

would be affected if the grandfathering provisions were removed.[2] The study also notes that rural hospitals account for a much smaller share of Part B spending than do urban hospitals (10.8%) and that rural hospitals make much less use of off-campus provider-based departments (PBDs) than urban hospitals: Of all payments made to ". . . off-campus PBDs, rural hospitals represent 7.6% of payments to excepted off-campus PBDs [where the site-neutral policy does not apply] and 6.2% of payments to non-excepted off-campus PBDs."[3] Applying site-neutral payment policies as Congress intended would impact rural hospitals much more modestly than urban hospitals. We want to find a solution that protects rural providers while at the same time helping consumers with lower costs.

BCBS Plans also see a lack of site-neutral payment in our own commercial claims data. Two studies of outpatient services conclude that prices for services delivered in HOPDs are significantly higher—often five times more expensive—than when provided in an independent physician's office.[4] For example, one of the studies found that the prices for a routine 20-week OBGYN diagnostic ultrasound in an HOPD are more than 200% higher than those in the office setting. In addition, in 2022 common outpatient imaging studies, like X-rays of the foot, shoulder, ankle, wrist, and chest were on average 250% higher at HOPDs than those performed in an office setting.[5] These studies also find that HOPD prices are growing much faster than prices in other settings.

Permanently Extend and Expand Certain Telehealth Flexibilities. BCBS companies recognize the benefit of telemedicine in expanding consumer access to care when and where they need it. Telehealth and other digital health tools have been critical in addressing access gaps in communities with significant provider shortages, particularly for behavioral health treatment. BCBSA urges continued efforts to improve access to these services, while ensuring flexibility to address the care needs of each community and enhancing trust and consumer protections through HIPAA-aligned privacy protections.

To meet these goals, BCBSA supports actions to make pandemic-era telehealth flexibilities permanent under Medicare as well as legislation to increase access to mental health and substance use disorder (MH/SUD) treatment. Specifically, BCBSA supports the passage of:

- Key sections of the *CONNECT for Health Act* (S. 2016), introduced by Sens. Brian Schatz (D–HI), Roger Wicker (R–MS), John Thune (R–SD), Mark Warner (D–VA) and Cindy Hyde-Smith (R–MS), including Sections 101 and 102, which remove geographic and originating site restrictions under Medicare, enabling patients to access care in the comforts of their homes regardless of their location; Sections 107 and 108, which would repeal the 6-month in-person visit requirement prior to receiving telemental services and waive telehealth requirements during Public Health Emergencies; and Sections 301–303 which require quality measure development, provide resources, guidance and training for beneficiaries and providers.
- Key sections of the Senate Finance Committee's Telemental Health Discussion Draft, led by Sens. Ben Cardin (D–MD) and John Thune (R–SD), including Section 1, which removes in-person visit requirements for rural and federally qualified health centers, removes geographic site restrictions, and provides coverage of audio-only telehealth services when coverage of these services is "reasonable and necessary," and Section 7, which requires review and reporting on HIPAA-compliant telemental mobile apps.
- Section 107 of S. 3430, the *Better Mental Health Care, Lower-Cost Drugs and Extenders Act,* introduced by Sens. Ron Wyden (D–OR) and Mike Crapo (R–ID),

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[2] Avalere. "CMS Site-Neutral Payments Affect Small Share of Spending." January 10, 2024, *https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending*.

[3] *Ibid.*

[4] Blue Health Intelligence, "Costs for Common Health Care Procedures Significantly Higher When Performed in Hospital Outpatient Departments," September 14, 2023, *https://www.bcbs.com/sites/default/files/file-attachments/site-neutral/BHISite-Neutral-Issue-Brief.pdf;* Blue Health Intelligence, "Hospital Outpatient Prices Far Higher, Rising Faster than Physician Sites," December 14, 2023, *https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending*.

[5] Blue Health Intelligence, "Costs for Common Health Care Procedures Significantly Higher When Performed in Hospital Outpatient Departments," September 14, 2023, *https://www.bcbs.com/sites/default/files/file-attachments/site-neutral/BHISite-Neutral-Issue-Brief.pdf;* Blue Health Intelligence, "Hospital Outpatient Prices Far Higher, Rising Faster than Physician Sites," December 14, 2023, *https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending*.

which requires the Centers for Medicare & Medicaid Services (CMS) to provide information on licensure requirements for telehealth providers, including ways to qualify through interstate licensing compacts.
- S. 1001, the *Telehealth Expansion Act,* introduced by Sens. Steve Daines (R–MT) and Catherine Cortez Masto (D–NV), which would permanently exempt high-deductible health plans from the requirement of a deductible for telehealth and other remote care services.

Promote Policies to Expand Maternal Health Care and Improve Outcomes. People who live in rural communities have a higher probability of severe maternal morbidity and maternal mortality than people who live in urban communities, even after accounting for clinical conditions and socioeconomic factors.[6] BCBSA supports legislation that will expand access to maternal care and improve maternal health outcomes for people in rural communities, including:

- S. 948, *Healthy Moms and Babies Act,* introduced by Sens. Maggie Hassan (D–NH) and Chuck Grassley (R–IA), which would coordinate "whole-person" care, as well as outcome-focused and community-based prevention, would establish demo programs to expand telehealth services for pregnant and postpartum women in Medicaid.
- S. 712, the *Connected MOM Act,* introduced by Sens. Bill Cassidy (R–LA) and Maggie Hassan (D–NH), which would require CMS to report and provide resources for states for the coverage of physiologic devices and related services under Medicare to improve maternal and child health outcomes for pregnant and postpartum women.

Promote Workforce and Care Integration. Unfortunately, access to high-quality health care is often impacted by shortages of appropriate providers and support staff. Patients in rural communities feel the consequences of these shortages every day. BCBSA supports investments in initiatives that will expand, diversify, and better integrate the health care workforce; expand the availability of non-physician practitioners; and address provider burnout and promote workforce wellness. These initiatives will improve access to care which can lead to better health outcomes. To further these goals, BCBSA supports the passage of:

- Keys sections of the *Better Mental Health Care, Lower-Cost Drugs and Extenders Act,* including Section 101, which would Expand eligibility for incentives under the Medicare Health Professional Shortage Area Bonus Program to practitioners furnishing mental health and substance use disorder services; Section 104, which would promote integrated care within Medicare; Section 110, which would provide guidance and strategies to states on increasing their mental health and substance use disorder care provider capacity within Medicaid; and Section 113, which would provide guidance to states on mental health care or substance use disorder care integration with primary care in Medicaid and CHIP.
- S. 2556, the *Improving CARE for Youth Act,* introduced by Sens. Tom Carper (D–DE) and Bill Cassidy (R–LA), which would eliminate same day billing restrictions in Medicaid, allowing for better integrated care.
- S. 1378, the *COMPLETE Care Act,* introduced by Sens. Catherine Cortez Masto (D–NV) and John Cornyn (R–TX), which improves access to mental health care for seniors on Medicare by covering certain startup costs for local providers as they implement integrated care models. This bill is similar to Section 104 of the *Better Mental Health Care, Lower-Cost Drugs and Extenders Act.*

Conclusion

BCBSA commends the Committee for holding today's important hearing. More action is needed to solve the problems that rural communities uniquely face, and we look forward to working with Congress to advance health care access, quality and affordability in rural and underserved areas. If you have any questions or would like additional information, please contact me or Keysha Brooks-Coley, vice president of advocacy, at Keysha.Brooks-Coley@bcbsa.com.

David Merritt
Senior Vice President, Policy & Advocacy

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[6] American Journal of Public Health, "Rural-Urban Disparities in Adverse Maternal Outcomes in the United States, 2016–2019." February 2023. *https://ajph.aphapublications.org/doi/epdf/10.2105/AJPH.2022.307134*.

Links:

https://urldefense.com/v3/__https://click.lmsbcbs.com/?qs=4515b21af15876bbfba72339782455509135526ef2ff4b6657658012115eaaf4f4a0070e281ac3af8a79c318fdb10d353d0978d4fe73d30a__;!!OlwRUik!WomF-Vbj9WMo6OF8QHIexGkVPxyk4oWD2VYTiOpubuL1rvXoam5JOq5DObM0xCSAJAKhchkv4So0lF_0n-9l$

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https://www.cbo.gov/system/files/2023-09/hr5378table.pdf

CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM
320 Ft. Duquesne Boulevard, Suite 20–J
Pittsburgh, PA 15222
(412) 803–3650
www.CHQPR.org

Statement of Harold D. Miller, President and CEO

Chairman Wyden, Ranking Member Crapo, and distinguished members of the Committee on Finance, thank you for the opportunity to provide input on ways that Congress can help preserve and strengthen healthcare services in rural areas. Over the past decade, more than 100 rural communities across the country have lost access to essential healthcare services, such as maternity care, inpatient care, and emergency care, and hundreds more are at risk of losing some or all of those services over the next several years because of the financial problems facing rural hospitals and clinics. Current federal programs fail to address the root causes of these problems, and in some cases they are making things worse.

In order to prevent additional rural hospital closures and to support high-quality healthcare services in rural areas, I urge that Congress enact legislation that includes the following provisions:

- Require that Medicare Advantage (MA) plans pay Critical Access Hospitals and other small rural hospitals at least as much as Original Medicare pays the hospitals for the same services, and require that the plans pay claims from small rural hospitals in a timely fashion.
- Require that MA plans contract for services with any rural hospital or clinic that is willing to provide services to Medicare beneficiaries enrolled in the MA plan for the same payments that the hospital or clinic would receive if the beneficiaries were enrolled in Original Medicare.
- Require that a Qualified Health Plan sold on a health insurance exchange must include a small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.
- Require that in order to be included in the Federal Employee Health Benefits (FEHB) Program, a health plan must include a small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.
- Require that the Centers for Medicare and Medicaid Services (CMS) promptly approve a State Plan Amendment submitted by a state Medicaid agency that would require Medicaid Managed Care Organizations (MCOs) to pay small rural hospitals and clinics at least as much as those hospitals and clinics are paid by Medicare.

These requirements would require little or no increase in federal spending, yet they could help prevent many rural hospital closures. The requirements for Medicare Advantage plans would simply ensure that the large amounts of money CMS is already paying to these plans on behalf of rural Medicare beneficiaries are used to provide adequate payments to rural hospitals and clinics rather than to in-

crease profits for the health insurance companies. Similarly, the requirements for commercial insurance policies would ensure that the premiums rural residents are paying for these policies and the federal subsidies for those premiums are used to pay adequately for the services those rural citizens need. These federal requirements could encourage state insurance departments to take similar actions.

In addition, **in order to prevent additional closures of rural labor and delivery services and to enable the delivery of high-quality maternity care in small rural hospitals, I urge that Congress enact legislation that includes these provisions:**

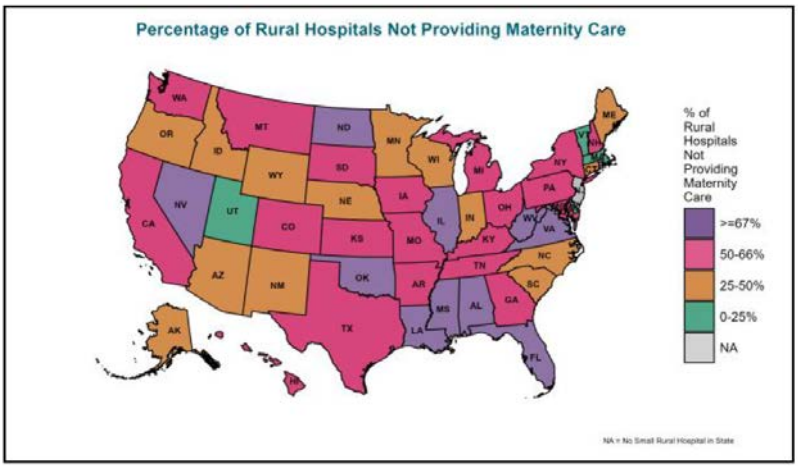
- Require that State Medicaid agencies and Medicaid Managed Care Organizations pay for labor and delivery services at small rural hospitals using a combination of Standby Capacity Payments and Delivery Fees instead of solely with fees for services, and require that payments for labor and delivery services are adequate to support the minimum fixed costs of providing labor and delivery services at rural hospitals with small numbers of births.
- Require that the Federal Employee Health Benefits (FEHB) Program provide incentives for federal employees to enroll in health insurance plans that pay for labor and delivery services at small rural hospitals using a combination of Standby Capacity Payments and Delivery Fees instead of solely with fees for services.

The rationale for these recommendations is provided below.

The Crisis Facing Rural Healthcare

Almost 700 rural hospitals—over 30% of all rural hospitals in the country—are at risk of closing in the near future, and over 300 of these hospitals are at *immediate* risk of closing. Most of the at-risk hospitals are located in isolated communities where loss of the hospital could result in the loss of all or almost all local healthcare services, including emergency care and primary care. Millions of people could be directly harmed if these hospitals close, and people in all parts of the country could be affected through the negative impacts on workers in agriculture and other industries.

Many rural hospitals have only been able to remain open by eliminating essential services in their communities. For example, over the past decade, more than 200 rural hospitals have stopped delivering babies, and *fewer than half of the rural hospitals in the U.S. currently offer labor and delivery services*. Consequently, the number of rural *hospital closures* does not measure the full extent of the *loss of healthcare access* experienced by rural communities.

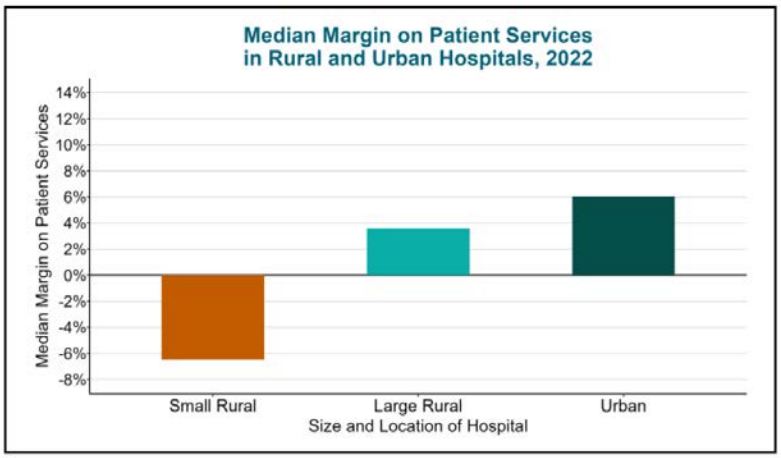


***Small* Rural Hospitals and Their Communities Need the Most Help**

The reason that rural hospitals are being forced to eliminate services or shut down entirely is because health insurance plans pay them less than what it costs to deliver essential services. The hospitals' financial losses have been growing because the cost of delivering healthcare services has been increasing and payments from health plans haven't kept up.

Higher costs have had a negative impact on profit margins at every hospital in the country. But in most cases, urban hospitals and even large rural hospitals have continued to make profits on patient services. Their profit margins may be *lower* than in the past, but the margins are still *positive*.

In contrast, most *small* rural hospitals have been *losing* money on patient services for several years, including prior to the pandemic. For them, "lower margins" means even bigger losses, and the bigger the losses, the sooner the hospital will run out of money and be forced to close. **Most of the rural hospitals that are at risk of closing are small rural hospitals, not larger rural hospitals.** We define a rural hospital as "small" if its annual expenses are below the median for all rural hospitals (about $40 million in 2022).

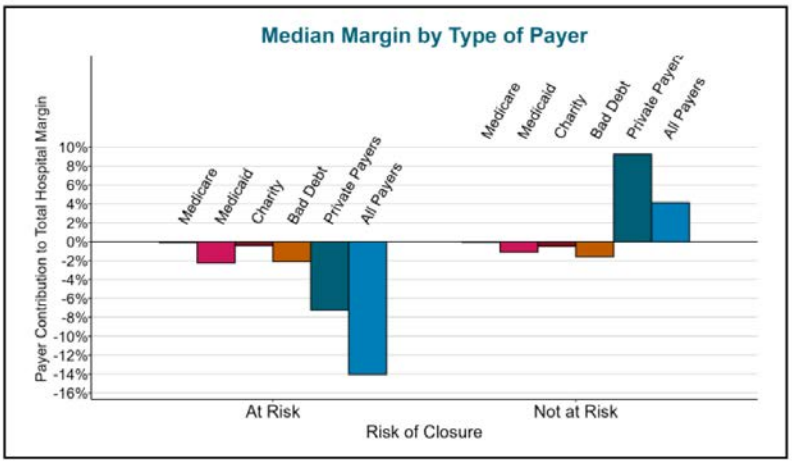


There are over 1,000 small rural hospitals in the U.S., *representing more than one-fourth of the short-term general hospitals in the country.* Small rural hospitals deliver not only traditional hospital services such as emergency care, inpatient care, and laboratory testing, but most of them also deliver primary care and inpatient rehabilitation services. Most of the communities they serve are at least a half-hour drive from the nearest alternative hospital, and in many cases, there are no other sources of health care in their community.

Most small rural hospitals were able to offset their financial losses and avoid closure over the last several years because of the significant amount of federal pandemic assistance grants they received. However, those grants have now ended, while costs have continued to increase, so small rural hospitals are facing bigger losses with no way to pay for them.

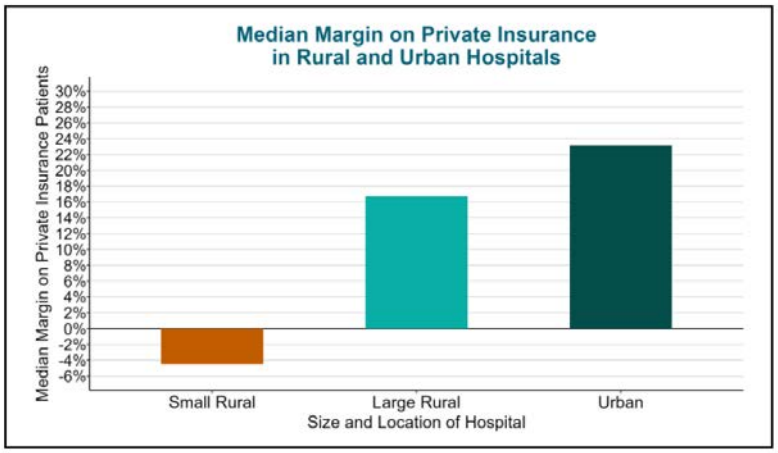
Low Payments from Private Insurance Plans Are Forcing Hospitals to Close

The primary reason hundreds of rural hospitals are at risk of closing is that private insurance plans are paying them less than what it costs to deliver services to patients. Although the at-risk hospitals are losing money on uninsured patients and Medicaid patients, losses on private insurance patients are the biggest cause of their overall losses.



Most large rural hospitals and urban hospitals make large profits on patients with private insurance. The exact opposite is true at most small rural hospitals. **Private insurance plans typically pay small rural hospitals less than what they pay large hospitals and much less than what it costs a rural hospital to deliver services in a small rural community.**

A common myth about small rural hospitals is that most of their patients are on Medicare and Medicaid and that low payments from those programs are causing the hospitals to lose money. The fact is, on average, half of all of the services at small rural hospitals are delivered to patients with private insurance. As a result, even a small percentage loss on these patients has a big negative impact on the hospital's overall margin.



There are multiple ways in which private insurance companies underpay small rural hospitals for their services:

- The insurance company pays the hospital less than it pays larger hospitals for the same service;
- The insurance company fails to pay more when the cost of delivering a service is higher in the rural area than urban areas;
- The insurance company uses problematic prior authorization rules to deny payment for a service even though the patient needed treatment and it was covered by their insurance;
- The insurance company rejects the claim submitted by the hospital for minor technical reasons;
- The insurance company delays payments by many months, forcing the hospital to borrow money from other sources to pay its own bills;
- The insurance company refuses to contract with the hospital unless it accepts low payments, since insurance plans are not required to contract with small rural hospitals under current network adequacy standards.

Large hospitals can afford to hire staff and consulting firms to negotiate with insurance companies for higher payments, to challenge inappropriate prior authorization denials, and to resubmit rejected claims until they are paid. Small rural hospitals do not have the resources to do those things, so the small hospitals end up with large financial losses for a large portion of their patients.

Medicare Advantage Plans Are a Growing Part of the Problem

Although large hospitals routinely complain that Medicare underpays them for services, Medicare is often the *best* payer for small rural hospitals. Most small rural hospitals are classified as Critical Access Hospitals, and CMS pays them for services to Medicare beneficiaries based on what it actually costs the hospitals to deliver those services, rather than paying fees that were designed for larger hospitals.

However, **the requirement to pay Critical Access Hospitals based on the actual cost of services does not apply to Medicare beneficiaries enrolled in Medicare Advantage (MA) plans. Moreover, Medicare Advantage plans are operated by commercial insurance companies, and they are permitted to use all of the same problematic methods of delaying and denying payments as other commercial insurance plans.**

About half of Medicare beneficiaries nationally are now enrolled in Medicare Advantage plans rather than Original Medicare. Although the enrollment rate has been lower in rural areas than urban areas, it has been increasing rapidly as a result of aggressive marketing efforts by Medicare Advantage plans. As a result, **many small rural hospitals are experiencing greater financial losses each year as more seniors in their community enroll in Medicare Advantage plans.**

(It is important to note that Critical Access Hospitals are supposed to be paid 101% of the actual cost of services by Medicare, but due to Congressional sequestration requirements, they currently only receive 99% of the cost. As a result, they are being forced to lose money even on Original Medicare patients. However, the payments from Medicare Advantage plans are typically even less than this.)

Current Federal Programs Fail to Address the Problems

Unfortunately, none of the recent programs created by Congress or by CMS have addressed the root causes of the problems facing rural hospitals and clinics, and in some cases, they have made the problems worse.

The Rural Emergency Hospital Program

Since 2023, rural hospitals with fewer than 50 beds have been allowed to convert to "Rural Emergency Hospital" status if they eliminate their inpatient services. Eliminating inpatient care means senior citizens and other residents of the rural community have to be transferred to a distant city if they need a short hospital stay for treatment of a chronic disease exacerbation or a common condition like pneumonia. Because of staff shortages in larger hospitals, there may not be a hospital bed readily available in any nearby city, which could result in seniors and other community residents failing to receive the care they need in a timely fashion. Also, because the rural hospital is also required to eliminate its swing beds if it converts to a Rural Emergency Hospital, local residents who currently receive inpatient rehabilitation and/or long-term nursing care in those beds can no longer receive those services close to home.

It is a myth that rural hospitals are losing money solely or primarily because they provide inpatient care to small numbers of patients. In fact, in most cases, it is just the opposite—the revenues generated by inpatient care at a small rural hospital exceed the direct costs of delivering that care. As a result, in most cases, requiring a rural hospital to eliminate inpatient care would reduce the hospital's revenues more than the reduction in costs, making the hospital worse off financially as well as reducing access to care for local residents.

The biggest causes of financial losses at most small rural hospitals are inadequate payments from insurance companies for emergency department visits and for primary care clinic visits. **Converting to a Rural Emergency Hospital would do nothing to ensure that Medicare Advantage plans, commercial health plans, or Medicaid managed care organizations pay the hospital adequately for emergency services, primary care services, and other outpatient services.** These are the payers and services that are causing the hospital to lose money today.

Moreover, a Critical Access Hospital can only participate in the Rural Emergency Hospital program if it gives up cost-based payment from Medicare for outpatient services. This would reduce the hospital's *Medicare revenues* on outpatient services rather than reduce the hospital's *losses from private insurance plans.* Although the Rural Emergency Hospital would receive a supplemental annual payment of about $3 million from Medicare, that may or may not be sufficient to offset all of the higher losses the hospital would experience due to the change in Medicare payments. As a result, the Rural Emergency Hospital would likely continue to experience losses in the future.

Value-Based Payments

CMS has created a variety of "value-based payment" programs that claim to reward high-quality, efficient care. However, most of these programs do not pay more or differently for the services that patients need. They either provide shared savings bonuses if a provider manages to reduce the total amount that Medicare spends on the provider's patients, or, increasingly, the programs require providers to take financial risk for total Medicare spending on their patients.

Most small rural hospitals cannot benefit from CMS "shared savings" programs. Most small rural hospitals do not have enough patients to meet the minimum requirements for participation in the Medicare Shared Savings Program, and even if they band together to do so, it is difficult for them to qualify for shared savings bonuses because the minimum savings threshold is so high and because rural residents are less likely to be receiving the kinds of unnecessary services that could be eliminated in order to save money. If a rural hospital hires additional staff or consultants to help it succeed in the shared savings program, it will increase its costs with no guarantee of receiving any additional payments to offset the higher expenses. If the hospital reduces the number of services it delivers to patients, it

will create savings for Medicare but it will also reduce its own revenues by more than any shared savings bonus it would receive.

Both rural hospitals and residents of rural communities would be harmed by forcing rural hospitals to take on financial risk for total healthcare spending. "Downside risk" is especially problematic for small rural hospitals, because they do not deliver and cannot control many of the most expensive services their residents may need, and a requirement that the rural hospital pay penalties when community residents need expensive services at urban hospitals would worsen the rural hospitals' financial problems. The primary goal of so-called "population-based payment" programs is to reduce Medicare spending, not to preserve access to care or to improve the quality of services for patients. The bonuses and penalties in these programs create a financial incentive for providers to withhold services that patients need, to discourage patients from receiving high-cost services, and to avoid providing care to patients who have serious health problems. This can harm rural residents rather than help them.

How to Prevent Closures of Rural Hospitals and Rural Maternity Care

Significant changes must be made in both the amounts and method of payment for rural hospital services in order to prevent more rural hospitals from closing in the future. Rural hospital closures threaten the nation's food supply and energy production, because farms, ranches, mines, drilling sites, wind farms, and solar energy facilities are located primarily in rural areas, and they will not be able to attract and retain workers if the workers cannot get adequate healthcare services.

Require That Health Insurance Payments Cover the Cost of Services in Rural Communities

Health insurance plans must pay amounts that are adequate to support the cost of services in rural areas. Payments that are sufficient to cover the cost of services at large hospitals will not be adequate at small rural hospitals because it costs more to deliver healthcare services in rural communities. This is not because rural hospitals are inefficient, but because of the smaller number of patients served relative to the fixed costs of the services. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher.

As discussed above, the primary reason small rural hospitals and clinics are losing money is not low payments from Medicare, but low payments and payment denials by Medicare Advantage plans, commercial insurance plans, and Medicaid managed care organizations. While an increase in Medicare payments to small rural hospitals and clinics could help reduce their losses, there is no reason why the Medicare program should subsidize inadequate payments from private insurance plans.

Congress can and should take action to force private insurance plans to pay rural hospitals adequately. The specific steps it could take to do so include:

- **Require that Medicare Advantage (MA) plans pay Critical Access Hospitals and other small rural hospitals at least as much as Original Medicare pays the hospitals for the same services, and require that the plans pay claims from small rural hospitals in a timely fashion.**
- **Require that MA plans contract for services with any rural hospital or clinic that is willing to provide services to Medicare beneficiaries enrolled in the MA plan for the same payments that the hospital or clinic would receive if the beneficiaries were enrolled in Original Medicare.**
- **Require that a Qualified Health Plan sold on a health insurance exchange must include a small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.**
- **Require that in order to be included in the Federal Employee Health Benefits (FEHB) Program, a health plan must include a small rural hospital or rural health clinic in its provider network if the hospital or clinic is willing to accept payments for services from the insurance plan equivalent to what it would receive for the same services from Medicare.**

- **Require that the Centers for Medicare and Medicaid Services (CMS) promptly approve a State Plan Amendment submitted by a state Medicaid agency that would require Medicaid Managed Care Organizations (MCOs) to pay small rural hospitals and clinics at least as much as those hospitals and clinics are paid by Medicare for the same services.**

As noted earlier, these requirements would require little or no increase in federal spending, yet they could help prevent many rural hospital closures. The requirements for Medicare Advantage plans would simply ensure that the large amounts of money CMS is already paying to these plans on behalf of rural Medicare beneficiaries are used to provide adequate payments to rural hospitals and clinics rather than to increase profits for the health insurance companies. Similarly, the requirements for commercial insurance policies would ensure that the premiums rural residents are paying for these policies and the federal subsidies for those premiums are used to pay adequately for the services those rural citizens need.

Moreover, **these federal requirements could encourage state insurance departments to take similar actions.** For example, state insurance departments could also require that insurance plans operating in the state contract with small rural hospitals that are willing to accept payments similar to what they receive from Medicare and to require that the plans pay small rural hospitals in a timely manner.

It is important to understand that because the at-risk hospitals are so small, increasing payments to levels sufficient to prevent closures would only cost about $5 billion per year, *i.e.*, only 1/10 of 1% of total national healthcare spending. Since most of the underpayment problem is caused by private health insurance plans, most of the increased spending would need to come from these plans, not from the federal government. Moreover, most of the higher payments would support primary care and emergency care, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Spending would likely increase as much or more than this if hospitals close, because reduced access to preventive care and failure to receive prompt treatment will cause residents of the communities to be sicker and need more services in the future.

Encourage Use of Standby Capacity Payments to Support Rural Maternity Care Services

The ability of rural hospitals to deliver maternity care services depends on whether payments from both Medicaid and commercial insurance plans are adequate to cover the costs of those services. Payments per birth that are adequate at a large hospital will be too low to support maternity care at a small rural hospital. The reason is that the total cost of having physicians, nurses, midwives, and anesthetists available to deliver babies on a 24/7 basis can be the same at a small hospital as a larger hospital, but since there are fewer births at the small hospital, the same payment per birth would generate insufficient revenue to cover that cost.

It is often assumed that low Medicaid payments and uninsured patients are the reasons hospitals lose money on maternity services, but over 40% of births in rural communities are paid for by private health plans, so inadequate payments from private payers also threaten the viability of rural maternity care. Consequently,

- States need to ensure that Medicaid payments for maternity care services at small rural hospitals are adequate to cover the costs of delivering those services, including payments made through Medicaid Managed Care Organizations (MCOs); and
- Employers need to ensure that the health insurance plans they use are paying adequate amounts for maternity care services at rural hospitals.

However, **financial losses in delivering maternity care at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* currently used to pay for these services.** A rural maternity care hospital must be staffed and ready to deliver a baby at all times, even though there will be no deliveries at all on many days. Currently, however, the hospital is only paid when it actually delivers a baby. As a result, when there are fewer pregnancies than expected, the hospital will lose money, even if payments would have been adequate for a larger number of births. Moreover, since payments are typically higher for Cesarean sections, a hospital that supports natural childbirth and reduces its C-section rate could lose money as a result.

A better approach is for private insurers and Medicaid programs to pay hospitals for maternity care services using a combination of two different types of payments instead of just fees for individual services:

1. **Standby Capacity Payments.** If a rural hospital maintains the round-the-clock staffing needed to deliver babies and perform C-sections at any time, each health insurance plan should pay the hospital a monthly or quarterly Standby Capacity Payment for each woman of childbearing age who lives in the hospital's service area and who is insured by that health plan. The amount of the Standby Capacity Payment should be equal to the total amount the hospital needs to spend in order to maintain adequate on-call staffing for labor and delivery services, divided by the total number of insured women ages 15–44 in the community. In aggregate, the Standby Capacity Payments from all health plans for their members would provide the hospital with sufficient revenue to cover the fixed costs of labor and delivery services.
2. **Delivery Fees.** In addition to the Standby Capacity Payments, the hospital should receive a Delivery Fee when it provides labor and delivery services for an individual mother. If most or all of the hospital's fixed costs for labor & delivery are paid for through the Standby Capacity Payments, the Delivery Fee would only need to cover the extra (variable) costs associated with individual births. As a result, the Delivery Fee could be smaller than current fee-for-service payments for labor and delivery. In addition, the Delivery Fee should be the same amount for a vaginal delivery and a C-section, so there is no financial penalty for the hospital or physicians if they increase the proportion of vaginal deliveries and avoid unnecessary C-sections.

Under this two-part payment system, both spending for the health plans and revenue for the hospital would be far more predictable than under the current payment system.

Alternatively, the State Medicaid agency or health insurance plan could continue paying for individual births, and then provide an additional payment to the hospital at the end of the year to make up any difference between the total payments made for births during the year and the amount the hospital would have received from a Standby Capacity payment and smaller Delivery Fees.

Congress could help **prevent additional closures of rural hospital labor and delivery services and enable the delivery of high-quality maternity care in rural communities by enacting legislation that would encourage adequate payments for maternity care and the use of Standby Capacity Payments. Legislation should include provisions that:**

- Require that State Medicaid agencies and Medicaid Managed Care Organizations pay for labor and delivery services at small rural hospitals using a combination of Standby Capacity Payments and Delivery Fees instead of solely with fees for individual services, and require that payments for labor and delivery services are adequate to support the minimum fixed costs of providing labor and delivery services at rural hospitals with small numbers of births.
- Require that the Federal Employee Health Benefits (FEHB) Program provide incentives for federal employees to enroll in health insurance plans that pay for labor and delivery services at small rural hospitals using a combination of Standby Capacity Payments and Delivery Fees instead of solely with fees for individual services.

The Need for Immediate Action

Action is needed immediately to prevent more closures of rural hospitals and rural maternity care units. Once a hospital announces it is closing, it is likely too late to save it. Moreover, long before it shuts down entirely, the hospital will probably be forced to eliminate important healthcare services, such as maternity care, in an effort to stay afloat. If a hospital continues to try and deliver maternity care services despite large financial losses, it could result in closure of the entire facility and the loss of all healthcare services. Loss of local healthcare services will not only harm patients' health, it could also cause employers to leave the community.

Failure to provide payments that will sustain small rural hospitals and rural maternity care services would be penny-wise and pound-foolish. Spending by health insurance plans would likely increase by a greater amount if the hospitals close or their maternity care units close. This is because the reduced access to preventive care and delays in treatment resulting from a rural hospital closure will cause residents of the community to have more serious health problems that require expensive serv-

ices in urban hospitals. Similarly, spending would likely increase if rural maternity care units close, because mothers and babies are more likely to experience complications if they do not have access to local prenatal, post-partum, and delivery services. Paying more now to preserve rural healthcare services is a better way to invest resources and to improve the health of all citizens.

Links:

https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

https://ruralhospitals.chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf

https://ruralhospitals.chqpr.org/downloads/Two_Types_of_Hospitals_in_US.pdf

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COALITION FOR RURAL MEDICARE EQUALITY
601 New Jersey Ave., NW, Suite 620
Washington, DC 20001

The Coalition for Rural Medicare Equality ("Coalition") thanks the Senate Finance Committee for holding the May 16, 2024, hearing on rural health care and the important role that rural health care plays in supporting and improving our communities. We appreciate the opportunity to share our perspectives on how the current way Medicare reimburses critical access hospitals (CAHs) and rural health clinics (RHCs) ends up inadvertently hurting rural patients and providers. The Coalition is comprised of rural health care providers and experts in rural health policy and operations around the country. The mission of the Coalition is to achieve the same cost, access, and quality of health care for rural beneficiaries that is afforded to all other classes of Medicare beneficiaries.

CAHs and RHCs are reimbursed under a cost-based model. This is by design to help these essential facilities continue to care for rural communities where access to care is limited. However, because of the way Medicare pays these facilities, beneficiaries served there end up paying more in coinsurance. In fact, according to the Office of Inspector General at the Department of Health and Human Services, beneficiaries can end up paying between 2–6 times as much in coinsurance for outpatient services at a CAH.[1] At a Medicare Payment Advisory Commission (MedPAC) meeting in March 2024, the Commission staff explained that, unlike patients at other facilities, patients who use CAHs and RHCs pay 20 percent coinsurance on charges. According to MedPAC, because charges are, on average, 250 percent of the cost, the cost-sharing for a rural patient is often a full 50 percent of the full payment to the hospital. In extreme cases, a patient can pay 100 percent of the cost.[2] This not only unfairly penalizes many rural patients, but it also hurts CAHs and RHCs, which see patients bypass their facilities for hospitals that are reimbursed under a prospective payment system. This is especially troubling considering that, according to a report from the Center for Healthcare Quality and Payment Reform, 150 rural hospitals closed between 2005 and 2019, and almost 700 rural hospitals are in danger of closing.[3] Seven hundred rural hospitals are a full 30 percent of all rural hospitals in the country.

In addition to the unfair impact of the current reimbursement system on coinsurance rates, the current reimbursement system limits the ways in which CAHs and RHCs can participate in programs in which those facilities can receive payment for reporting and improving quality of care. This situation has resulted in increased disparity in health outcomes between rural and urban areas. Forty years ago, age-adjusted mortality rates in rural and urban areas were equal. By 2019, mortality was 20 percent higher in rural areas.[4]

The Coalition believes all Medicare beneficiaries deserve access to quality, affordable health care regardless of their ZIP code or which kind of facility in which they receive care. We also believe in the importance of supporting the hospitals that serve our rural communities. As the Senate committee with jurisdiction over Medicare, we urge members of the Senate Finance Committee to work with the Coalition to address issues with the way CAHs and RHCs are currently reimbursed. By doing this, we can ensure that Medicare supports care for all beneficiaries who depend on it, both now and in the future. For more information on the issues described in this

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[1] *https://oig.hhs.gov/oei/reports/oei-05-12-00085.pdf.*
[2] *https://www.medpac.gov/wp-content/uploads/2023/10/March-2024-meeting-transcript.pdf.*
[3] *https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.*
[4] *https://stacks.cdc.gov/view/cdc/109049.*

statement, and the Coalition's proposed solutions, we encourage you to visit *stopunfairruralcopays.org*. You can also contact the Coalition by email at Jbell@ stopunfairruralcopays.org. Thank you once again for your focus on improving rural health care and for the opportunity to submit this statement.

COUNCIL OF ACADEMIC FAMILY MEDICINE
16th Street, NW, Suite 700
Washington, DC 20036
703–786–7997

Statement of Winston Liaw, M.D., MPH, Chair, Academic Family Medicine Advocacy Committee on Behalf of the Council of Academic Family Medicine; Chair, Department of Health Systems and Population Health Sciences, University of Houston

The member organizations of the Council of Academic Family Medicine (CAFM) are pleased to submit testimony to the Senate Finance Committee hearing, "Rural Health Care: Supporting Lives and Improving Communities." CAFM collectively includes family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, research scientists, and others involved in family medicine education.

The geographic maldistribution of primary care physicians is a problem in the United States, especially in rural parts of the nation. Rural areas lack access to primary care physicians and other specialties compared to urban and suburban areas. The COVID–19 pandemic exacerbated the situation in rural areas, which already lacked an adequate physician workforce and healthcare infrastructure. While 20% of the U.S. population lives in rural communities, only an estimated 10% of physicians practice in those communities. The distribution of physicians is influenced by training; most physicians practice within one hundred miles of their residency program.

Medicare accounts for two-thirds of public funding for residency training and program requirements that influence physician workforce distribution, making it the dominant driver of graduate medical education (GME) policy in the United States. The last major revision to Medicare GME policies took place over twenty years ago, in the Balanced Budget Act of 1997 (BBA).

The Government Accountability Office (GAO) recently released a study[1] on physician workforce, stating that "use of federal efforts intended to increase GME training in rural areas was often limited and challenging. CMS reported difficulties associated with offering GME training in rural areas, as well as using Medicare funding to support rural GME training." Recognizing the problems identified by the GAO, the Council on Graduate Medical Education (COGME) recommends that "CMS and other agencies could create other incentives that permit rural hospitals to establish fair 'total resident amounts' for GME funding and decrease the disparities between urban and rural funding."[2]

Unfortunately, rural hospitals typically cannot afford to create residency programs because they operate on narrow margins and require a predictable funding source. Moreover, caps on the number of Medicare-funded GME residents created by the Balanced Budget Act of 1997 have limited the growth of GME in rural areas and have not kept pace with the 27% rise in residents since enactment.

For the above reasons, we support two GME-based solutions to the shortage of rural primary care physicians. Over the past 5 years, federal GME policy has been undermined by an erosion in definitions of rural places.

First, we strongly support S. 230, The Rural Physician Workforce Production Act of 2023. This bipartisan, budget-neutral bill tackles the geographic maldistribution of physicians in rural areas stemming from the current structure of Medicare-funded GME. The bill's provisions would help rural teaching hospitals through changes such as lifting the caps and removing Medicare limits on rural resident

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[1] Government Accountability Office, Physician Workforce: Location and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs, GAO–17–411, May 2017, at 25–26.

[2] Council on Graduate Medical Education. Investing in a Health Workforce that Meets Rural Needs. Feb 2021. *https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/publications/cogme-rural-health-issue-brief.pdf.*

training growth; extending equitable federal funding to rural hospitals for residency training, such as Sole Community Hospitals and Critical Access Hospitals; increasing support for Medicare reimbursement of urban hospitals that send residents to train in rural healthcare facilities; establishing an elective per resident payment initiative to ensure rural hospitals have the resources to bring on additional residents; and multiple definition changes to update Medicare GME policy.

CAFM asks the Senate Finance Committee to enact one provision of S. 230 as part of any rural health package considered this year. The bill includes a change to the definition of a rural training location. The revised definition would consist of rural training outside of an urban Metropolitan Statistical Area (traditional Medicare definition of rural) or in a location with a rural-urban (RUA) code of four or higher or in a sole community hospital or within 10 miles of one. This definition more accurately depicts rural training and would allow more entities to qualify for GME payments. The narrow change addresses ongoing concerns about the current definitions of rural training locations used under the current GME program. Eighteen months of training in a rural location (as defined by Rural Urban Commuting Area codes or RUCAs) more than doubles the placement of graduates in rural community practice, and they are more likely to stay there than residents trained in an urban location.

Second, over the past few years, Congress has authorized 1,200 new Medicare GME slots with a formula to allocate 10 percent to rural hospitals over 5 years. These new residency slots were historic investments in Medicare graduate medical education and were intended to encourage physician training in rural communities. Unfortunately, a loophole allows non-rural hospitals to receive these slots, with only 12 allocated to truly rural hospitals. H.R. 8235, the Rural Physician Workforce Production Act, changes the definition to truly rural and provides a short-term fix for these hospitals for the next two years until the program sunsets.

Both CAFM-supported solutions reflect a place-based approach to funding graduate medical education (GME) in rural communities as a strategy to populate and retain physicians in rural practice. Both solutions are narrow but significant, and they start to address a comprehensive problem. Finally, the two policies are the best immediate means to resolve the geographic maldistribution of primary care physicians in the United States. A key solution to this problem is increasing physician training in rural areas. We look forward to working with you on this critical issue.

EDWARDS LIFESCIENCES
1 Edwards Way
Irvine, CA 92614

Edwards Lifesciences would like to thank Chairman Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee for hosting this important hearing on the future of health care in rural communities in the U.S. As the global leader of patient-focused innovations for structural heart disease, Edwards is in a unique position to share specific insights with the Committee based on our experience with transcatheter aortic valve replacement (TAVR) and its availability in rural communities.

In 2011, the FDA approved the Edwards SAPIEN valve as the first transcatheter aortic valve in the United States for use in patients with severe aortic stenosis (AS). Severe AS is a degenerative disease associated with significant mortality and morbidity, and replacement of the aortic valve is the only way to effectively treat the disease. There are two ways to replace the valve: surgical aortic valve replacement (SAVR) and TAVR. TAVR provides substantial value to our health care system by improving the experience of receiving treatment and population health overall by offering a minimally invasive and life-saving treatment option to patients suffering from AS, while simultaneously reducing health care costs.[1] Compared with SAVR, TAVR is associated with improved morbidity and equivalent mortality across all levels of surgical risk. Because TAVR is less invasive than SAVR, patient recovery is faster, hospital stays are shorter, and resource utilization is reduced. Compared to SAVR patients, TAVR patients experience better quality of life due to a faster, less painful recovery process following treatment, as well as a return to normal heart

[1] Baron et al., Contemporary Costs Associated With Transcatheter Versus Surgical AVR in Medicare Beneficiaries. Circ Cardiovasc Inter. 2022.

valve function that allows for a more active lifestyle.[2, 3, 4, 5] It should, therefore, come as no surprise that TAVR has now surpassed SAVR to become the standard of care for the treatment of severe AS.[6, 7, 8]

We believe the TAVR approval and coverage experience overall is a success story, highlighting the importance of FDA, CMS, and stakeholder collaboration. This partnership generated meaningful evidence that ultimately helped to support the continuous innovation and advancement in TAVR technology and expanded access to more patients.

Even with all the advancements, considerable disparities in patient access to TAVR remains—particularly in rural areas and other underrepresented communities where hospitals do not have the resources nor patient volumes to meet the site and operator requirements included in the CMS coverage requirements.

When TAVR was first approved in 2011, Edwards worked with FDA, CMS, the medical and patient communities, and industry to manage the introduction of this technology to the U.S. market and ensure that it was being used responsibly and safely. CMS crafted a TAVR National Coverage Determination (NCD) that recognized the need for a heart team to evaluate and treat TAVR patients, and invoked coverage with evidence development (CED) to allow us to work with providers to collect necessary data aligned with the FDA post-market requirements. These efforts have enabled us to track inequities associated with site eligibility requirements contained within the TAVR NCD[9, 10, 11, 12, 13] As one such example, our insights collected as part of CED revealed that implementing temporary flexibilities to hospital and provider requirements in response to the COVID public health emergency (PHE) did not compromise patient care.[14]

Using these same data, researchers have now evaluated TAVR outcomes during the PHE9 and compared them to outcomes before the flexibilities were allowed. These studies demonstrate there were no changes in TAVR outcomes when programs could operate within the pandemic-era NCD requirements. TAVR outcomes remained excellent during this time, demonstrating that hospitals and heart teams can be entrusted with these flexibilities without compromising patient outcomes. This de-facto case study demonstrates that TAVR is a mature therapy and that the COVID–19 flexibilities that impact the provision of TAVR must be made permanent. The policies that we believe should be extended include:

- **Flexibilities related to face-to-face encounters and provider specialty allow flexible staffing models to ensure access to life-saving treatments as ongoing staffing challenges persist.** In addition to a nation-wide nursing

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[2] Leon MB, et al. Transcatheter Aortic-Valve Implantation for Aortic Stenosis in Patients Who Cannot Undergo Surgery. N Engl J Med. 2010: 363:1597–1607.

[3] Smith, CR. Transcatheter Versus Surgical Aortic-Valve Replacement in High Risk Patients. N Engl J Med. 2011; 364:2187–2198.

[4] Leon MB, et al. Transcatheter or Surgical Aortic-Valve Replacement in Intermediate-Risk Patients. N Engl J Med. 2016;374:1609–1620.

[5] Mack, MJ, et al. Transcatheter Aortic-Valve Replacement with a Balloon Expandable Valve in Low-Risk Patients. N Engl J Med. 2019; 380:1695–1705.

[6] Carroll, JD, et al. STS–ACC TVT Registry of Transcatheter Aortic Valve Replacement. J Am Coll Cardiol. 2020 Nov, 76 (21) 2492–2516.

[7] Nkomo VT, et al. Burden of valvular heart diseases: a population-based study. Lancet. 2006;368(9540):1005–1011.

[8] U.S. Food and Drug Administration. FDA approves first artificial aortic heart valve placed without open-heart surgery [press release]. *http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm278348.htm*. Published November 2, 2011. Accessed November 3, 2011.

[9] Marquis-Gravel, G, et al. Geographic Access to Transcatheter Aortic Valve Replacement Centers in the United States: Insights From the Society of Thoracic Surgeons/American College of Cardiology Transcatheter Valve Therapy Registry. JAMA Cardiol. 2020; 5(9): 1006–1010.

[10] Nathan, AS, et al. Socioeconomic and Geographic Characteristics of Hospitals Establishing Transcatheter Aortic Valve Replacement Programs, 2012–2018. Circ Cardiovasc Qual Outcomes. 2021; 14(11): e008260.

[11] Nathan, AS, et al. Racial, Ethnic, and Socioeconomic Disparities in Access to Transcatheter Aortic Valve Replacement Within Major Metropolitan Areas. JAMA Cardiol. 2022 7(2): 150–157.

[12] Alkhouli, M, et al. Racial Disparities in the Utilization and Outcomes of TAVR: TVT Registry Report. JACC Cardiovasc Interv . 2019;12(10): 936–948.

[13] Brennan JM, et al., Racial Differences in the Use of Aortic Valve Replacement for Treatment of Symptomatic Severe Aortic Valve Stenosis in the Transcatheter Aortic Valve Replacement Era. J Am Heart Assoc. 2020. 9 (16): e015879.

[14] Spoon, D, et al. "Transcatheter Aortic Valve Replacement (TAVR) Outcomes during the Public Health Emergency (PHE) Flexibility Period." Accepted for publication in Mayo Clinic Proceedings. May 2025.

shortage, provider burnout, and continued hospital resource constraints, access to TAVR will continue to be challenged by a growing shortage of 2,000 cardiovascular surgeons by 2030 due to retirement and few entrants to the physician specialty.[15]

- **The waiver of facility and provider volume requirements.** This flexibility provides Medicare coverage and economic resources to programs in low population density areas, preventing the loss of local, community programs in areas where patients may otherwise delay care due to travel burden. It is estimated that 13.7 million beneficiaries over age 65, including 2.2 million minorities and 500,000 with low-income, live in communities that do not have access to TAVR.[16]
- **Expansion of telehealth authorities.** Telehealth has been critical to patient access during the PHE and provides an alternative option for patient assessment to address disparities in care that were further exacerbated for TAVR patients by the COVID–19 pandemic. Access trends among Medicare patients receiving TAVR reveal Hispanic (46%), Asian (38%), and Black (21%) patients more frequently leverage telehealth as an alternative to an in-person pre-TAVR eligibility screening versus White (20%) patients.[17] Notably, there is bipartisan support in Congress for extending this flexibility.

These changes were reflected in the following regulations during the PHE:

- ***Interim Final Rule CMS–1744–IFC:***
  - Waiver of Face-to-Face or In-Person Requirement: NCD face-to-face requirement for evaluations will not apply during the PHE.
  - Waiver of Physician Specialty Requirement: The chief medical officer for a facility may authorize another physician specialty to meet physician specialty requirements specified in an NCD during the PHE.
- ***Interim Final Rule CMS–3401–IFC:***
  - Waiver of NCD Procedural Volumes: Procedure volume requirements specified in the NCD for facilities and practitioners will not be enforced during the PHE.

The excellent TAVR-related outcomes have continued and provide evidence that TAVR cases can be conducted under flexible NCD criteria without sacrificing quality of care. No significant difference in all-cause mortality, stroke, valve-related complications, quality of life or readmissions has been observed between pre- and post-PHE registry data for TAVR.[9,18] **Reinstating these restrictions now that the PHE has been declared over adds unnecessary limitations on patient access at rural and community hospitals. Further, making these flexibilities permanent could be of particular benefit to rural hospitals, allowing them to serve more patients rather than sending them to centralized surgical centers.** Scarcity of resources creates barriers to access, and rural areas are often some of the most under-resourced. It is critical to eliminate any unnecessary burdens on patients, including through robust fit-for-purpose evidence development. Improving patients' access to TAVR within local communities is important because it can prevent life-threatening delays in treatment and enhance health care efficiency through a less-invasive alternative to SAVR.[19, 20]

Challenges presented by the COVID–19 pandemic led to significant re-evaluation of many long-standing health policies. In support of rural hospitals and rural communities, Congress can use this unique opportunity to examine the impact of specific policies on patient access and value in the delivery of care. At Edwards, we remain committed to ensuring that all patients have equitable access to life-saving innovations. TAVR stands as a powerful example of the importance of ongoing, real-world data collection and the efficiencies in the regulatory process that can be gained when we all work together to measure performance and outcomes in new patient

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[15] Williams, TE, et al. (2010). A formidable task: Population analysis predicts a deficit of 2,000 cardiothoracic surgeons by 2030. The Journal of thoracic and cardiovascular surgery, 139(4), 835–841.

[16] 2020 ACS 5 year data; table S0103, non-white population data. Hospitals within 20 miles of ZIP code.

[17] Medicare 5% File, TAVR CY2020.

[18] TVT Registry, TAVR 2020.

[19] Malaisrie, S, et al. Mortality while waiting for Aortic Valve Replacement. Ann Thorac Surg. 2014; 98:1564–71.

[20] Damluji, A, et al. Transcatheter Aortic Valve Replacement in Low-Population Density Areas: Assessing Healthcare Access for Older Adults With Severe Aortic Stenosis. Circ Cardiovasc Qual Outcomes. 2020;13(8): e006245.

populations. We look forward to working with the members of this Committee to help address system-wide disparities in access to high quality care.

Thank you for the opportunity to provide these comments. Should you have any questions, please contact Edwards Senior Vice President of Government Affairs, Leah Kegler at leah—kegler@edwards.com or 703–855–0737.

FEDERATION OF AMERICAN HOSPITALS
750 9th Street, NW, Suite 600
Washington, DC 20001
202–624–1500
FAX 202–737–6462
https://www.fah.org/

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the Senate Finance Committee hearing entitled "Rural Health Care: Supporting Lives and Improving Communities." We appreciate the Committee's efforts to better understand the health needs of rural Americans, and we look forward to continuing to work with Congress on these critical issues.

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. Tax-paying hospitals account for approximately 20 percent of community hospitals nationally.

Every day across our nation, millions of Americans in small communities depend on rural hospitals for vital and lifesaving care. Rural hospitals operate 24/7 and are pillars of the communities they serve. Many operate on thin margins and struggle to keep their doors open, with low patient volumes and a patient mix that is generally older and from lower-income backgrounds, relying heavily on Medicare and Medicaid. This unique patient demographic in rural regions often lends to a dichotomy: a high volume of Medicare-dependent patients, but a lower volume of total patients overall.

Today's hearing reflects the Committee's recognition of these challenges, and we look forward to continuing to work together to improve access to health care services in rural communities. FAH is committed to improving the health of rural Americans nationwide. To that end, we offer the following recommendations in the areas of telehealth, financial sustainability, workforce, and Medicare Advantage.

Telehealth

Since the COVID–19 pandemic, the increase in health care services provided via telehealth has promoted timely access to patient-centered care, enhanced patient choice and, most importantly, improved access to care in rural areas. Today, many patients travel over an hour for a routine doctor's appointment, and often much further to seek specialty care. Telehealth eliminates this geographic barrier and greatly lowers the hurdle for accessing quality care, enabling hospitals to meet patients literally where they are. In rural areas where it is difficult to recruit physicians and other highly trained staff, telehealth and other remote technologies can also help make up for staffing shortfalls or staff burnout. With telehealth flexibilities set to expire at the end of 2024, we urge lawmakers to build on this progress and make permanent pandemic-era Medicare telehealth provisions to ensure rural Americans have access to the care they need to improve their health.

Financial Sustainability

Rural hospitals play a pivotal role in providing access to care for over 60 million Americans in underserved communities. Providing stability to rural hospitals is critical to addressing the health needs to rural Americans. The MDH and LVH adjustment payment programs were created to ensure that qualifying rural hospitals can continue to provide much needed services in their communities by better reflecting the actual costs of providing care in rural areas, where patients are more likely to be older, lower income and sicker than those in urban areas. We urge lawmakers to make these important programs permanent to provide the financial stability, security, and certainty needed to help prevent closures and disruptions to care in rural communities.

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. Thus, the FAH strongly opposes any policies that threaten access to health care, including so-called "site-neutral" payment policies that would decrease Medicare payments to hospitals. These payment cuts do not take into account the fact that hospitals are already only paid 82 cents on the dollar by Medicare and hospitals require more funding than other sites of care because they treat sicker, lower-income patients with more complex and chronic conditions, provide 24/7 access to care in the community, and are held to a higher regulatory and safety standard. Additionally, these cuts disproportionately impact patients in rural and underserved communities where hospitals are already at risk of closing or reducing service lines such as emergency rooms and maternity care. If site-neutral payment cuts were to be enacted, rural hospitals would particularly be impacted by the financial strain, forcing difficult decisions regarding the viability of operations in rural areas.

Workforce

Perhaps the greatest challenge facing hospitals today is maintaining an adequate workforce. Hospitals in rural and underserved communities are experiencing a combination of provider burnout, physician and staffing shortages, and difficulty attracting workers to these areas. These factors cause significant strain on hospital operations and have a direct effect on their ability to meet the needs of the patients and communities in which they serve.

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.

Medicare Advantage

According to the Chartis Center for Rural Health, the growth of Medicare Advantage (MA) in rural areas could further worsen the financial stability of rural hospitals nationwide as many rural providers may not be able to effectively navigate MA's administrative requirements for payment, such as prior authorizations, which leads to increased denials.[1] A 2022 U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) report found that MA plans systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees. The OIG Report also identified patterns by which MA plans apply utilization controls to improperly withhold coverage or care from MA enrollees, including:

- *Improper prior authorization denials.* OIG found that 13 percent of prior authorization requests denied by MA plans would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* 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 MA plans actually met Medicare coverage rules and MA plan billing rules.[2]

These OIG findings reflect a broader pattern of MA plan practices that inappropriately deny, limit, modify, or delay the delivery of or access to services and care for MA beneficiaries. While these practices are harmful to hospitals nationwide, they are especially harmful to rural hospitals, many of whom are already facing tight margins. We urge lawmakers to rein in MA prior authorization and other abuses to ensure that rural hospitals can continue to provide 24/7 access to care in the community.

We look forward to working with the Committee on these critical issues impacting rural health. If you have any questions or want to discuss these comments further, please contact Charlene MacDonald at (202) 615–0599.

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[1] "Unrelenting Pressure Pushes Rural Safety Net Crisis Into Uncharted Territory" (Feb 2024), *https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf.*

[2] "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.*

MEDICAL GROUP MANAGEMENT ASSOCIATION
1717 Pennsylvania Ave., NW, #600
Washington, DC 20006
T 202–293–3450
F 202–293–2787
https://www.mgma.com/

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

Re: MGMA Statement for the Record—Senate Committee on Finance Hearing, "Rural Health Care: Supporting Lives and Improving Communities"

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Committee for holding this important hearing on supporting and improving rural healthcare. We appreciate the Committee examining the multifaceted issues facing medical groups in these regions; patient access to care is paramount, and we hope our response today will assist the Committee in enacting legislation to address the current challenges facing practices in rural areas.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

Rural practices face a multitude of challenges in maintaining their ability to operate and provide high-quality care. More than 15% of all Americans live in rural areas, and patients in these areas generally tend to be older and sicker than patients in urban centers.[1] The reality of operating a rural practice, coupled with inflation, staffing shortages, and Medicare physician payment cuts, coalesce to make it difficult for these practices to thrive. Federal policy should support and promote the success of these vital medical groups.

Key Recommendations

- **Provide an annual inflation-based physician payment update based on the Medicare Economic Index (MEI) and modernize the budget neutrality aspect of Medicare payment.** Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023,* which would provide a long-needed annual Medicare physician payment update tied to inflation, as measured by the MEI. Congress needs to also mitigate the negative impact of the antiquated budget neutrality requirements of the Medicare Physician Fee Schedule (PFS) by enacting the *Provider Reimbursement Stability Act of 2023*.
- **Make commonsense changes to the Merit-based Incentive Payment System (MIPS)** such as alleviating the reporting burden, and extending the Small, Underserved, and Rural Support (SURS) program that expired in 2022.
- **Work to address the physician shortage** by properly funding Graduate Medical Education (GME) programs and increasing Medicare-supported medical residency positions.
- **Implement prior authorization reform.** Prior authorization burden is particularly felt by rural practices and contributes to staff burnout. Congress should enact an updated version of the *Improving Seniors' Timely Access to Care Act* to alleviate what has historically been the number one regulatory burden facing medical groups. The *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* would make additional needed reforms to the prior authorization process if passed into law.
- **Permanently institute many of the telehealth flexibilities currently in place.**

[1] Centers for Disease Control and Prevention, About Rural Health, Nov. 28, 2023.

- **Provide positive financial incentives to support rural practices transitioning into value-based care.** Congress should extend the Alternative Payment Model (APM) incentive bonus at 5%, provide resources to assist practices with the transition into APMs, and allow the Centers for Medicare & Medicaid Services (CMS) the ability to set the qualifying participant threshold at an appropriate level that does not discourage APM participation. Numerous provisions in the *Value in Health Care Act of 2023* would help address these concerns.
- **Support the development of physician-led, value-based care models designed to succeed in rural and underserved communities.**

Medicare Reimbursement

While rural practices face unique challenges compared to their urban counterparts, these issues are exacerbated by the dire Medicare physician reimbursement outlook medical groups face throughout the nation. Under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), Congress repealed the flawed Sustainable Growth Rate (SGR) and reformed Medicare's approach to physician payment. While well intentioned, physician payments have not kept up with inflation or the cost of running a medical practice under MACRA's revised methodology for updating the Medicare PFS.

In addition to no annual positive payment update, medical groups also experience annual reimbursement cuts stemming from 2021 PFS changes and correlating budget neutrality requirements. CMS finalized a 3.37% cut to the Medicare conversion factor in its 2024 Medicare PFS; from January 1st to March 8th of this year, medical groups absorbed a 3.37% reduction to reimbursement. Following congressional action to partially mitigate 1.68% of the cut in the *Consolidated Appropriations Act of 2024* (CAA, 2024), physician practices are left with a 1.69% reduction for the rest of the year. These ongoing cuts are untenable for practices and must be averted to ensure the financial viability of medical groups.

The 2024 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on Medicare participation: "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation. . . . Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[2] This echoes what medical groups are saying, with 87% of groups reporting reimbursement not keeping up with inflation impacts current and future Medicare patient access.[3]

In the face of ongoing Medicare cuts, the cost of running a medical practice continue to rise—according to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63% from 2013–2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe. Eighty-nine percent of medical groups reported an increase in operating costs in 2023.[4]

An annual inflation-based physician payment update based on the MEI is needed to prevent further damage to rural medical groups' ability to continue operating. Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023,* which would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI.

Further, MGMA recommends the Committee work to mitigate the harmful impact of Medicare's budget neutrality requirements. The *Provider Reimbursement Stability Act of 2023* would modernize many aspects of Medicare budget neutrality and would make significant changes to alleviate the adverse effects practices are experiencing. The legislation would increase the triggering threshold from $20 million to $53 million (while adding an update to keep pace with inflation), institute new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates, and more.

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[2] 2024 Medicare Board of Trustees Annual Report, *https://www.cms.gov/oact/tr/2024,* May 6, 2024.

[3] MGMA, 2023 Annual Regulatory Burden Report, *https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf,* Nov. 2023.

[4] MGMA *Stat* poll, *https://www.mgma.com/mgma-stat/higher-costs-persist-for-medical-groups-even-as-inflations-growth-slows,* July 12, 2023.

MGMA urges Congress to make changes to budget neutrality in unison with the long-needed annual inflationary update. The current policies work in concert to undermine the financial viability of medical practices, as medical groups will be facing another cut in 2025 absent congressional intervention.

Merit-based Incentive Payment System (MIPS) Reform

MACRA instituted the Quality Payment Program (QPP) that includes MIPS which was intended to be an on-ramp in the transition to value-based care for medical groups to join APMs. Unfortunately, the program has been beset with issues. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities and MIPS cost practices $12,811 per physician to participate.[5] Aside from onerous reporting requirements that do not drive meaningful clinical improvements and unfairly penalize clinicians, the $500 million funding for the MIPS exceptional performance bonus expired at the end of 2022. MGMA urges Congress to extend the exceptional performance bonus, which will support physician practices as they work to comply with MIPS requirements.

Rural, small, and medically underserved practices can be disproportionately disadvantaged under MIPS. The SURS program provided direct support for these practices, but funding appropriated under MACRA expired in February 2022. MGMA encourages Congress to extend this critical program by passing the *SURS Extension Act,* as it is needed to assist practices in rural and underserved areas understand the continuously changing policies in MIPS and succeed in the program.

Healthcare Workforce

MGMA has been a longtime champion of increased funding and reasonable improvements to the GME program, as the U.S. healthcare system will face a shortage of up to 86,000 physicians by 2036.[6] We appreciate the progress Congress has made over the past few years adding Medicare-funded GME slots through the *Consolidated Appropriations Acts of 2021 and 2023,* but there is still a critical need for more doctors to treat our nation's aging population.

The *Resident Physician Shortage Reduction Act of 2023* is an important bipartisan piece of legislation that would help address the physician shortage facing the nation which is especially pronounced in rural communities. This bill would increase Medicare-supported medical residency positions by 14,000 over the course of 7 years. These slots are a lifeline to ensuring patients have access to care and we urge the Committee to support its passage.

Similarly, the Teaching Health Center Graduate Medical Education (THCGME) program provides essential training for doctors in certain outpatient settings. The THCGME program represents a great opportunity to address healthcare disparities since most of the teaching health centers are in rural and high-need areas, with over 60% of the training sites being in medically underserved communities according to Health Resources and Services Administration. MGMA recommends the Committee provide sustainable funding to this program to promote physicians treating rural and underserved communities.

There are additional critical workforce challenges as staffing shortages across clinical and nonclinical positions remain a concern for medical group practices. Fifty-six percent of medical groups reported staffing as their biggest productivity roadblock in an April 18, 2023, MGMA *Stat* poll.[7] As Congress continues to examine ways to bolster the healthcare workforce, MGMA hopes the Committee takes a comprehensive view of the staffing concerns facing medical groups to better strengthen the workforce programs under its purview.

Prior Authorization Burden Contributing to Staff Burnout

A major contributor to the healthcare workforce shortage is the worsening problem of physician and staff burnout, with 65% of physicians having reported experiencing

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[5] Dhruv Khullar, Amelia Bond, Eloise May O'Donnell, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947,* Jama Network, May 14, 2021.

[6] Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2021 to 2036, *https://www.aamc.org/media/75236/download?attachment,* Mar. 2024.

[7] MGMA *Stat* poll, *https://www.mgma.com/mgma-stats/as-healthcare-staffing-woes-linger-reduced-capacity-remains-the-biggest-roadblock-to-productivity,* Apr. 20, 2023.

burnout in 2022.[8] Many of the issues discussed in this letter compound to increase burnout—when you add prior authorization requirements that MGMA members consistently rank as their number one regulatory burden on top of these issues, it only hastens staff resignations and employee turnover. MGMA is increasingly alarmed by reports of rising prior authorization requirements—89% of medical groups stated that prior authorization requirements are very or extremely burdensome.[9] Ninety-two percent of physician practices reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests.[10] Practices are already facing significant workforce shortage issues—this situation is simply unsustainable.

The *Improving Seniors' Timely Access to Care Act,* which we anticipate will soon be reintroduced, would make welcomed changes to ease this burden. Previous iterations of this legislation had widespread bipartisan, bicameral support with over 53 Senators and 327 Representatives cosponsoring the bill in 2022. We strongly urge Congress to pass this long-needed legislation, as well as the *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* as these bills would make additional important changes to prior authorization.

Innovative Models and Technology

Telehealth

Over the past several years, telehealth technology has proven critical in maintaining access to care throughout the COVID–19 Public Health Emergency (PHE). Telehealth services are even more important for patients in rural areas where the closest practice may be hours away and patients may not have access to transportation. It is critical to enact policies building off the demonstrable success of telehealth services during the COVID–19 PHE to enable medical groups to best serve patients where they are and not unnecessarily restrict care.

MGMA appreciates Congress' extension of many important telehealth flexibilities through 2024 in the *Consolidated Appropriations Act of 2023*. Many of these policies, such as eliminating geographic and originating site restrictions, should be permanently implemented as telehealth should not be constrained to Medicare beneficiaries in facilities located in rural areas, as required prior to the flexibilities granted under the COVID–19 PHE waivers. Legislation like the *CONNECT for Health Act of 2023* would permanently institute many of these policies, facilitating sustainable telehealth treatment for patients.

APM Development

Value-based care (VBC) models must be designed to address the challenges facing rural practices if CMS wants to meet its goal of having every Medicare beneficiary in an accountable care arrangement by 2030. Rural practices face numerous barriers to both joining and successfully participating in VBC arrangements as the application requirements and parameters around many of the CMS Innovation Center (CMMI) models often do not allow rural groups to participate. Seventy-eight percent of medical groups reported that Medicare does not offer an Advanced APM that is clinically relevant to their practice, with 56% of members being interested in participating in a clinically relevant model if one were to exist.[11]

CMMI has yet to test any of the models PTAC has recommended and is missing an important opportunity to expand methods of participation. MGMA supports leveraging the expertise of PTAC to develop new, voluntary, physician-led APMs that meet the needs of rural practices.

APM Incentive Payment and Qualifying Participant Threshold

Shifting program requirements and financial incentives instituted under MACRA do not align with enabling rural practices to successfully participate in APMs. Congress recently extended the APM incentive payment at 1.88% for 2024—a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

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[8] Jackson Physician Search and MGMA, Back from Burnout: Confronting the Post-Pandemic Physician Turnover Crisis, *https://www.mgma.com/deep-dives/back-from-burnout-confronting-the-post-pandemic-physician-turnover-crisis?utm_source=referral&utm_medium=pressrelease&utm_campaign=bde-gen-oct-2022-jpsreport,* Oct. 7, 2022.

[9] *Supra* note 4.

[10] *Id.*

[11] *Id.*

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year, but Congress intervened by freezing the threshold in the *Consolidated Appropriations Act of 2023*. Practices should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate—MGMA supports giving CMS the flexibility to adjust the QP threshold so that it is not set arbitrarily high. The *Value in Health Care Act of 2023* would work to address the APM incentive payment and QP threshold problems facing practices and we support its passage.

Conclusion

MGMA thanks the Committee for its leadership in examining the multitude of issues facing rural medical groups. We look forward to working with you to craft commonsense policies that will allow medical groups in rural areas to continue providing high-quality patient care. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202–293–3450.

Sincerely,

Anders Gilberg
Senior Vice President, Government Affairs

NATIONAL ASSOCIATION OF CHAIN DRUG STORES
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703–549–3001
https://www.nacds.org/

Statement of Steven C. Anderson, FASAE, CAE, IOM, President and Chief Executive Officer

Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Wyden and Ranking Member Crapo for the opportunity to submit a statement for the record for the Senate Committee on Finance's hearing on "Rural Health Care: Supporting Lives and Improving Communities."

NACDS greatly appreciates the Committees work to improve healthcare access, innovation, and lower costs. The U.S. healthcare system incurs the highest spending and conversely yields the worst health outcomes, compared to other high-income countries.[1] The situation is even worse for **rural Americans, who tend to be sicker than their urban counterparts.** Rural Americans are more likely to die from heart disease, stroke, cancer, chronic respiratory disease, and unintentional injury.[2] Causes of this tremendous disparity include lower access to healthcare and social determinants of health such as poverty.[3] To achieve superior results, the nation desperately needs new solutions and should look toward community pharmacies. **Across the United States, but especially in rural areas, Medicare beneficiaries visit pharmacies significantly more often than primary care providers—14 visits compared to 5 visits yearly.**[4] These visits offer critical touchpoints to improve healthcare access, equity, and outcomes.

Meaningfully modernizing our healthcare system, including overdue Pharmacy Benefit Manager (PBM) reform and better leverage of the unique clinical expertise of the nation's pharmacies and pharmacists, will help prioritize health outcomes, healthcare access, and reduce spending. **Stopping the egregious PBM practices that have proven counterproductive to the nation's goals of lowering healthcare costs is fundamental to better deploying pharmacies to help take care of rural Americans.** While community pharmacies continue to offer undeniable scale and clinical expertise to profoundly improve patients' health outcomes

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[1] The Commonwealth Fund. U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. January 2023, available at: *https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.*

[2] *https://www.cdc.gov/ruralhealth/about.html#:~:text=More%20than%2046%20million%20Americans,stroke%20than%20their%20urban%20counterparts.*

[3] *Ibid.*

[4] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7364370/.*

and save downstream healthcare dollars, this capacity remains vastly untapped and undermined by pharmacy reimbursements from PBMs that are often below cost.

About **90% of Americans live within 5 miles of a community pharmacy**[5] and 86% of adults report that pharmacies are easy to access.[6] Importantly, 97% of Americans live within 10 miles of a pharmacy. Pharmacies are open extended hours—including nights and weekends—when other healthcare providers are unavailable. Across populations, people visit pharmacies more often than other healthcare settings. Moreover, **80%** of Americans support pharmacists helping patients prevent chronic diseases, a top driver of healthcare costs. And, nearly **3 out of 4 Americans support pharmacists testing for and treating common illnesses,** such as flu and COVID–19.[7]

When pharmacies were more fully leveraged during the recent public health emergency, pharmacy interventions averted more than 1 million deaths, prevented more than 8 million hospitalizations, and **saved $450 billion in healthcare costs.**[8] Additionally, a recent study found that a 50% uptake of a pharmacist-prescribing intervention to improve blood pressure control was associated with **$1.137 trillion in cost savings** and could save an estimated 30.2 million life years over 30 years.[9]

The accessibility and clinical expertise of pharmacists and pharmacies lends very well to driving solutions that improve healthcare access, promote innovations, and mitigate preventable spending that results from suboptimal health outcomes. This includes helping to bridge gaps in healthcare access resulting from the expected shortage of 86,000 physicians by 2036, which is likely to disproportionately harm rural Americans.[10] The unique footprint and infrastructure of community pharmacies should be leveraged in advancing healthcare solutions for the American people that prioritize outcomes, prevention, cost-savings, access, and equity. To better leverage pharmacies in transforming healthcare to help meet the needs of the American people, NACDS strongly recommends the Committee members consider:

1. **Support "Real PBM Reform" with the passage of measures like S. 2052, the *Protect Patient Access to Pharmacies Act,* H.R. 5400/S. 2436, the *NO PBMs Act,* and H.R. 1613/S. 1038, the *Drug Price Transparency in Medicaid Act*** as well as support broader reforms to halt the manipulative practices of Pharmacy Benefit Managers (PBMs) that continue to increase healthcare costs for patients and threaten the viability of community pharmacies to continue serving their communities, including in rural areas. PBM profits are soaring across all payer types while they make people pay more for their medicines and make it difficult for pharmacies of any size to stay open. People and communities across this country rely on their pharmacies. Many of the policies included in these measures are reflected in H.R. 5378, the *Lower Costs, More Transparency Act,* which was recently passed by the House of Representatives, and the Senate Finance Committee-approved *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act.* NACDS urges swift enactment of these reforms in 2024.
2. **Support access to pharmacist services through the successful passage of the *Equitable Community Access to Pharmacist Services Act* (H.R. 1770/S. 2477)** in Medicare Part B. S. 2477 seeks to foster Medicare beneficiary choice to access pharmacist services for common health threats, like influenza and COVID–19, building on the effectiveness and broad reach of pharmacy-based care during the recent public health emergency, including in rural and underserved areas, that saved hundreds of billions of dollars in healthcare costs.[11]
3. **Encourage the inclusion of community pharmacies in innovative healthcare models across public and private payers,** especially in the design and implementation of value-based care models that seek to explore opportunities to expand healthcare access, advance healthcare outcomes and equity, and promote healthcare savings.

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[5] *https://www.japha.org/article/S1544-3191(22)00233-3/fulltext.*
[6] *https://accessagenda.nacds.org/dashboard/.*
[7] *https://www.nacds.org/pdfs/Opinion-Research/NACDS-OpinionResearch-National.pdf.*
[8] *https://pubmed.ncbi.nlm.nih.gov/36202712/.*
[9] Dixon DL, Johnston K, Patterson J, Marra CA, Tsuyuki RT. Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States. JAMA Netw Open. 2023;6(11).
[10] *https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.*
[11] *https://pubmed.ncbi.nlm.nih.gov/36202712/.*

1. PBM Reform

PBMs' opaque and self-serving business practices, including their abuse of pharmacy performance measures in the Medicare Part D program, lead to inflationary effects on drug prices, restrictions on patient access, and unfair and below-cost pharmacy reimbursement. The ability of pharmacies to provide prescription medications and related care to patients in rural settings is often controlled and manipulated by the three largest vertically integrated PBM insurers, which threatens pharmacies' viability and the patients who rely on them for care and access.

America's pharmacies have been struggling with reimbursement challenges for decades, due to or exacerbated by the absence of oversight and understanding of the competition-eroding practices of PBMs that impact timely patient access, pharmacy sustainability, and pharmacy's innovative vision to empower patients' total health and wellness. As illustrated by MedPAC, **Medicare Part D's direct and indirect remuneration (DIR) fees, or fees that PBMs claw back from pharmacies weeks or months after they pay pharmacy claims, skyrocketed from $8.7 billion (11%) in 2010 to $62.7 billion (29%) in 2021,** which is in part due to the expanded market leverage of PBM-insurers and a non-transparent pharmaceutical supply chain. As we've seen historically, these challenges could lead to beneficiary non-adherence, financial harm to beneficiaries, downstream hospitalizations resulting in increased healthcare costs, and more pharmacy closures.

NACDS applauds Chairman Wyden and Ranking Member Crapo for prioritizing this bipartisan issue of PBM reform this Congress and for your continued commitment to fight for better healthcare and lower costs for Americans. Comprehensive PBM reform is needed to help our healthcare system innovate and instill increased transparency and accountability for PBMs, to help ensure the economic viability of pharmacies, and to help foster heightened access to healthcare and improved health outcomes for the people and communities they serve.

The Pharmacy Benefit Manager Marketplace and Impact on Pharmacies

Prescriptions filled by patients who are paying cash without any form of insurance or discount card account for only about 3% of the total volume of prescriptions.[12] While approximately 91% of prescriptions filled have a payment component coming from Medicare Part D, Medicaid, or a commercial insurance plan, these plans are ordinarily administered by PBMs. The top three PBMs manage about 80% of prescription drug volume.[13] Five of the top six PBMs are owned by large national health insurers. This business environment makes it very difficult for pharmacies to negotiate fair business practices and transparency because the PBMs and health insurers have more commercial market power and leverage in the relationship due to their size and scale. This creates a one-way street with negative consequences for patients, pharmacies, employers, taxpayers, and communities—seemingly for all but the PBMs and payers.

Retail pharmacies are in crisis, facing unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing prescription drugs. Dire financial pressures have forced an alarming number of pharmacies to take drastic steps, such as possibly paring back hours of operation and delaying innovative care services that otherwise could improve health outcomes. PBMs' retroactive fees and claw backs often occur weeks or months after a transaction closes, when the PBM arbitrarily decides to recoup a portion of the pharmacy's reimbursement. These fees and claw backs have made the economic viability of community pharmacies increasingly difficult, due to the unpredictability of reimbursement and the increased damage to bottom lines.

PBM tactics may be contributing to pharmacy closures, which leads to a reduction in access to vital healthcare services, especially in rural areas where options are already limited. Communities across the nation depend on neighborhood pharmacies among all healthcare destinations. **A recent study published in the *Journal of the American Medical Association* found that pharmacy closures led to a significant drop in medication adherence for older adults taking cardiovascular medications, which has obvious, negative implications for patient health and healthcare costs.** Preserving patient access to robust pharmacy provider services and networks like health screenings, disease state management, vaccinations (*e.g.,* flu, COVID–19), patient counseling, medication adherence, and test-

[12] Source: IQVIA, National Prescription Audit & RxInsight, June 2022; Approximately 5.4% of patients use a discount card to assist with payment.

[13] *https://www.xcenda.com/insights/skyrocketing-growth-pbm-formulary-exclusions-concerns-patient-access.*

ing—all in addition to essential medication access—can help improve health outcomes and generate overall healthcare savings for Americans.

We look forward to continuing to work with the Committee and other Members of Congress to stop the manipulation by PBMs both domestically and internationally once and for all because the clock is ticking. Without PBM reform, we can expect there to be continued increases in patients' medication costs, limits on patients' choice of pharmacies, restrictions on access to medicines that are right for patients, and jeopardy of the sustainability of the pharmacies and pharmacy teams on whom patients rely.

To that end, please see below **NACDS' Principles of PBM Reform** to increase transparency and ensure comprehensive reform of harmful PBM tactics and practices:

I. Help to Preserve Patient Access to Pharmacies by Addressing PBM's Retroactive Pharmacy Fees

Retroactive DIR Fees/Claw Backs—Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursements may diminish access to care *(e.g., pharmacies being forced to close their doors or pare back hours and healthcare services)* when PBMs are unpredictable, not transparent, and payment falls below a pharmacy's costs to acquire and dispense prescription drugs. Policymakers should consider enacting laws that prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment and obligating them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services.

II. Provide Fair and Adequate Payment for Pharmacy Patient Care Services

Reasonable Reimbursement & Rate Floor—Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to continue providing valuable medication and pharmacy care services to communities. Policymakers should enact laws to adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs to help maintain robust public access to pharmacies.

Standardized Performance Measures—A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies' input and create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the State level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should enact laws to standardize PBMs' performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract to promote harmonization in the healthcare system and improvements in health outcomes.

III. Protect Patient Choice of Pharmacies

Specialty—Some PBMs require patients with rare and/or complex diseases to obtain medications deemed "specialty drugs" from designated "specialty pharmacies" or mail-order pharmacies which impedes patient access to their convenient local neighborhood pharmacies where specialty drugs are filled as well. Prescription drugs should not be classified as "specialty drugs" based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should enact laws to establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access and prohibit PBMs from steering patients to only specialty pharmacies, including those owned by the PBMs, for their prescription needs.

Mail Order—Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM.

Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.

Any Willing Pharmacy—Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should enact laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM to help maximize patient outcomes, and cost savings and ensure patient access to any willing pharmacy of their choice.

IV. Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients

Audits—PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality of care patients receive. Policymakers should enact laws that support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.

Oversight Authority—There are growing concerns that pro-pharmacy and pro-patient legislative successes might be undercut if PBMs fail to comply with such laws and/or states fail to fully enforce these laws. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM reimbursement practices that may harm patients and the healthcare system as we know it, especially at the pharmacy counter, and empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursements.

2. Support Access to Pharmacist Services

Despite their proven ability to improve health outcomes and save downstream healthcare dollars, today, pharmacists are among the only healthcare professionals omitted from Medicare statute as Part B providers. Consequently, pharmacists' accessibility and clinical expertise have been largely untapped in promoting better care quality, value, and access, including in rural and underserved communities. Bipartisan legislation (H.R. 1770/S. 2477, the *Equitable Community Access to Pharmacist Services Act*) would help address this omission in Medicare by providing payment for essential pharmacist services under Medicare Part B and ensure pharmacists can continue to protect vulnerable senior communities. As mentioned above, pharmacy interventions during the COVID–19 pandemic averted more than 1 million deaths, prevented more than 8 million hospitalizations, and saved $450 billion in healthcare costs.[14] This legislation builds on that proven success and would help support Medicare beneficiaries with the option to seek routine care for common illnesses from their local pharmacies. This legislation is critical to helping enhance access and quality, in a manner that meaningfully supplements existing care capacity in a tangible and cost-effective way. Consider, for example, individuals who may benefit from having additional access options and the choice to seek routine healthcare services at their local pharmacies, instead of foregoing care until their condition worsens and ultimately leads to a costly hospital visit that could have been avoided. Congress can help the nation achieve a healthier and more sustainable healthcare ecosystem, prioritizing access, outcomes, and value, especially in rural communities, by supporting the successful passage of the *Equitable Community Access to Pharmacist Services Act.*

Throughout the COVID–19 public health emergency, pharmacies were a trusted, equitable provider of vaccinations, tests, and antivirals, providing about 340 million COVID–19 vaccines, in addition to more than 42 million tests, and dispensing more than 8 million antiviral courses.[15] Compared to medical centers, pharmacies provided more than 90% of COVID–19 vaccinations.[16] During 2022–2023, more than two-thirds of adult COVID–19 vaccinations were administered at pharmacies.[17]

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[14] *https://pubmed.ncbi.nlm.nih.gov/36202712/.*
[15] *https://www.liebertpub.com/doi/10.1089/hs.2023.0085.*
[16] *https://www.iqvia.com/insights/the-iqvia-institute/reports/trends-in-global-adult-vaccination.*
[17] *https://www.liebertpub.com/doi/10.1089/hs.2023.0085.*

With respect to testing, pharmacies provided 87% of the free tests administered through the Improving Community Access to Testing (ICATT) program.[18] Similarly, in considering pharmacies' impact on antiviral access, HHS reported that 87.5% (35,000 of the 40,000) antiviral dispensing sites were pharmacies.[19] Pharmacies unequivocally demonstrated their ability to meaningfully expand critical access to care across vulnerable communities during the recent public health emergency, and the American people have taken notice. According to a poll conducted by Morning Consult and commissioned by NACDS in October 2023, **81% of adults in the U.S. believe it's important for their state to update its policies to ensure that patients permanently have the same access to pharmacy vaccination, testing, and treatment services that were available during the COVID–19 pandemic.**[20]

Not only did pharmacies provide unparalleled access to COVID–19 vaccines, tests, and antivirals, pharmacies surpassed expectations when it came to serving vulnerable and underserved communities. For example, 43% of people vaccinated through the Federal Retail Pharmacy Program were from racial and ethnic minority groups, exceeding CDC's goal of 40%—the approximate percent of the U.S. population comprised of racial and ethnic groups other than non-Hispanic White.[21] Pharmacies also supported concerted efforts to foster testing and antiviral access in vulnerable and rural communities, helping to ensure access points across diverse populations, especially in those communities without other healthcare providers within reach.

We urge the Committee to leverage community pharmacies moving forward to help achieve your goals to improve health and lower downstream spending, including in rural and underserved areas. It is clear that the American people deserve more accessible options to improve their health, including access to the clinical care and expertise of their local pharmacist that proved irreplaceable over the last three years. The Committee can help make better health and lower downstream costs a reality by supporting the successful passage of the *Equitable Community Access to Pharmacist Services Act*. More information on this important legislation is available from the Future of Pharmacy Care Coalition.

3. Encourage the Inclusion of Community Pharmacies in Innovative Healthcare Models

Healthcare payment model reform to reward value-based care, better quality, and improved clinical outcomes can help align incentives toward what really matters—better health, while lowering unnecessary and preventable costs for our healthcare system. However, despite a multitude of research examples and published literature on the value of pharmacies and pharmacists to improve health outcomes through clinical services and save downstream healthcare dollars, pharmacists and pharmacies have yet to be directly engaged as care providers in the existing CMS Innovation Center's value-based care models—and further opportunities exist to engage pharmacies in value-based care across commercial payers, as well. NACDS urges the Committee to consider opportunities for commercial plans to include pharmacists and pharmacies in innovative healthcare models, including value-based care. More detail on the tremendous value of including pharmacies in the CMS Innovation Center's work, for example, to advance value-based care can be found in a 2021 report.

The 2021 report highlights a myriad of evidence supporting the clinical effectiveness of pharmacists to move the needle on healthcare quality, outcomes, and value, including in rural and underserved populations. For example, a CMS Innovation Center-funded, pharmacy-led chronic care management initiative was designed to serve an underserved population. This initiative aimed to optimize patient health and reduce avoidable hospitalizations and emergency visits for high-risk patients by integrating pharmacists into safety net clinics. This collaborative program resulted in reduced rates of uncontrolled blood sugar by nearly a quarter (23%), improvements in LDL with 14% more patients controlled, and improvements in blood pressure with 9% more patients controlled at 6 months in the intervention group (collaborative care model with pharmacists as leads) versus the control group (primary care

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[18] Miller MF, Shi M, Motsinger-Reif A, Weinberg CR, Miller JD, Nichols E. Community-based testing sites for SARSCoV-2—United States, March 2020–November 2021.MMWR Morb Mortal Wkly. 2021;70(49):1706–1711.

[19] U.S. Department of Health and Human Services. *https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasuresagainst-covid19.html.*

[20] *https://www.nacds.org/pdfs/Opinion-Research/NACDS-OpinionResearch-National.pdf.*

[21] *https://www.gao.gov/assets/720/718907.pdf.*

physicians only). Through this project, pharmacists identified 67,169 medication-related problems in 5,775 patients, which resulted in a 33% reduction in readmissions per patient per year.[22]

Additionally, pharmacists as medication experts are positioned to help reverse increased spending attributable to suboptimal medication use and promote better health outcomes. For example, it was estimated that up to $21.9 billion could be saved within the U.S. healthcare system by optimizing medication use.[23] Also, it has been estimated that lack of medication adherence causes 125,000 deaths, at least 10% of hospitalizations, and hundreds of billions of preventable healthcare spending.[24] Healthcare spending on non-optimal medication therapy is estimated at **$528.4 billion per year**[25] and medication non-adherence is estimated to cost the system **$290 billion** per year.[26] Importantly for Medicare beneficiaries, it was recently estimated that medication nonadherence for diabetes, heart failure, hyperlipidemia, and hypertension resulted in billions of Medicare fee-for-service expenditures, millions in hospital days, and thousands of emergency department visits that could have been avoided. If the 25% of beneficiaries with hypertension who were nonadherent became adherent, Medicare could **save $13.7 billion annually, with over 100,000 emergency department visits prevented and 7 million inpatient hospital days that could be averted.**[27] Pharmacists can help curb these wasteful spending trends and improve health more broadly.

Also, looking across quality measures used in existing CMS programs, pharmacists are well positioned to help address a wide variety of quality measures by optimizing medication use, improving uptake of preventive care, like screenings and vaccinations, and supporting improvements in chronic disease control. Research continues to support pharmacists' ability to meaningfully impact these priority clinical areas, yet pharmacies and pharmacists have not had the opportunity to directly engage in the CMS Innovation Center's models, and opportunities exist to further leverage pharmacies in innovative healthcare models across private payers, as well.

The Committee should act on opportunities to improve outcomes, advance access, and reduce preventable healthcare spending by leveraging community pharmacies in innovative healthcare models. Doing so would not only strengthen development of innovative care models, but would also support needed advancements in healthcare access, including in rural areas, in addition to healthcare technology and data interoperability.[28]

Conclusion

NACDS thanks the Committee for the opportunity to share ideas on how Congress can meaningfully improve healthcare especially for rural Americans. As PBMs attempt to run out the clock on real PBM reform, we urge the Committee to continue to keep this bipartisan healthcare matter top of mind this Congress to help protect Americans and their pharmacies. For questions or further discussion, please contact NACDS' Sara Roszak, Senior Vice President, Health and Wellness Strategy and Policy at sroszak@nacds.org or 703–837–4251.

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[22] Chen SW. Comprehensive Medication Management (CMM) for Hypertension Patients: Driving Value and Sustainability. University of Southern California. *http://betheresandiego.org/storage/files/cmm-for-htn-usc-steven-chen-condensed-slide-deck.pdf;* Chen SW. Integration of Pharmacy Teams into Primary Care. The Center for Excellence in Primary Care and the Center for Care Innovations. May 2015. *https://www.careinnovations.org/wp-content/uploads/2017/10/USC.CEPC_.pharm_webinar_FinalV.pdf.*

[23] Shrank WH, Rogstad TL, Parekh N. Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings. JAMA. Published online October 07, 2019322(15):1501–1509. doi:10.1001/jama.2019.13978.

[24] Viswanathan M, Golin CE, et al. Interventions to Improve Adherence to Self-Administered Medications for Chronic Diseases in the United States: A Systematic Review. Ann Intern Med. 2012. *https://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states.*

[25] Watanabe JH, McInnis T, Hirsch JD; "Cost of Prescription-Drug Related Morbidity and Mortality;" Annals of Pharmacotherapy; March 26, 2018. *http://journals.sagepub.com/doi/10.1177/1060028018765159.*

[26] Rosenbaum L, Shrank WH; "Taking Our Medicine—Improving Adherence in the Accountability Era"; New England Journal of Medicine; August 22, 2013. Shrank WH, Polinski JM; "The Present and the Future of Cost-Related Non-Adherence in Medicare Part D;" J Gen Intern Med 30(8):1045–6.

[27] Lloyd, Jennifer T., Maresh, Sha, Powers, Christopher, Shrank, WH, Alley, Dawn E; "How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program?"; Medical Care; January 2019.

[28] *https://leavittpartners.com/wp-content/uploads/2023/04/Pharmacy-Data-Interoperability-04.03.23.pdf.*

Links:

https://pharmacycare.org/

https://www.nacds.org/pdfs/pharmacy/2021/MedicareMedicaidInnovationMission.pdf

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NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS
1009 Duke Street
Alexandria, VA 22314

On behalf of the over 5,500 Rural Health Clinics (RHC) across the nation, we sincerely appreciate the opportunity to provide a statement for the record.

The RHC program, first created in 1977, provides outpatient care for over 60% of rural America and 11% of the entire country (approximately 38.7 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America. However, we hope this statement will serve as a resource for the Committee on healthcare trends presenting challenges and opportunities unique to RHCs.

While much of the conversation around rural health is surrounding rural hospitals and other inpatient facilities, we implore the Committee to prioritize legislation that supports the sustainability of the entire healthcare delivery system in rural communities—inpatient **and** outpatient.

This statement is centered around the following RHC-specific issues:

1. Telehealth Policy;
2. Outdated Conditions of Certification for RHCs; and
3. Medicare Advantage;

Telehealth Policy

Telehealth represents a massive opportunity to improve access to care in rural areas. However, the current telehealth policy threatens rural health clinics, giving fee-for-service providers stronger incentives to invest in telehealth than safety-net providers. The longer this remains the case, the more likely it is that RHCs and FQHCs will fall behind in the adoption of telehealth relative to their traditional peers.

RHCs and FQHCs were not included in HHS's emergency expansion of telehealth policy. For a few weeks at the beginning of COVID, fee-for-service providers were able to offer telehealth services to their patients, while RHC and FQHC patients were forced to come in-person to receive a Medicare-covered healthcare service. The CARES Act rectified this issue and allowed RHCs and FQHCs to serve as distant site providers but that legislation did not allow RHCs and FQHCs to bill for telehealth normally. Instead, the CARES Act created a "special payment rule" that paid RHCs outside their normal All-Inclusive Rate methodology at a level that is significantly less than what RHCs receive for in-person services. This stands in stark contrast to traditional physician offices which receive payment parity between in-person and telehealth services.

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, billed whenever an RHC provides one of the 200+ telehealth services reimbursable by Medicare, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth properly, which hinders their ability to properly participate in ACOs and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that telehealth should work this way for all services, not just mental health services. Furthermore, despite receiving reimbursement parity for mental health services delivered via telehealth, data has not shown widespread improper utilization of this benefit, *i.e.,* non-safety net providers taking advantage of the enhanced reimbursement methodology.

We are pleased to see legislation introduced this Congress that would rectify this payment issue, including the CONNECT for Health Act of 2023 (S. 2016) and the Telehealth Modernization Act (S. 3967). These would both eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs.

We are pleased to see the recent work of the House committees of jurisdiction on telehealth post-2024. The Energy and Commerce Subcommittee on Health marked up and unanimously advanced a package of telehealth flexibilities based on the Telehealth Modernization Act, through December 31, 2026. Notably, this legislation includes a fix to the current RHC/FQHC telehealth reimbursement disparity.

While the Ways and Means Committee also advanced a 2-year extension, they simply extended current RHC/FQHC policy, *i.e.,* a continuation of the special payment rule and payment disparity.

We look forward to seeing the Senate Finance Committee's continued work on this issue prior to current flexibilities expiring on December 31, 2024, and urge the Committee to rectify the RHC/FQHC telehealth reimbursement disparity in the next extension, demonstrating its ongoing support of our nation's outpatient safety-net providers and the patients they serve.

Outdated Conditions for Certification

The Rural Health Clinic program was created in 1977, and the regulations governing the conditions for certification were finalized in 1978. As you might imagine, the 45-year-old ruleset is in severe need of modernization. For this reason, we strongly support the Rural Health Clinic Burden Reduction Act (S. 198), which is a compilation of uncontroversial and cost-neutral policies that simply modernize the RHC conditions for certification.

When RHCs were created, the program broke ground by being the first place where Nurse Practitioners could bill Medicare directly for their services. However, as this was new territory for Nurse Practitioners, Congress included a series of physician oversight responsibilities as a condition for RHC certification.

Flash forward to 2023, and 27 states have granted Nurse Practitioners full practice authority. But state scope of practice does not matter if the NPs work in a Rural Health Clinic because the RHC conditions for certification still require physicians to see patients in the clinic and review medical charts among other oversight responsibilities. The end result is that these NP-led RHCs are forced to comply with outdated federal RHC scope of practice rules even though they would have full practice authority in other facility types in their state.

The current statute governing conditions for certification as an RHC simply does not allowing clinicians to practice to the top of their license. The RHC Burden Reduction Act would rectify this by aligning RHC scope of practice laws with state scope of practice laws.

Other outdated conditions for certification require RHCs to maintain lab equipment that is rarely used and discourage the integration of behavioral health in the RHC setting. These rules only add unnecessary burden and cost for RHCs. Congress has an opportunity to improve rural health in a cost-neutral manner by passing the RHC Burden Reduction Act to modernize the Rural Health Clinic conditions for certification.

Medicare Advantage

The RHC program incentivizes providers to practice in rural areas through two major benefits: enhanced Medicaid reimbursement and enhanced traditional Medicare reimbursement.

Operating as an RHC provides no benefit relative to Medicare Advantage (MA) reimbursement. This fact stands in contrast to Federally Qualified Health Centers (FQHCs), who receive supplemental payments from Medicare which make up the difference between what traditional Medicare would pay and what the Medicare Advantage plans contract with them for. This policy ensures that FQHCs are not disadvantaged if their patients are increasingly choosing to enroll in Medicare Advantage plans.

As Medicare Advantage enrollment now exceeds traditional Medicare enrollment, RHCs are facing increasing financial strain from MA plans who are spreading rapidly in certain rural markets and refuse to pay RHCs the All-Inclusive Rate (AIR) that traditional Medicare does. In a recent NARHC survey, 48% of RHC respondents indicated that MA reimbursed them slightly (18.4%) or significantly (29.5%) less than traditional Medicare.

Additionally, RHCs must negotiate contracts with each and every Medicare Advantage plan and are reimbursed according to the terms of that contract. Some RHCs are able to negotiate reimbursement comparable to traditional Medicare but many RHCs have little leverage to walk away from the negotiating table in areas where Medicare Advantage plans have significantly increased enrollment. These negotiation challenges also may increase pressures on RHCs to consolidate as oftentimes larger systems have more negotiating power.

These data points are of significant concern to RHCs. Without adequate reimbursement, RHCs will no longer be able to provide essential outpatient services in rural, medically underserved communities across the country.

NARHC advocates for the creation of a reimbursement floor policy. Such a policy would allow RHCs and Medicare Advantage plans to continue to negotiate contracts with each other while also ensuring that MA plans must offer a reasonable reimbursement level that does not jeopardize access to care. As the FQHC wrap policy provides FQHCs benefits relative to Medicare Advantage, an RHC floor payment policy would ensure that the shift from traditional Medicare to Medicare Advantage does not harm access to care in rural America.

Additionally, like nearly all providers across the country who contract with Medicare Advantage plans, Rural Health Clinics feel immense administrative burden associated with the stringent prior authorization utilized by MA plans. NARHC is appreciative of the efforts by CMS to lessen these impacts and reduce the waiting time as well as increase transparency on the cause for denials, however particularly for rural patients with transportation challenges, any prior authorization timeline longer than real-time decisions significantly delays and interrupts access to care.

RHCs consistently report the need, but not the financial resources, to hire additional administrative staff to process prior authorizations, as well as track down reasons for denials, including for previously approved care. We encourage the Committee to consider further opportunities to address these access barriers this Congress, as well as to hold plans accountable for negative impacts to the health of the patient resulting from their delays and denials.

Conclusion

The National Association of Rural Health Clinics thanks the Senate Finance for organizing this hearing. We hope that the above statement helps illuminate some of the policy obstacles and opportunities facing the 5,500 Rural Health Clinics across the country. Should the Committee have any questions, the NARHC is happy to serve as a resource. Please contact us by phone at (202) 543–0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.

Links:

https://www.narhc.org/News/30432/Survey-Emphasizes-Scale-and-Significance-of-the-RHC-Program

https://www.narhc.org/News/28244/NARHC-Sends-Letter-to-Trump-Administration-on-Telehealth-Services-During-Covid-19-Pandemic

https://www.narhc.org/News/28271/CARES-Act-Signed-Into-Law

https://www.narhc.org/narhc/RHC_Burden_Reduction_Act.asp

https://ojin.nursingworld.org/table-of-contents/volume-26-2021/number-2-may-2021/post-covid-19-reimbursement-parity-for-nurse-practitioners/

NATIONAL COMMUNITY PHARMACISTS ASSOCIATION
100 Daingerfield Road
Alexandria, VA 22314–2888
703–683–8200 **Phone**
703–683–3619 **Fax**
https://www.ncpa.org/

Chairman Wyden, Ranking Member Crapo, and members of the committee:

The National Community Pharmacists Association (NCPA) welcomes the opportunity to provide a statement for the record to the full committee hearing on Rural Health Care: Supporting Lives and Improving Communities. NCPA represents America's community pharmacists, including 19,400 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications

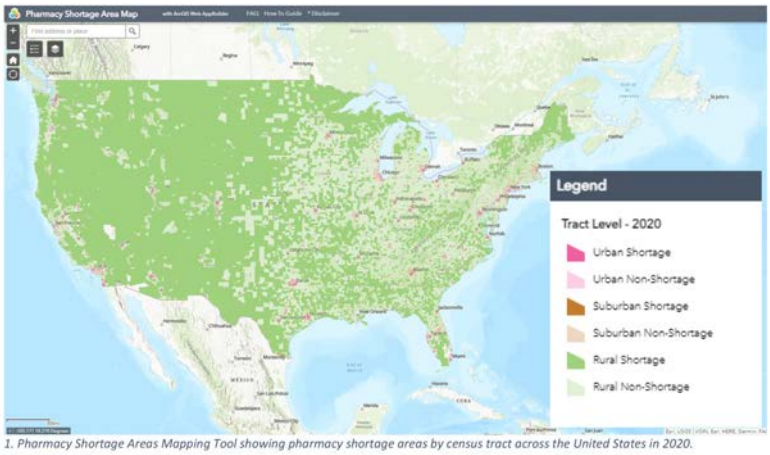
in both community and long-term care (LTC) settings. Together, our members represent a $94 billion healthcare marketplace, employ 230,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers.

With 44% of independent community pharmacies located in an area with populations less than 10,000,[1] our members are deeply embedded in the fabric of rural communities, providing essential health care services to millions of Americans living in underserved areas. Research from the USC–NCPA Pharmacy Access Initiative shows that across the country, roughly 25% of neighborhoods are pharmacy shortage areas,[2] and when a pharmacy shortage area gains pharmacy access, it is most likely due to an independent pharmacy opening.[3] Through our advocacy efforts, educational programs, and innovative initiatives, NCPA is committed to ensuring access to quality health care for all, regardless of geographic location.

Rural communities face unique challenges in accessing quality health care services. Limited resources, including healthcare facilities and providers, geographic isolation, and socioeconomic factors, contribute to disparities in health outcomes. These challenges are further exacerbated by the closure of rural hospitals and the shortage of primary care physicians, leaving many rural residents without access to critical health services.

Community pharmacists play a vital role in addressing these challenges and improving health outcomes in rural areas. As trusted healthcare providers, pharmacists are often the most accessible healthcare professionals in rural communities. They provide essential services, including medication therapy management, immunizations, chronic disease management, and preventive care screenings, helping patients manage their health conditions and avoid costly hospitalizations.

We are pleased to highlight the USC–NCPA Pharmacy Access Initiative, a collaborative effort between the University of Southern California (USC) School of Pharmacy and NCPA, aimed at expanding access to pharmacy services in underserved communities. This initiative has developed a Pharmacy Shortage Areas Mapping Tool, which identifies pharmacy shortage areas at the neighborhood level. This tool was developed using prior research from the University of Southern California College of Pharmacy combined with spatial analysis. An example of the mapping generated is shown below in Figure 1 and Figure 2.

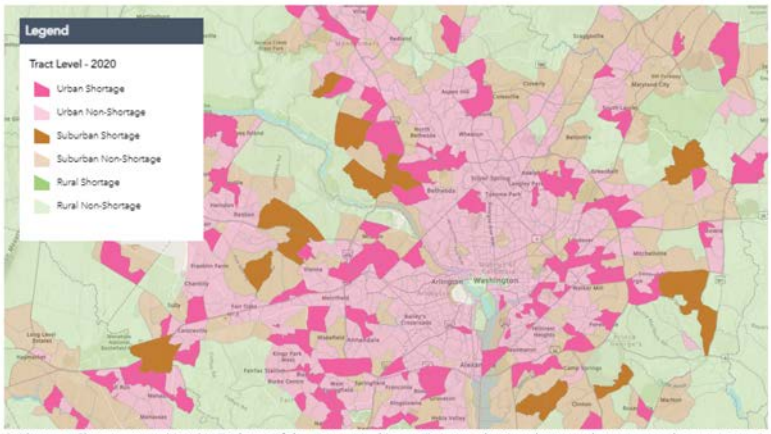


1. Pharmacy Shortage Areas Mapping Tool showing pharmacy shortage areas by census tract across the United States in 2020.

[1] National Community Pharmacists Association. NCPA Digest 2023. [Internet]. Alexandria (VA): National Community Pharmacists Association; [cited 2024 May 15]. Available from: *https://ncpa.org/sites/default/files/2023-10/2023-digest.pdf.*

[2] USC Schaeffer. High-Tech Map Promotes Access to Medicine and Pharmacy Services. USC Schaeffer. [Internet]. 2022 October 21. [cited 2024 May 15]. Available from: *https://healthpolicy.usc.edu/article/high-tech-map-promotes-access-to-medicine-and-pharmacy-services/*.

[3] USC–NCPA Pharmacy Access Initiative research.



2. Pharmacy Shortage Areas Mapping Tool map of the greater Washington D.C. area showing pharmacy shortage areas by census tract in 2020.

The Pharmacy Shortage Areas Mapping Tool can also be used to see the formation of pharmacy shortage areas due to pharmacy closures. According to research from the USC-NCPA Pharmacy Access Initiative, 104 rural neighborhoods became pharmacy shortage areas between 2018 and 2020, and 80% of these newly designated pharmacy shortage areas were due to an independent pharmacy closing its doors. While the USC-NCPA Pharmacy Access Initiative seeks funding for updated data to generate a timelier estimate, we anticipate that the drastic number of pharmacy closures across the country has caused the number of pharmacy shortage areas to increase, including in rural communities. IQVIA estimates that in 2023, over 1,000 pharmacies closed across the country.

As policymakers, there are several actions you can take to support rural health care and strengthen the role of community pharmacists:

1. Request CMS to reevaluate and update current pharmacy access standards in Medicare Part D to ensure that those living in rural areas have access to brick-and-mortar pharmacies. CMS must update Medicare Part D pharmacy access standards to reflect socioeconomic status and access to transportation. Through our research with the USC–NCPA Pharmacy Access Initiative, we have seen that current access standards do not reflect true pharmacy access and have outlined our pharmacy access distance thresholds based on research from and prior to the creation of the Pharmacy Shortage Areas Mapping Tool in Table 1 below. In comparing access using our pharmacy access distance thresholds to the current CMS Medicare Part D access standards, we found that many neighborhoods that lack pharmacy access are not captured using the CMS Medicare Part D access standards of 2-mile (urban), 5-mile (suburban), and 15-mile (rural) distance thresholds.

   New access standards at a minimum should account for low access to transportation by lowering the distance threshold in these areas to no more than 0.5 miles to an in-network pharmacy, regardless of urbanicity. In areas without transportation access issues, urban neighborhoods should be within 1 mile of a pharmacy, suburban neighborhoods should be within 2 miles of a pharmacy, and rural neighborhoods should be within 10 miles of a pharmacy.

Table 1. Distance Thresholds Used in the Analysis

Urbanicity [a]	Tract Characteristics [b]	Distance Threshold	CMS Standards [c]
Urban	Low-income and low-vehicle ownership	0.5 mile	2 miles
Urban	N/A	1 mile	

Table 1. Distance Thresholds Used in the Analysis—Continued

Urbanicity [a]	Tract Characteristics [b]	Distance Threshold	CMS Standards [c]
Suburban	Low-income and low-vehicle ownership	0.5 mile	5 miles
Suburban	N/A	2 miles	
Rural	Low-income and low-vehicle ownership	0.5 mile	15 miles
Rural	N/A	10 miles	

[a] Urbanicity is based on population density; (>3,000, Urban population per square mile; 1,000–3,000 population per square mile, Suburban; <1,000 populating per square mile, Rural).

[b] Low-income indicated at least 20% of the tract population has incomes less than 100% of the FPL, and low-vehicle ownership indicates at least 100 households without a vehicle for the tract.

[c] Based on a memorandum issued by the Centers for Medicare and Medicaid Services (CMS) for Part D plans.

2. Expand pharmacist scope of practice: Remove regulatory barriers and enable pharmacists to practice at the top of their license, allowing them to provide a wider range of services, including prescribing medications and conducting point-of-care testing.

In conclusion, the National Community Pharmacists Association is committed to improving health outcomes in rural communities and ensuring access to quality pharmacy services for all Americans. Through initiatives like the USC–NCPA Pharmacy Access Initiative and with the support of policymakers like you, we can make meaningful progress in addressing the unique healthcare needs of rural America. Thank you for your attention to this important issue, and I look forward to working together to build healthier, stronger communities across the nation. Should you require further information or have questions, please reach out to anne.cassity@ncpa.org or 703–838–2682.

NATIONAL RURAL HEALTH ASSOCIATION
50 F St., NW, Suite 520
Washington, DC 20001
202–639–0550
https://www.ruralhealth.us/

May 30, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record on the Rural Health Care: Supporting Lives and Improving Communities held by the full Committee on May 16, 2024.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Rural health care needs support more than ever. Using hospitals as a proxy for the well-being of rural health care generally, over 170 rural hospitals have closed or discontinued inpatient services since 2010. Nearly 450 more rural hospitals are considered vulnerable to closure with 50% operating with negative margins. Congress must invest in rural health to ensure providers remain open and accessible to rural residents. Approximately 80% of rural America is medically underserved and seeing historic workforce shortages. As the Committee states, rural residents face unique barriers to accessing health care and tend to be older, sicker, and poorer than their urban counterparts. The policy solutions in our response would have a significant impact on access, affordability, and provider stability.

Summary Recommendations for Congressional Action

Congress has reconfirmed their commitment to the rural communities repeatedly over the years by providing new protections to ensure rural provider viability and to ensure patient access to health care services in rural communities. NRHA and its members share this goal of ensuring that federal health care payment policies recognize the unique practice environment in rural areas and the important contributions rural providers bring to the Medicare program and its beneficiaries.

NRHA appreciates the opportunity to provide these comments and requests that the Finance Committee consider and advance the following legislation to improve access to health care in rural communities:

- S. 3967, the Telehealth Modernization Act and S. 2016, the CONNECT for Health Act and to make all Medicare telehealth flexibilities permanent and create payment parity for Rural Health Clinics (RHCs)
- S. 948, the Healthy Moms and Babies Act aims to improve maternal and child health by increasing services, supports, and access to coordinate care and technology in rural areas
- S. 803, the Save Rural Hospitals Act, aims to enhance reimbursements to more accurately reflect the actual costs incurred by these hospitals
- S. 1110, the Rural Hospital Support Act, to make Medicare Dependent Hospital (MDH) and Low-Volume Hospital (LVH) programs permanent is essential to provide certainty to hospitals and safeguard their financial viability moving forward
- S. 1571, the Rural Hospital Closure Relief Act, to allow a limited waiver of the 35-mile requirement for Critical Access Hospital (CAH) to assist struggling rural PPS hospitals
- S. 4322, the Rural Emergency Hospital Improvement Act, to implement technical fixes to the REH designation
- S. 198, the RHC Burden Reduction Act would address RHCs outdated legislative barriers
- S. 1673, the Protecting Access to Ground Ambulance Medical services Act, extends increases Medicare payments for rural ground ambulance services
- S. 230, the Rural Physician Workforce Production Act which would lift GME caps and foster a more equitable distribution of medical education resources to rural areas
- H.R. 8235, the Rural Physician Workforce Preservation Act, to exclude reclassified hospitals from receiving slots allocated to rural hospitals unless geographically located in a rural area
- S. 2418, the Improving Care and Access to Nurses Act, to modernize Medicare policies, removing barriers that currently restrict the practice capabilities of these professionals

Further, NRHA encourages Committee members to collaborate with colleagues to support legislation outside their immediate jurisdiction including:

- S. 3193, the Telehealth Response for E-prescribing Addiction Therapy Act allows telehealth, including audio-only, to be used for prescribing buprenorphine for opioid use disorder
- S. 1851, the Midwives for MOMS Act, proposes to expand midwifery education programs, can greatly assist in filling critical gaps in care
- S. 4079, the Rural Obstetrics Readiness Act, to support initiatives that enhance OB readiness in hospitals without dedicated OB units
- 340B Drug Pricing Program protections including SUPPORT 340B Act; H.R. 7635 340B PATIENTS Act; H.R. 2534 PROTECT 340B Act; and H.R. 8144 Rural 340B Access Act

Telehealth

COVID–19 Flexibilities

NRHA urges the Committee to consider **S. 3967, the Telehealth Modernization Act and S. 2016, the CONNECT for Health Act** in order to make all Medicare telehealth flexibilities permanent and create payment parity for RHCs.

The temporary flexibilities introduced during the COVID–19 Public Health Emergency, including expanded telehealth services and eased regulatory requirements, have been vital in maintaining healthcare access during the pandemic. Making these flexibilities permanent would support a sustained improvement in healthcare accessibility and efficiency in rural areas. Key flexibilities include: 1) RHCs and Federally Qualified Health Centers (FQHCs) serving as distant site providers, 2) audio-only telehealth for rural beneficiaries without reliable internet access, 3) an

expanded list of authorized telehealth practitioners (including physical therapists, occupational therapists, speech-language pathologists), 4) removing geographic site requirements, and 5) allowing the beneficiary's home to serve as an originating site.

Further, RHCs may not be able to support telehealth services because of the added costs associated with furnishing them. Rural providers are less equipped to provide telehealth services without upgrading their technological infrastructure, and that can come at a significant cost. Ensuring that RHCs receive payment parity for telehealth services compared to in-person services will help expand access to beneficiaries living in rural areas. The overhead for the RHC's brick-and-mortar clinic exists, in addition to the costs associated with telehealth, making payment parity a necessity. Without payment parity, it is more challenging for RHCs to make the necessary transition to telehealth.

Broadband

Supporting policies that continuously improve and expand broadband infrastructure in rural America is essential for effective telehealth delivery. Retaining audio-only telehealth services is one way to address the digital divide, as nearly one in four rural Americans cite internet access as a major barrier. However, the goal should be to make broadband accessible for all rural communities to realize the full potential of telehealth in expanding access to healthcare.

Tele-Behavioral Health

Telehealth has also shown its usefulness in providing behavioral health care to rural communities. **S. 3193, the Telehealth Response for E-prescribing Addiction Therapy Act** allows telehealth, including audio-only, to be used for prescribing buprenorphine for opioid use disorder (OUD). This act is pivotal for rural communities where nearly three-quarters of counties lack a buprenorphine provider. Current flexibilities for prescribing medications for opioid use disorder (MOUD) via telehealth expire at the end of 2024, showing the urgent need for legislative action to ensure continued access.

Rural Provider Stability

Financial and Regulatory Challenges

Rural Hospitals: Rural hospitals operate under the same regulatory burdens as larger urban hospitals; however, the cost of compliance per discharge is often higher due to lower patient volumes. This is further complicated by rising costs in labor, drugs, and supplies, with hospitals seeing a 17.5% increase in overall expenses from 2019 to 2022, which has not been adequately matched by increases in Medicare or Medicaid reimbursement. These escalating costs, combined with inadequate reimbursement rates, have led many rural hospitals to operate at a loss, with some being forced to close. Half of rural hospitals across the country are operating on negative margins and 418 hospitals are identified as vulnerable to closure. Legislative relief from outdated and unnecessarily burdensome regulations and improved reimbursement could provide rural hospitals with the flexibility needed to sustain operations and continue serving their communities effectively.

Rural hospitals are significantly impacted by a predominantly public payer mix, with Medicare and Medicaid making up a substantial portion of their patient base. This reliance on public health programs, which often reimburse at rates lower than the cost of providing care, places rural hospitals in a precarious financial position, particularly as they also serve a higher percentage of uninsured patients. In 2020, rural hospitals faced substantial financial shortfalls, including $5.8 billion in Medicare underpayments and $1.2 billion in Medicaid underpayments, compounded by $4.6 billion in uncompensated care. These issues are further exacerbated by Medicare sequester cuts and the potential implementation of Medicaid Disproportionate Share Hospital (DSH) cuts.

To address these reimbursement issues, legislative actions such as adjusting the Medicare wage index policy and ensuring payments reflect real labor costs are crucial. Current proposals like **H.R. 3635/S. 803, the Save Rural Hospitals Act,** aim to enhance reimbursements to more accurately reflect the actual costs incurred by rural hospitals. Medicare designations designed to support the unique financial circumstances of rural hospitals, such as the MDH and LVH designations, are scheduled to expire at the end of 2024. Supporting **S. 1110, the Rural Hospital Support Act,** to make these programs permanent is essential to provide certainty to hospitals and safeguard their financial viability moving forward. The Committee should also move forward with **S. 1571, the Rural Hospital Closure Relief Act,** to allow a limited waiver of the 35-mile requirement for CAHs to assist struggling rural PPS hospitals stay viable.

Another significant reform for rural hospitals would be cost report modernization. Medicare cost report methods date back to 1965 and have remained largely unchanged. Cost report allocation is the foundation of all rural hospital financing. Estimates suggest that with exclusions Medicare covers 92% of hospital cost, not 101%. Often subsidiary services are non or low margin yet are critical for population health initiatives. One meaningful change to how CAHs can be reimbursed is to allow all costs associated with contracting with physicians to be included on the cost report. Congress should direct CMS to establish a working group to address key issues such as waiver or modification of CAH cost allocation regulations to allow greater integrated community services and review of cost exclusions that further reduce reimbursement to hospitals for essential services.

One silver lining of the Public Health Emergency (PHE) was that rural providers were freed from administrative burdens and outdated regulations. NRHA calls on the Committee to implement these flexibilities permanently to make rural health care administration and delivery more efficient. Of note, Congress should permanently end the 96-hour average length of stay rule for CAHs. Relatedly, NRHA urges Congress to remove the condition of payment that requires physicians to certify upon admission that a patient can reasonably expect to be discharged within 96 hours. Finally, the requirement for beneficiaries to have a 72-hour qualifying hospital stay before admission to a SNF should be removed as an outdated barrier to placing beneficiaries in the appropriate care setting.

Another threat to rural hospital stability is site neutral payment. Site neutral payment policies will disadvantage rural providers. While addressing the cost of care for rural residents is critical, it is essential that rural provider viability is not inadvertently impacted. Paying off-campus rural providers less than the full outpatient prospective payment rate contributes to destabilizing rural health care delivery. Off-campus provider-based departments (PBDs) may be the only source of care in many rural communities and thus play a critical role in keeping care local and ensuring that rural patients can receive the services that they need. Any decline in payments threatens a rural provider's ability to keep their doors open. Higher costs of PBDs in rural hospitals may be attributed to the need to spread fixed costs across a lower volume of services. Additionally, hospitals often furnish more complex care and must meet more stringent regulatory requirements than physicians' offices. Hospitals are highly regulated and the burdens that are associated with compliance should be accounted for in payment. The site neutral rate does not account for the type of care furnished nor the resources needed at off-campus PBDs.

Current House site-neutrality proposals would cost rural hospitals $272 million cuts over 10 years. If Congress pursues site neutral policies, NRHA emphasizes the need to exempt rural hospitals and off-campus PBDs. Any savings generated from site neutral payment should be reinvested in the rural health care infrastructure to enact the policy solutions and legislation presented in our response. Savings could also be redirected to help rural providers address their patients' social determinants of health, like transportation or food insecurity. Many safety net providers that offer transportation or other services for patients absorb this cost because it is not reimbursable but is a huge benefit to their patient population. Removing barriers to care and addressing some social risk factors that impact health will reduce costs in the long-term because patients are receiving preventive services.

Rural Emergency Hospitals: The Rural Emergency Hospital (REH) model presents an innovative approach to preserving health care services in rural areas by offering higher Medicare reimbursement in exchange for ceasing inpatient care. This designation is one tool in the toolbox for rural hospitals that may otherwise be facing closure. However, legislative improvements are needed to make this model more accessible and financially viable for hospitals that are struggling to maintain operations. NRHA urges the Committee to consider S. 4322, the Rural Emergency Hospital Improvement Act. This bill would implement technical fixes to the REH designation, such as allowing for rehabilitation, inpatient psychiatric, and obstetric distinct part units; opening eligibility to hospitals that closed between 2015 and December 27, 2020; creating a waiver program at CMS to allow certain facilities to convert to REH; allowing CAHs that convert to REH and back to CAH to retain necessary provider status; and more.

Medicare Advantage: Reforms in Medicare Advantage (MA) are necessary to prevent further financial strain on rural hospitals. The growth of MA enrollment is higher in nonmetropolitan counties than in metropolitan counties. MA penetration in rural areas varies by community, but overall 45% of rural Medicare beneficiaries are enrolled in an MA plan. As rural enrollment grows, CAHs and RHCs financial

stability are threatened. CAHs receive 101% of reasonable costs from Traditional Medicare and RHCs receive their specific all-inclusive rate. Yet MA plans do not always pay CAHs and RHCs at their Traditional Medicare rate, undermining their financial base. In fact, about 35% of surveyed RHCs indicated that they are paid on a fee-for-service basis rather than on an encounter basis. Ensuring that MA plans reimburse at least at Traditional Medicare rates and considering rural providers in the rate-setting processes, are vital steps to prevent the financial decline of these critical institutions. Federally Qualified Health Centers (FQHCs), for example, receive a wrap around payment from Medicare when MA plans do not pay the Traditional Medicare rate.

MA plans also often delay and deny payments, even if they previously approved the service for the beneficiary and the service was furnished. Rural providers cannot shoulder delayed or missing payments, especially as some NRHA members have noted that they are waiting on several hundred thousand dollars of payments from plans. Addressing these disparities will help stabilize rural healthcare providers and ensure that rural residents continue to have access to necessary healthcare services.

Rural Health Clinics: RHCs play a pivotal role in providing primary care in rural areas by serving 38.7 million patients per year, or 62% of all rural Americans. RHCs, like hospitals, also rely heavily upon government payers with an average of 64% of patients covered by government payers. Strengthening RHCs through improved funding and regulatory support can significantly impact the health outcomes of rural populations.

Low-cost and noncontroversial, **S. 198, the RHC Burden Reduction Act** is a commonsense piece of legislation that would make a significant difference on the day-to-day operations of RHCs by addressing outdated legislative barriers. This important bill would align RHC physician supervision requirements with state scope of practice laws governing physician assistant and nurse practitioner practice, remove outdated laboratory requirements, allow RHCs to provide an increased amount of behavioral health services, among other technical tweaks.

Further, NRHA has supported legislative work toward increasing RHC capacity for quality measure reporting through a voluntary program that would provide enhanced reimbursement. The House introduced legislation outlining this idea in the 117th Congress and we urge the Senate to consider this proposal. Addressing challenges such as the RHC payment methodology and enhancing support for these clinics can help stabilize the broader rural healthcare infrastructure, ensuring that primary care is accessible and sustainable.

Emergency Medical Services: Enhanced federal support for emergency medical services (EMS) is crucial for rural areas where response times are typically longer, and operational costs are high due to vast geographic coverage areas. Rural ambulance response times are more than double that of urban ambulances and nearly 10% of patients wait over 30 minutes for EMS personnel to arrive. About a third of rural EMS agencies in the U.S. are in immediate operational jeopardy because they cannot cover their costs, largely from insufficient Medicaid and Medicare reimbursements, which pay on average a third of actual EMS costs. Legislation such as **S. 1673/H.R. 1666, the Protecting Access to Ground Ambulance Medical Services Act,** extends increases Medicare payments for rural ground ambulance services, is essential to sustain these vital services that often operate at a financial loss.

Transition to Value-Based Care

As health care delivery seeks to move towards value-based care, NRHA is concerned that rural providers are integrated into new models and payment opportunities. However, rural providers face challenges related to quality programs that require reporting on measures not relevant to the low-volume, rural context. This limits their participation in innovative payment models, like those administered by CMS' Innovation Center (CMMI), that could improve patient outcomes and provide alternative revenue streams. Frequently, fee-for-service reimbursement does not align with the reality of operating rural facilities, particularly due to low patient volumes. Value-based care models must consider the different rural payment mechanisms, particularly for RHCs and CAHs. Rural providers are poised to gain from value-based care, yet they struggle to participate or even be included in CMMI models.

Congress charged CMMI with developing and testing new payment and service delivery models that must achieve cost savings. The decades of underinvestment in rural health care delivery makes achieving cost savings extremely difficult. Alternative payment methodologies for rural providers and higher acuity patient mix can

create additional barriers to model integration. Congress should direct investments to building out and supporting rural providers in value-based care. The Committee should grant greater authority to the HHS Secretary, through CMMI, to develop and implement voluntary alternative rural payment models. Such models should include a global budget or enhanced cost-based reimbursement. In addition, NRHA believes that exempting rural providers from CMMI's cost-savings mandate would alleviate some barriers to entry in innovative demonstration projects. Congress must equip CMMI with the authority to waive the cost savings requirement in order to develop rural-centric models or to allow rural providers to engage in CMMI models broadly without achieving cost savings at the outset.

340B Drug Pricing Program

Maintaining and strengthening the 340B Drug Pricing Program is critical for rural covered entities. This program allows these facilities to provide discounted drug prices to low-income patients, supporting the financial health of hospitals that operate on thin margins. 340B is a lifeline that allows rural safety net providers to keep their doors open and furnish critical services by stretching scarce federal resources. Rural hospitals and clinics rely upon 340B savings to help them keep needed services local for patients. NRHA developed a set of principles that should guide Congress in any 340B reform to ensure rural access to the program is protected. NRHA was pleased to see several of these principles reflected in the **Senate 340B Working Group's discussion draft of the SUPPORT 340B Act.**

NRHA urges Congress against any limitations on the number and location of contract pharmacies with which rural covered entities work and encourages the Committee to introduce a Senate companion to **H.R. 7635, the 340B PATIENTS Act.** Ensuring that rural hospitals continue to benefit from 340B savings without undue restrictions is vital for keeping healthcare accessible and affordable in rural communities. NRHA also supports clear statutory restrictions on pharmaceutical benefit managers (PBMs) and payers' ability to treat 340B covered entities differently as outlined in **H.R. 2534, the PROTECT 340B Act** and reflected in the 340B Working Group's discussion draft, the SUPPORT 340B Act. These actors have increasingly discriminated against 340B patients, covered entities, and contract pharmacies. NRHA also asks that Congress add the new REH provider type to the 340B statute as a covered entity, as outlined in **H.R. 8144, the Rural 340B Access Act.** NRHA members cite 340B eligibility as the top concern when deciding whether to convert to an REH.

Rural Workforce Support

Graduate Medical Education

Rural areas experience significant disparities in medical professional availability, notably influenced by the geographic distribution of Graduate Medical Education (GME) slots. Despite evidence suggesting that physicians trained in rural settings are more likely to continue practicing in similar environments, only 2% of residency training occurs in rural areas. Congress acknowledged the maldistribution of training opportunities in the Consolidated Appropriations Act (CAA) of 2021, which allocated 10% of the 1,000 new GME slots to rural hospitals. However, only 5.9% of GME slots went to 5 geographically rural hospitals during the first round of awards while 42 hospitals reclassified as rural received 42% slots. Analysis shows only 3% of reclassified facilities will use slots to train residents for 50% or greater time in rural areas and 6% for rural training less than 50% of time, with the remaining 92% doing no formal rural training. Analysis also shows that the majority of new slots went to residency programs located in urban health professional shortage areas (HPSAs). In the second round, two geographically rural hospitals and one urban hospital with a Rural Track Program received slots. Distribution to reclassified hospitals is technically following the law;[1] however, NRHA is concerned with this allocation of GME slots set aside for rural training to geographically urban hospitals. Further, it appears the reclassified hospitals that received slots under the first round of distribution are not training residents in rural areas. Unfortunately, this is allowed because of the reference to § 1886(d)(8)(E) in the legislative text.

To correct these discrepancies and genuinely support rural healthcare, the Committee should consider a companion bill to **H.R. 8235, the Rural Physician Workforce Preservation Act.** This bill would exclude reclassified hospitals from receiv-

[1] The CAA, 2021 stated that 10% of slots must go to "[h]ospitals that are located in a rural area (as defined in section 1886(d)(2)(D)) or are *treated as being located in a rural area pursuant to section 1886(d)(8)(E)*." Hospitals treated as being located in a rural area are "reclassified" hospitals, or geographically urban hospitals that convert to "rural" for IPPS payment purposes.

ing the 10% of slots allocated to rural hospitals unless the hospital reclassified because they are in a rural Census tract of a metropolitan statistical area or are located in an area considered rural by state law or regulation. In addition, the Committee can support rural physician training through **S. 230, the Rural Physician Workforce Production Act** which would lift GME caps and foster a more equitable distribution of medical education resources to rural areas.

Another facilitator of rural training would be a minor definitional change in Rural Track Programs (RTPs). Currently, CMS only finances RTPs if greater than 50% of the training occurs in rural counties. While this covers most rural areas, it does not capture all. GME financing for RTPs should be expanded to programs training greater than 50% of the time in Federal Office of Rural Health Policy (FORHP) defined rural areas. FORHP defines rural as any non-metropolitan county plus areas in metropolitan counties with a Rural-Urban Commuting Area code of 4 or higher. There are currently 353 ACGME-accredited programs with >50% training occurring in FORHP rural areas and only 150 programs >50% occurring in rural counties.

The discrepancies in Indirect Medical Education (IME) payments further exacerbate the challenges faced by rural hospitals, particularly those with teaching programs. Sole Community Hospitals (SCHs) and MDHs that are paid at a hospital-specific rate are unfairly excluded from receiving IME payments, which limits their capacity to train medical residents. Equitable IME payment distribution will support the development of rural training programs, crucial for addressing the ongoing healthcare provider crisis in these communities.

Last, Section 131 of the CAA, 2021 provided hospitals with very low direct GME per resident amounts or FTE caps to reset those between December 27, 2020, and December 26, 2025. However, many rural teaching hospitals need a longer timeframe to take advantage of this opportunity. Rural hospitals should be given more time to reach their full training potential before a new cap is implemented. NRHA suggests that the Committee consider extending this deadline until 2030 or allowing a hospital in a geographically rural area with less than 12 FTEs to reset an FTE cap or PRA at any time.

Utilizing All Health Professionals

The maldistribution of physicians in rural areas necessitates innovative approaches to healthcare delivery and use of nonphysician practitioners (NPPs). Expanding the scope of practice for nurse practitioners (NPs), physician assistants (PAs), and other non-physician practitioners (NPPs) presents a viable solution to alleviate workforce shortages. Legislation like **S. 2418, the Improving Care and Access to Nurses Act,** aims to modernize Medicare policies, removing barriers that currently restrict the practice capabilities of these professionals. By allowing greater autonomy and expanding their roles, rural areas can better utilize the available healthcare workforce to address gaps in care provision, especially in primary and preventative care settings.

Nursing Home Staffing

Rural nursing homes are particularly vulnerable to staffing shortages, which are exacerbated by newly established stringent federal staffing mandates. The recently finalized CMS staffing standards, though well-intentioned, do not account for the unique challenges faced by rural facilities, such as the historic labor shortages and the closure of facilities in these areas. Over 200,000 more long-term care workers are needed to meet pre-pandemic staffing levels. On top of record-low workforce numbers, rural communities saw almost 500 rural nursing homes close between 2008 and 2018. This trend is not slowing. In fact, the long-term care landscape is worse in certain predominantly rural states such as Montana where 16% of the state's nursing homes closed in 2022. In the same year in Iowa, 13 of 15 nursing homes closures occurred in rural areas. A lack of post-acute care beds has ripple effects in rural health care. Patients are unable able to get access to acute care in their local rural communities because hospitals cannot discharge patients who no longer require inpatient care but cannot safely return home due to lack of long-term care facilities. Congress should look to improve the nursing workforce and home- and community-based services (HCBS) to lessen the pressure on rural nursing homes and improve patient outcomes. It is vital that legislation such as the Better Care Better Jobs Act be reintroduced, providing support for nursing homes through planning grants, quality measures, and technical assistance aimed at improving staffing and care quality without imposing unattainable requirements that could lead to further closures of rural nursing homes.

Maternal Health

The scarcity of obstetric care in rural hospitals has led to higher rates of maternal morbidity and mortality. Many rural hospitals have been forced to close obstetric units due to financial constraints and workforce shortages, exacerbating the crisis in maternal health. In 2023 alone, 23 hospitals, predominantly in rural areas, announced the closure of their OB units. This trend is alarming as over half of rural hospitals are now without an OB unit. The lack of OB provider availability, with an estimated 58.7% of rural counties lacking an obstetrician, 81.7% lacking advanced practice midwives, and 56.9% lacking family physicians who deliver babies, further compounds the issue. These shortages and closures highlight the urgent need for policy interventions that ensure the continuity of maternal care in rural communities.

To address these significant challenges in rural maternal health, robust federal support is essential. Medicaid reimbursement rates set by states do not cover the full cost of providing obstetric services. This may mean particular financial losses for hospitals providing these services in rural areas, where a higher proportion of births are covered by Medicaid. Increasing Medicaid reimbursement would help to keep obstetric services open to serve rural individuals. Proposals like **S. 948, the Healthy Moms and Babies Act** are crucial as they aim to improve maternal and child health by increasing services, supports, and access to coordinate care and technology in rural areas. Moreover, legislation such as **S. 1851, the Midwives for MOMS Act,** which proposes to expand midwifery education programs, can greatly assist in filling critical gaps in care. These efforts are particularly vital in rural areas that rely on midwives and other non-obstetrician practitioners due to ongoing workforce constraints.

Most pregnancy-related deaths are preventable with proper medical care, making it imperative for Congress to support initiatives that enhance OB readiness in hospitals without dedicated OB units. **S. 4079, the Rural Obstetrics Readiness Act,** was recently introduced to address this need. The bill includes grants from the Department of Health and Human Services (HHS) to expand OB emergency training and equipment in rural hospitals. Such measures would not only improve the immediate response capabilities of rural hospitals but also ensure a broader safety net for expectant mothers in underserved areas.

Thank you for your consideration of these comments. NRHA would be pleased to serve as a resource as the Committee considers legislation to protect and improve access to care in rural communities. Please contact Carrie Cochran-McClain at ccochran@ruralhealth.us if you have any questions.

Sincerely,

Alan Morgan
Chief Executive Officer

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NISKANEN CENTER
1201 New York Ave., NW, Suite 200B
Washington, DC 20005
https://www.niskanencenter.org

The Bipartisan Immigration Policy That Helps Rural Americans Get Access to Local Physicians

The Association of American Medical Colleges (AAMC) **predicts** that there will be a shortfall of as many as 124,000 physicians by 2034. This is the product of two diverging trends: Americans are **getting older** and their demand for physicians is increasing, while the supply of physicians is shrinking due to retirements and the **slow training** of new physicians.

The worsening physician shortfall will not impact all Americans equally: underserved communities, such as rural areas, are expected to be hit the hardest. These populations, who already struggle disproportionately with healthcare access and wait times, will see these challenges exacerbated as they have to travel further and wait longer to see a doctor.

The **Conrad 30 waiver program**—which incentivizes international medical graduates (IMGs) to practice in areas with **high medical need**—can help address this rural doctor shortage in the U.S. A bipartisan group of Senators recently introduced legislation to supplement the Conrad 30 waiver program and increase its benefits for Americans in rural and underserved communities.

Original Conrad 30 Program Overview

Designed by former North Dakota Senator Kent Conrad, the original **Conrad 30 waiver program** allows states to offer up to 30 waivers allowing IMGs studying in the U.S. on a J–1 visa. The waivers let them skip the 2-year foreign residency requirement after graduation if they practice in a medically underserved area or with a medically underserved population.

Since J–1 visas are not dual-intent (that is, they are solely visitor or exchange visas), recipients cannot apply for an immigrant visa, adjustment of status, or an **H** or **L** visa automatically after studies are completed. IMGs wishing to remain in the United States must return to their home countries for at least 2 years before applying for one of these visas, thus experiencing profound disruptions to their per-

sonal and professional lives. This is something Conrad 30 waivers for rural U.S. areas with doctor shortages can address.

Doctors granted Conrad-30 waivers can only practice in areas within **federally designated categories,** such as Medically Underserved Areas (MUAs) or Health Professional Shortage Areas (HPSAs). Recipients may also work specifically with a Medically Underserved Population (MUP). The program is a needed boost for rural areas of the U.S. experiencing doctor shortages, as **only 1% of doctors** in their last year of medical school say they want to live in communities under 10,000, and 2% want to live in towns of 25,000 or fewer.

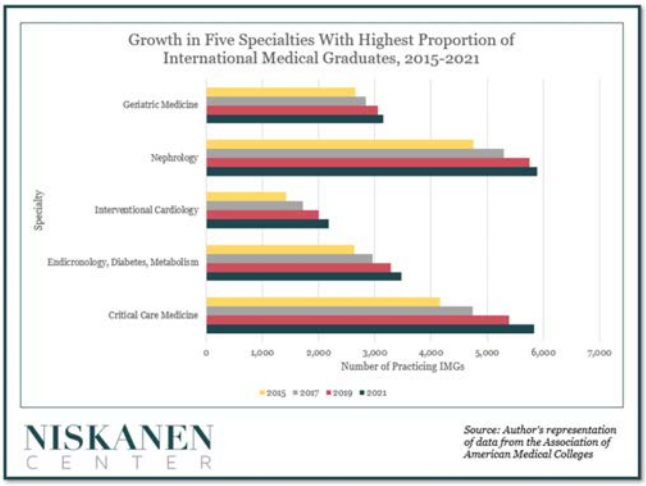
States are also granted significant authority in managing the program, from approving applicants to determining how they are geographically distributed. They can also approve up to 10 **"flex"** applicants who do not work in a federally designated area of need but meet shortage criteria set by the state and reserve specific slots in their waiver pool for specialists.

Stringent job protections for Americans are also built into the program. While states oversee the specific requirements of what an employer applying for a Conrad 30 waiver needs to demonstrate, they must generally attest that they have been **unsuccessful** in recruiting a U.S. physician for the same position.

Strengths

Over the past 15 years, the program has brought over **15,000 physicians** to areas and patients with significant medical needs. Using a conservative estimate from a study on patient panel sizes translates to at least **44 million patients** treated by a Conrad 30 doctor since the start of the program.

IMGs are also disproportionately concentrated in areas with anticipated shortages. For example, they **accounted** for over 50% of geriatric medicine practitioners in 2021. As the share of older Americans continues to **increase,** the need for these specialists will also grow just as their numbers are expected to **diminish.** IMGs are also highly represented in essential fields such as kidney diseases, interventional cardiology, diabetes care, and critical care medicine. The concentration of likely Conrad 30 recipients in these fields demonstrates how necessary the program is for these specialties.



The program also touts promising completion and retention rates in rural areas with doctor shortages. A 2018 Iowa-based study found that 92% of Conrad 30 recipients in the state met their original 3-year obligation and 68% were retained beyond their required time frame.

Challenges

Because of the program's decentralized nature, collecting standardized, regular data on its status and outcomes is challenging, making it difficult to offer suggested improvements.

One study, however, did report anecdotal doubts that the program facilitates integration, attributing this to the high-stress environments of many designated areas, their isolated locations, and the limited duration of the service period.

Furthermore, the full breadth of issues affecting rural communities and challenges within the U.S. healthcare system sit well outside the scope of this one narrow immigration program, and its impact, while important, remains limited (for more work from Niskanen on healthcare policy, see the links at the end of this statement).

Conrad State 30 and Physician Access Reauthorization Act and the DOCTORS Act

The primary vehicle for Conrad 30 reform in recent years is the **Conrad State 30 and Physician Access Reauthorization Act.** It was re-introduced in the 118th Congress with **broad bipartisan** support, including from Republicans in rural states like Senator John Thune of South Dakota, Senator Shelley Moore Capito from West Virginia, and Senator John Boozman from Arkansas.

The bill—which has also garnered support from several key healthcare associations, including the American Medical Association, the National Rural Health Association, and the American Hospital Association—significantly improves the Conrad 30 program by further addressing rural doctor shortages and overhauling the program's weaknesses.

First among these is the reauthorization and extension of Conrad 30 for 3 more years, enabling current medical students and potential employers to better (and more definitively) set long-term plans.

It also increases the number of slots for every state from 30 to 35—provided that 90 percent of the waivers available to the states receiving at least five were used in the previous fiscal year. Waiver spots continue to increase by five under this metric, with the threshold being increased to 95% once the number reaches 45 waivers. Increases would be maintained unless waivers granted decrease by 5%.

This update is particularly timely, as the U.S. population had increased significantly since 2003, when the original 30 spots-per-state allocation was established. What's more, recent data indicates that most states used 90% or more of their available waivers, demonstrating the necessity of this provision.

The bill strengthens worker protections, as organizations seeking to employ Conrad recipients must disclose the number of working hours, level of compensation, and other benefits recipients could receive during their time there. Recipients would also now be able to switch locations if they are subject to workplace violations, and states that lose spots to these departures would be able to recapture lost waivers.

The dual intent issue raised by J–1 visas would be addressed by clarifying that expressing interest in receiving a future Conrad 30 waiver does not make an applicant ineligible. Finally, the bill mandates a yearly report on Conrad 30 usage to Congress, which will help remedy the existing data gap on the program.

The **Directing Our Country's Transfer Of Residency Slots (DOCTORS) Act** is another bipartisan bill that was introduced by Senators Amy Klobuchar of Minnesota and Joni Ernst of Iowa. Though the Conrad 30 program allows each state 30 visas annually for qualified IMGs, some states, like Texas and Indiana, use all the available visas while others use none. In FY 2023, only 18 states used all available visas, meaning *395 waivers* went unused. The DOCTORS Act then distributes the unused Conrad visas equally among the states seeking more physicians. It's a common-sense proposal that holds the promise of addressing our physician shortages more efficiently using a program already authorized by Congress.

Conclusion

When operating as intended, the Conrad 30 program helps rural U.S. areas experiencing doctor shortages and gives many IMGs a chance to thrive in America, benefiting all parties involved. Patients who may otherwise have had no recourse but to wait months or years to receive medical attention gain improved access to local healthcare. Employers who manage understaffed practices in locations typically unattractive to recent medical graduates obtain an invaluable new employee pool. And international medical graduates who would otherwise need to upend their lives can stay in the United States and are granted increased stability and security in their personal and professional lives.

The Conrad 30 Reauthorization bill and the DOCTORS Act offer a rare opportunity for policymakers to take action on something unilaterally benefiting all parties involved. In passing the bill, policymakers will strengthen the conditions necessary for

the aforementioned outcomes to come to fruition while signaling that the program's myriad benefits transcend partisanship.

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PREMIER INC.
444 North Capitol Street, NW, Suite 625
Washington, DC 20001
T 202–393–0860
F 202–393–6499
https://www.premierinc.com/

Premier Inc. appreciates the opportunity to submit a statement for the record on the Senate Finance Committee hearing titled *"Rural Health Care: Supporting Lives and Improving Communities"* on May 16, 2024. Premier applauds the Committee's leadership in this area and strongly supports efforts to develop innovative policy approaches to expand access to this critical and vulnerable population. As discussed in more detail below, Premier highlights opportunities to strengthen the quality and sustainability of care for patients and providers in rural and underserved areas, including:

- Expanding patient access to home infusion care by revising Medicare reimbursement policy for these services;
- Extending key Medicare telehealth flexibilities and the Medicare hospital at home program;
- Promoting financial stability for rural providers;
- Supporting policies that help strengthen the rural healthcare workforce.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company, uniting an alliance of more than 4,350 U.S. hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 2.7 billion hospital outpatient and clinic encounters and 177 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. IMPROVE PATIENT ACCESS TO HOME INFUSION

Patients served under the Medicare Part B home infusion therapy services benefit are among the country's most vulnerable and often suffer from advanced chronic diseases, such as congestive heart failure, cancer and primary immune deficiency. For decades, home infusion has offered these patients the ability to receive safe and effective care in their homes, which improves their quality of life, minimizes exposure to infectious diseases and provides a more cost-effective option for patients to receive critical medications.

These services are particularly valuable to patients in rural areas who otherwise could be forced to travel significant distance to access care. Unfortunately, the Centers for Medicare & Medicaid Services' (CMS') interpretation of the Medicare home infusion benefit has led to access gaps, which are most prevalent in many rural and underserved areas, *as revealed in CMS' own reporting on the program,* which shows no home infusion services provided to beneficiaries in Arkansas, Montana, North Dakota, South Carolina, Vermont, and Wyoming.

Premier urges Congress to pass *The Preserving Patient Access to Home Infusion Act (S.1976/H.R.4104)* to promote patient access to home infusion care by aligning Medicare reimbursement policy with the successful model employed by commercial plans.

III. EXTEND ACCESS TO TELEHEALTH

Telehealth was a critical tool during the COVID–19 public health emergency, allowing providers to continue to furnish much-needed services to patients from the safety of their homes. The flexibilities that CMS granted around Medicare telehealth served to highlight that many services can be effectively and efficiently furnished remotely. Congress recognized the value in easing barriers to virtual care and extended several key telehealth flexibilities in the Consolidated Appropriations Act (CAA) of 2023 through the end of calendar year (CY) 2024, as advocated by Premier.

Today, telehealth continues to serve as a means for providers to expand care to many patients who previously had access barriers, particularly in rural and underserved communities. Congressional action, however, is needed to preserve this important care tool, which is especially critical for those using telehealth to reach specialists at longer distances, for access to mental and behavioral health practitioners and those receiving ongoing remote care for chronic conditions. **Premier urges Congress to further extend the telehealth flexibilities as policymakers continue to evaluate the impact of these policies on patient care.**

As Congress considers extending telehealth flexibilities it is critical that it also extends use of audio-only technology. Nearly a *quarter of beneficiaries* that received a telemedicine service during the COVID–19 pandemic did so by using audio-only telephone technology in both 2020 and 2021. Accessing video technology can be particularly challenging and creates barriers for beneficiaries who are low-income, elderly or who live in rural areas where the broadband infrastructure cannot support streaming video. The COVID–19 public health emergency (PHE) has highlighted

that many services can be effectively delivered as audio-only and do not require a video-connection. **Premier urges Congress to allow for use of audio-only technology for services where it would be clinically appropriate.** For example, many patients have benefited from receiving virtual behavioral health services through interactive audio-only technology. CMS could continue to differentiate which services are eligible to be furnished via audio-only as compared to those that require both audio and video technology. CMS should provide stakeholders with the opportunity to weigh in on these lists as part of annual rulemaking.

IV. EXTEND HOSPITAL AT HOME PROGRAM

In November 2020 in response to the COVID–19 pandemic, CMS promulgated the Acute Hospital Care at Home (AHCAH) waiver, which allowed patients to receive certain acute care services from the comfort and safety of their homes. With these flexibilities as the springboard, more than 300 hospitals across 37 states have embraced the "hospital at home" concept and have tailored their programs to meet specific patient and organizational objectives. The AHCAH program enables providers to effectively monitor and care for patients as they recover in the comfort of their own homes. This can include remote monitoring capabilities, in-home provider visits, telehealth, medication management and many other care strategies. This new avenue of care has freed up hospital capacity, offered a safe and effective method to care for COVID–19 patients, and reduced avoidable emergency department visits.

We appreciate efforts by Congress to extend these COVID–19 flexibilities through CY 2024 while CMS continues to evaluate the program. Preliminary studies from both *CMS* and *external researchers* have found that Medicare patients treated under the CMS hospital at home initiative had low rates of mortality and few hospital readmissions. **Premier urges lawmakers to further extend the Medicare hospital at home program beyond 2024 as it continues to evaluate how these flexibilities can best support patient access to high quality care in their homes.** As part of this, Congress should examine alternatives and refinements to the current hospital at home waiver to permit further adoption in rural and underserved areas.

V. ENSURE ADEQUATE PAYMENT TO RURAL PROVIDERS

Health systems and hospitals continue to operate under enormous financial challenges stemming from a combination of increased labor costs, record inflation and lagging reimbursement rates that do not account for these unprecedented financial challenges. The impact of this problem falls disproportionately on facilities in rural and underserved communities, as providers are increasingly sparse in these areas and therefore require a premium to recruit. Premier has *expressed significant concerns to CMS* that the methodology used to determine annual hospital payment updates does not adequately capture the true costs hospitals have faced over the last few years, especially as it relates to labor. A PINC AI™ analysis found that labor costs have increased by more than 15 percent since the start of FY 2020 through the first half of FY 2023 and do not show signs of returning to a lower level.

Premier urges Congress to develop legislation that requires CMS to re-evaluate the data sources it uses for calculating labor costs and adopt new or supplemental data sources that more accurately reflect the cost of labor, taking into account geographic disparities in rural and underserved areas, such as more real time data from the provider community inclusive of contract labor. This would provide a more accurate, blended and aggregated payment adjustment to all hospitals across the nation based upon their true labor costs. Doing this would also allow payments to ebb and flow as needed to account for any readjustments that occur to labor costs in the future.

Additionally, **Premier recommends Congress develop long-term solutions to stabilize Medicare payments, including eliminating the Medicare sequestration cuts, which have a significant impact on providers in rural and underserved areas.** Congress should also consider how any provider cuts currently being contemplated may inequitably impact rural providers. By establishing policies that create stable, predictable payments for Medicare providers, Congress will help ensure stability for providers in rural and underserved areas and address unjustified geographic payment disparities.

Finally, **Premier urges Congress to take additional actions to promote provider stability and strengthen access to care for patients in rural areas** by:

- **Reforming Rural Emergency Hospitals (REH) policies.** Congress established the REH provider designation as an option for rural communities to maintain access to emergency and certain outpatient services in light of poten-

tial hospital closures. To date, only 21 hospitals have converted to REH status. While many more hospitals may benefit from this policy, there are statutory restrictions that make the provider type untenable for many rural hospitals. **Premier encourages Congress to work with stakeholders to address statutory barriers that have limited uptake of the REH provider type to ensure this new provider type is a viable option for rural hospitals and their communities.**

- **Extending Medicare-Dependent Hospital (MDH) program and Low-Volume Hospital (LVH) payment adjustment.** Congress established the MDH program in the late 1980s to support small rural hospitals where Medicare patients made up a significant portion of their inpatient population. The LVH program, which was established in 2005, provides higher Medicare payments to qualifying rural hospitals to help offset the higher costs associated as a result of low inpatient volume. Congress has modified the LVH payment methodology several times in order to allow more hospitals to qualify. Both programs have been critical to ensuring the sustainability of rural hospitals and access to care in rural communities. However, both the MDH program and adjustments to the LVH program expire at the end of CY 2024. **Premier urges Congress to stabilize rural hospital funding by extending both the MDH program and LVH payment adjustment for multiple years.**
- **Extend support for Community Health Centers (CHC).** CHCs increase access to crucial primary care by reducing barriers related to cost, lack of insurance, distance and language for more than 30 million patients nationwide, many in rural and underserved communities. Through the timely delivery of preventative care, CHCs improve the well-being of countless Americans and reduce government spending on healthcare. In addition, CHCs serve on the front lines in our battle against addiction and mental health and are a lifeline for many patients and their communities. The CHC Fund (CHCF) accounts for nearly 70 percent of health center funding and authorization for the program is set to expire at the end of CY 2024. CHC funding is vital to communities nationwide, over half of which are rural. Further, this funding supports CHC data modernization efforts and preparation for future public health emergencies. Funding for CHCs has historically always received bipartisan support in Congress. **Premier urges Congress to work together to provide stable and strong multi-year funding for CHCs** which support critical care in underserved areas and play a vital role in America's rural communities.
- **Delay cuts to Medicaid Disproportionate Share Hospital (DSH) Program.** The Medicaid DSH program was created to help offset uncompensated care costs for hospitals that provide care to large numbers of Medicaid and uninsured patients. These hospitals provide critical services and are economic and healthcare anchors in their communities. More than 2,500 hospitals nationwide receive DSH payments which help keep many hospitals financially viable and able to provide care to vulnerable individuals. The Affordable Care Act (ACA) required reductions to the Medicaid DSH program over time, beginning in FY 2014, under the assumption that the law would increase health insurance coverage and therefore hospitals would be providing less uncompensated care. Unfortunately, the coverage levels anticipated under the ACA have not been fully realized and therefore the levels of uncompensated care provided by DSH hospitals to uninsured and underinsured remains at pre-ACA levels.

  Premier appreciates recent efforts by Congress to delay the onset of these cuts until January 1, 2025. **Premier urges Congress to act before the end of the year to prevent the pending Medicaid DSH cuts once again for at least 2 years and protect access to care for our nation's most vulnerable patients.**
- **Reauthorize the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act:** The SUPPORT Act, which passed in 2018 with robust bipartisan support, has been instrumental in helping our nation address the opioid epidemic through programs and policies that impact treatment, prevention and recovery. Unfortunately, the SUPPORT Act authorization lapsed as of Sept. 30, 2023. The ongoing opioid epidemic continues to overwhelm hospitals with an estimated 66 million emergency department visits and 760,000 inpatient admissions each year. **Premier urges Congress to reauthorize the SUPPORT Act to reduce barriers to receiving and delivering care for substance use disorders** by improving payment policies (including those that promote

telehealth services), reducing unnecessary regulatory and administrative burden for providers and strengthening the behavioral healthcare workforce.

VI. STRENGTHEN RURAL HEALTHCARE WORKFORCE

The healthcare workforce is currently experiencing severe shortages because of unprecedented pressures exacerbated by the pandemic, pushing our healthcare system to its limits. Projections by the Association of American Medical Colleges (AAMC) show that physician demand will grow faster than supply leading to a projected total physician shortage of up to 124,000 physicians by 2034. These shortages will have real impact on patients, particularly those living in rural and underserved communities. In addition to the physician workforce, we must also take steps to bolster the ranks of non-physician clinical roles, including nursing, but also other vital roles such as pharmacists, occupational therapists, respiratory therapists and more. **Premier believes addressing workforce shortages requires a multi-pronged approach and urges Congress to take the following actions:**

- **Extending workforce training programs.** The Teaching Health Centers Graduate Medical Education (THCGME) program, the Children's Hospital Graduate Medical Education Program (CHGME) and the National Health Service Corps (NHSC) program are not only fundamental for tackling the healthcare labor shortage, but they provide essential and comprehensive services for rural and tribal communities as well as children nationwide. These programs expand our ability to deliver primary care across the country and are fundamental to tackling the healthcare labor shortage. Premier appreciates recent legislation to extend many of these programs through CY 2024. **Premier urges Congress to continue its record of bipartisan support for workforce training programs and provide stable multi-year funding for these programs.** Congress should also consider support for "earn while you learn" programs that support the growth and development of healthcare workers while employed in a healthcare facility.

  Additionally, under the Conrad 30 program, each state is allocated 30 waivers that exempt J–1 physicians from the requirement to return to their country of origin in exchange for three years of service in an underserved community. Premier supports The Conrad State 30 and Physician Access Reauthorization Act (S. 665/H.R. 4942). While a temporary extension of the program's authorization until Sept. 30, 2024 was recently enacted, Premier urges Congress to further extend this program which has helped Americans in rural and underserved areas receive medical care.

- **Investing in residency training.** To help grow a sustainable physician workforce to meet patient needs, increased Medicare support for graduate medical education (GME, or residency training) is needed. **Premier urges Congress to take additional action to increase Medicare-supported GME slots by passing the bipartisan Resident Physician Shortage Reduction Act of 2023** (S. 1302/H.R. 2389). This legislation which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for 7 years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied needs, including hospitals in rural areas and hospitals serving patients from federally-designated health professional shortage areas.

- **Boosting non-physician pipeline.** An issue Premier frequently hears with respect to nursing shortages is that the pool of willing candidates exceeds the number of available training slots in schools of nursing, at least partly due to limited number of available training faculty. **Premier encourages Congress to consider ways to increase training facility capacity,** including examining whether all educators in such programs should require an advanced degree or if there are opportunities for flexible standards that might create additional training capacity if some educators are permitted to have a bachelor's degree only for example. **Premier also recommends that Congress seek opportunities to provide support to grant programs that expand vocational programs to help train advanced practice providers, such as nurse practitioners, and other clinical roles that do not require 4-year degrees, such as home health aides; nursing assistants; or technicians for pharmacy, radiology and laboratory.** Premier additionally encourages Congress to support approaches and programs that connect high school students to health careers by enhancing recruitment, education, training and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in healthcare, resulting in benefits for all patients and pro-

viders. Studies also show that underrepresented students are more likely to serve patients from those communities.

- **Reforming loan forgiveness programs.** Loan forgiveness programs should be considered to incent new talent to join the field. However, in many cases healthcare workers opt to not accept loan forgiveness funds because they are accounted for as income and can have a detrimental impact on an individual's finances if pushed into a higher tax bracket. Similarly, healthcare workers are often hesitant to accept employer assistance funds as they can also be counted as income and force the worker into a "benefit cliff." Therefore, **Premier urges Congress to ensure that the tax implications of loan forgiveness programs do not act as inadvertent disincentives to individuals participating.**

VII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments in response to the Finance Committee's hearing. Please consider Premier and our significant cohort of rural providers a resource as you continue this important work. If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy at melissa—medeiros@ premierinc.com.

Links:

https://www.cms.gov/files/document/hit-monitoring-report-feb-2023.pdf

https://www.congress.gov/bill/118th-congress/senate-bill/1976?q=%7B%22search%22%3A%5B%22s.+1976%22%5D%7D&s=5&r=1

https://aspe.hhs.gov/sites/default/files/documents/cb83f6f25c25c3a3529807f23cd2327d/medicare-telehealth-updated-trends-report.pdf

https://jamanetwork.com/journals/jama-health-forum/fullarticle/2811346

https://www.acpjournals.org/doi/10.7326/M23-2264

https://premierinc.com/downloads/Premier-Comments_-IPPS-FY-2024-Proposed-Rule_FINAL.pdf

https://premierinc.com/newsroom/blog/pinc-ai-data-cms-data-underestimates-hospital-labor-spending

https://www.aamc.org/media/54681/download

https://www.congress.gov/bill/118th-congress/senate-bill/665?s=2&r=1&q=%7B%22search%22%3A%22s.+665%22%7D

https://www.congress.gov/bill/118th-congress/house-bill/4942

https://www.congress.gov/bill/118th-congress/senate-bill/1302

https://www.congress.gov/bill/118th-congress/house-bill/2389

RURAL HOSPITAL COALITION
500 North Capitol St., NE
Washington, DC 20001
(202) 756–8334
https://www.larhc.org

Statement of Nancy Taylor, Counsel

Chair Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, on behalf of the Rural Hospital Coalition, which represents about 300 rural hospitals across 30 states, we want to express our sincere appreciation of your continued commitment to ensure rural hospitals receive adequate payments and services remain available to patients in rural communities. We further appreciate your continued support for the Low-Volume Hospital (LVH) Program and the Medicare Dependent Hospital (MDH) Program and encourage Congress to support these programs going forward.

The LVH Program and the MDH Program are two rural hospital add-on payments that receive Medicare reimbursement, which allows for rural hospitals to continue providing crucial care to Medicare beneficiaries in the community. To obtain the Low-Volume Hospital Payment Adjustment of 25%; the hospital must have less than 200 total discharges and be located more than 25 road miles from the nearest IPPS

hospital. The Medicare Dependent Hospital, a hospital must be in a rural area and be designated as MDH in prior years.

Rural hospitals are facing enormous financial challenges. Between the years 2005 and 2022, 186 rural hospitals closed, and according to the American Hospital Association (AHA), an estimated one in four rural hospitals remain at risk of closing.[1] These financial challenges are driven primarily by lower patient volumes and the markedly lower payment rate for rural hospitals by the government and private insurance companies.

Furthermore, rural hospitals are often the largest employers in their communities and when rural hospitals suffer, so too does the community at large. Between 1990 and 2020, rural counties that experienced hospital closures, or a facility no longer provided in-patient care, the county suffered higher unemployment rates, lower per capita income, and lower median household incomes.

We thank the Chair, Ranking Member, and other members of the Committee for their efforts over many years in extending these programs. While the Rural Hospital Coalition supports permanent establishment of these programs that help hospitals who meet the requirements, and we also support the extension of these essential programs in rural communities.

[1] Rural Health Research Gateway, June 2023.