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IMPROVING HEALTH CARE ACCESS IN RURAL COMMUNITIES: OBSTACLES AND OPPORTUNITIES

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BEFORE THE

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OF THE

COMMITTEE ON FINANCE

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IMPROVING HEALTH CARE ACCESS IN RURAL COMMUNITIES: OBSTACLES AND OPPORTUNITIES

WEDNESDAY, MAY 17, 2023

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:36 p.m., in Room SD–215, Dirksen Senate Office Building, Hon. Benjamin L. Cardin (chairman of the subcommittee) presiding.

Present: Senators Wyden, Stabenow, Carper, Casey, Whitehouse, Cortez Masto, Grassley, Thune, Lankford, Daines, Barrasso, and Blackburn.

Also present: Democratic staff: Martha P. Cramer, Staff Director for the Subcommittee on Health Care of the Senate Committee on Finance, and Health Policy Advisor for Senator Cardin; Michelle Galdamez, Legislative Aide for Senator Cardin; and Carolyn A. Perlmutter, Legislative Aide for Senator Cardin. Republican staff: Grace Bruno, Health Policy Advisor for Senator Daines; and Mathew May, Legislative Correspondent for Senator Daines.

OPENING STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. SENATOR FROM MARYLAND, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator CARDIN. The Subcommittee on Health Care of the Senate Finance Committee will come to order. First, I want to thank Senator Daines and Senators Wyden and Crapo for their help in allowing us to arrange this hearing. This hearing will deal with "Improving Health Care Access in Rural Communities: Obstacles and Opportunities."

I think this is one of our more important hearings. We recognize that we have, in the United States of America—and certainly in my State of Maryland—some of the most outstanding health-care facilities in the world. We are proud of the quality of health care that we have in our community. But if you do not have access to that care, that high quality is not going to help you very much. We know in rural America, there are challenges that we need to confront, but there are also opportunities that allow us to make advancements in those areas.

Maryland, as many people think, is an urban State, with Baltimore and the Baltimore suburbs and the Washington suburban counties around the Nation's Capitol. But Maryland has a large

rural population in the western part of our State, the eastern part of our State, southern part of our State, northern part of our State. Central Maryland is more urban; the rest is pretty rural. So this is an issue that is important to Maryland. It is important to every State in our Nation.

Rural communities have challenges today. One out of every five older Americans live in rural communities. It is an older population. It is a population that has less access to health-care providers.

When you take a look at the recent statistics from the Health Resources and Services Administration, they estimate that nearly 13 million adult citizens in rural communities have behavioral health issues that need health-care attention. And yes, they are about half as likely to have a health-care provider to provide those services. These are gaps in our health-care system that we need to take a look at and find ways to improve.

We know the workforce challenges. We have a workforce challenge generally in health care today. We recognize that, and COVID made it more challenging, because they are front-line workers. So, in rural communities, it is even more difficult to be able to attract the workforce that you need. These are areas that we need to take a look at as a committee, as to what we can do to help.

One of the areas that I have concentrated on since my days in the Senate has been oral health care. Oral health care is a general indication of general health care. We know that we have had challenges in access to oral health care in all of our communities, but in rural America, it is even more challenging to get the health-care professionals that are needed for regular oral health-care needs.

So, these are some of the areas that we want to take a look at. When the Affordable Care Act was passed, I was proud to be the sponsor of the amendment that established the National Institute for Minority Health and Health Disparities. Well, many people think that concentrates solely on racial minorities or ethnic minorities, but it also deals with underserved communities. And rural America is certainly an underserved community.

So, it is one of the areas of attention that we need to deal with in the United States Senate. There have been a lot of innovative approaches. I have seen, in my own State of Maryland, really excellent opportunities to try to close the gap. Several years ago, I was in Pocomoke City, MD, a pretty rural part of our State located all the way down on the lower Eastern Shore. They were using telehealth well before it had become a more popular option, in order to provide access to care that otherwise would not be there.

I have seen creative alliances. In Maryland, we had the Garrett Regional Medical Center located in Oakland, MD. That is as far west as you can go in our State. They have an alliance with the West Virginia University Health System, which has allowed them to get the sophisticated care at their hospital that otherwise would not be able to be given. And the use of our qualified health centers has also helped us bridge some of the gaps.

So today at this hearing, we have a distinguished panel of witnesses that will help us sort through what we can do as far as poli-

cies in the U.S. Senate, to help provide greater access to health care in the rural communities.

Before turning to our witnesses, let me turn to our distinguished ranking member, Senator Daines.

OPENING STATEMENT OF HON. STEVE DAINES, A U.S. SENATOR FROM MONTANA

Senator DAINES. Chairman Cardin, thank you, and thanks for your tireless efforts in health care over the years, and in oral health care, as well as just for being the champion for the rural parts of our States. It is also a pleasure to be joined today by Ms. Erin Aune from Glasgow, MT. There is rural, and then you get out to eastern Montana—that is *rural.*

We will have a more formal introduction soon, but, Erin, thanks for making the trip here to represent our State and rural health clinics. We are very glad you have made the long journey. There is no easy way to get from Glasgow, MT to Washington, DC.

Rural health is a key component of America's health care. It is a greatly important issue in my home State of Montana, as more than 720,000 Montanans live in designated rural areas. That is about three-quarters of the population of the entire State.

Almost every State in the Nation, as the chairman indicated is true in Maryland, has some semblance of a rural population, and in frontier States like Montana, we are all too familiar with the challenges that come with living where we do, including the challenge of accessing health care.

When we consider health care in a rural setting, one of the defining characteristics of access to care is distance as well as logistics, which more specifically means transportation. The majority of people in rural America live great distances from their nearest healthcare provider.

A trip to a hospital or a doctor's office often requires traveling several hours, sometimes a full day one way. Not only is this highly inconvenient and straining, but also very dangerous in emergencies. Extreme weather—that is where it could take a full day sometimes in States like Montana—and unpredictable terrain only add to the challenges that our folks in rural areas face.

Other threats to access we see disproportionately affecting rural communities are the increasing number of hospital closures and service line erosions. As our witness Dr. Holmes can attest, we have seen nearly 150 rural hospital closures in the past 13 years.

While closures briefly stalled in 2021, this can largely be attributed to provider relief funds and other assistance to keep providers afloat during COVID–19. Now, as we move beyond that pandemic, the number sadly is on the rise again. I also hear too often about the erosion of service lines in rural America.

In these areas, one of the first services to be eliminated is obstetric and maternity care. GAO in fact issued a report just last year that found access to these services has been in a steady decline, and more than half of rural counties do not have these services available at all. In fact, we just heard the story about a fellow Montanan, a woman who traveled from her home several hours away from Billings, in the weeks leading up to her due date. She moved into a hotel so that when she went into labor, she would be able

to get to the hospital for her delivery. Preparing for labor and delivery of newborns is difficult enough. No expectant mom should feel the need to go to these drastic lengths to receive routine prenatal and delivery care.

This is just one example of how service line erosion impacts rural residents, but it is illustrative of the challenge we need to help address, and this hearing will help us in that regard today. We must find sustainable ways to keep health care accessible in our rural communities. To that end, I am looking forward to discussion today from our colleagues and witnesses and hearing their perspectives. The last time, by the way, the Finance Committee had a robust conversation about rural health was 5 years ago, in 2018. I am glad we are revisiting the conversation today. Again, I want to thank the chairman for his leadership here. We are doing it post-pandemic, to examine the difficulties in progress over the past 5 years.

We are proud of Senator Grassley's leadership. In January of this year, the first new Medicare rural provider designation went into effect since the Critical Access Hospital designation was created all the way back in 1997. We are proud of the Montana leadership, which led to this designation. I think about my boy State speaker in Montana. It was a guy named Max Baucus. He spearheaded this, and now it is great to see Senator Grassley and others working to implement new and creative ways to serve the changing needs of our rural hospitals today.

So, thanks to the witnesses who, if you are from rural parts of our country, it was not easy to get here. We appreciate your expertise on this subject.

Mr. Chairman, I will turn it back to you.

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

Senator CARDIN. Thank you, Senator Daines. Senator Daines, I am going to yield to you for the introduction of your Montanan who is here.

Senator DAINES. Thank you. You even said "Montanan" correctly. [Laughter.] You know, there are not a lot of us out there. You stuck the landing there. Thank you.

Mr. Chairman, I am very glad to introduce Ms. Erin Aune this afternoon. Ms. Aune serves as the vice president of strategic programs at Frances Mahon Deaconess Hospital in her hometown of Glasgow, MT.

Previously, she served as the director of Glasgow Clinic Specialty Care Division at FMDH, overseeing orthopedics, general surgery, OB/GYN, and the operations and marketing of Hi-Line Med Spa, which she helped launched, bringing a new service line to that community. She has been with FMDH for 8 years. She serves on the hospital's senior leadership team, and also serves on the board of directors for the National Association of Rural Health Clinics.

Ms. Aune is very active in volunteering and participating in community events. She has served on the Glasgow Chamber of Commerce board of directors for the past 10 years.

I am just getting tired reading your background, Erin. Ms. Aune has also been married for almost 14 years to her husband Jake, a mom of two boys, aged 10 and 12, who keep her busy with sports.

Her older son had a stellar wrestling season this year, securing his spot on Team Montana and helping lead the team to the National Tournament in Des Moines, IA. When you are in Iowa and you are wrestling, it is big time. I know that. She also serves on the board of directors for the Glasgow Wrestling Club that her children are active participants in.

Ms. Aune, we are truly grateful. You took time out of your busy schedule to be with us here today, and I look forward to hearing your unique Montana perspective on the challenges as well as opportunities we face in rural health care.

Mr. Chairman, thank you.

Senator CARDIN. Well, welcome. It is wonderful to have you here, Ms. Aune.

The next person I will introduce is a Marylander. Ms. Sara Rich is president and CEO of the Choptank Community Health System. She has a master's in public administration from Western Michigan University and over 25 years' experience in local, State, and national health-care settings.

She joined Choptank in 2007 as the vice president of community programs. Ms. Rich was named the senior vice president and chief operating officer at Choptank in June of 2015, and in January 2017 she was appointed by the Choptank Community Health Systems board of directors as their CEO.

Our third witness will be David Herman. Dr. Herman serves as chief executive officer for Essentia Health, an integrated health system headquartered in Duluth, MN. Dr. Herman oversees 77 clinics, 14 hospitals, and 15,000 employees who care for patients in rural Minnesota, Wisconsin, and North Dakota.

Dr. Herman is a native of International Falls, MN. He received his medical degree from Mayo Medical School in Rochester, MN, and completed his residency in ophthalmology at Mayo School of Graduate Medical Education.

And our fourth witness is Mark Holmes. Dr. Holmes is the director of the Cecil G. Sheps Center for Health Services Research in the North Carolina Rural Health Research Center at the University of North Carolina at Chapel Hill, where he specializes in rural health, including hospital finances and Federal payment policies. You can explain all that to us. We can use your help.

He is also a professor of health policy and management at the Gillings School of Global Public Health. He grew up in rural Michigan—another person from Michigan. I am telling you, Senator Stabenow has a great deal of influence on our selection of witnesses.

We will start with Ms. Aune.

Ms. AUNE. Good afternoon, Chairman——

Senator CARDIN. By the way, your full statements will be made part of the record. You may proceed as you wish.

STATEMENT OF ERIN AUNE, MBA, CRHCP, VICE PRESIDENT OF STRATEGIC PROGRAMS, FRANCES MAHON DEACONESS HOSPITAL, GLASGOW, MT; AND BOARD OF DIRECTORS MEMBER, NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS, FREMONT, MI

Ms. AUNE. Okay. Good afternoon, Chairman Cardin, Ranking Member Daines, and members of the subcommittee. Thank you for

the opportunity to discuss the obstacles and opportunities in rural health.

My name is Erin Aune, and I am the vice president of strategic programs at Frances Mahon Deaconess Hospital in Glasgow, MT. I also serve on the board of directors for the National Association of Rural Health Clinics, which represents over 5,300 CMS-certified Rural Health Clinics in 45 States across the country.

During my testimony, I hope to take you on a journey of what it is like to access and help to provide health care while living in the heart of rural America. The Rural Health Clinics program was created in 1977 and remains the oldest Federal program aimed at improving access to outpatient care in rural, medically underserved areas.

The RHC program as a whole serves approximately 37.7 million patients per year, more than 11 percent of the entire population, and approximately 62 percent of the 60.8 million Americans who live in rural areas. The RHC program is a separate facility type from the Federally Qualified Health Center program, also represented on today's panel. Those serve a critical role in our country's health-care safety net.

I feel fortunate to represent one of those Rural Health Clinics located in Glasgow, MT. Now, if you are picturing mountains, we are not that side of the State. Glasgow lies in the northeast corner of Montana, and is an agricultural community with big skies and wheat fields as far as the eye can see.

Glasgow has been deemed "the middle of nowhere" by *The Washington Post,* as it is the most geographically isolated area, taking 4½ hours in any direction to get to a city. As a provider-based RHC attached to a critical access hospital, we have no choice but to be very strategic on how we can best serve our community and the surrounding areas.

Glasgow has a population of about 3,500 residents; 7,600 people live in the county and about 15,000 in the two neighboring counties. Fort Peck Indian Reservation is also located 15 miles to the east of us. With the closest major hospital over 300 miles away, we work very hard to provide our service area with as many service lines as possible, to relieve some burdens for our patients.

Our RHC provides a wide range of services, including primary care, behavioral health, general surgery, orthopedics, and OB/GYN. We are especially proud that we recently achieved 24–7 coverage in general surgery, OB/GYN, and orthopedics. My testimony today will focus on specific challenges and solutions in the workforce, as well as access to care barriers like transportation. I encourage you to read my full testimony submitted to the record for further details.

As is the case for other rural areas, recruitment challenges are significant in the middle of nowhere. After years of provider turnover and unfilled openings, we strategically found a staffing model which would allow us to provide specialty services locally. In 2020, we contracted with a company that provides 24–7 orthopedic coverage. The providers are a team of three full-time employees covering the month on a rotating basis. This model worked so well that we expanded to general surgery and OB/GYN, and are now considering it for radiology. Being able to offer these services lo-

cally provides better patient outcomes, continuity of care, a better work/life balance, and helps prevent provider burnout.

Further, we have sought to inspire our youth to pursue careers in health care, based on the quality of care they receive from our organization. This year, we will be hosting the first Med Camp for kids in grades 6 through 8, introducing them to multiple areas of the hospital and clinic. For other service lines, including behavioral health and maternal/fetal medicine, we are exploring the use of telehealth services and outreach.

While partnerships to offer telecrisis services through our emergency room are working well to address some of these needs, offering telehealth services presents challenges as well. A great deal of our patient population does not have access to a computer, the Internet, or a phone.

These services may seem like a great solution to help bring care to the patient, but when they cannot access the care, it becomes more of a burden and frustration to those we are seeking to help. Many of our patients travel 50 to 100 miles one way to attend an appointment at our facility, which leads me to one of the biggest barriers our community is facing: transportation.

I can share many stories with you, but one that stands out is from this winter, when a patient presented to the ER by ambulance, a non-emergency ride, which was denied by Medicaid. After the patient was discharged, they were planning to walk 30 miles home to Frazier in a temperature of negative 35 below, with wind chills.

We need more systemic solutions to address the impacts of transportation barriers. Canceled appointments lead to lapses in care, and this is only heightened when they need a higher level of care at a facility hours away. My clinic is just one of the 5,300 RHCs across the country, providing critical services in innovative ways to serve the needs of our patients.

Issues, such as outdated conditions of participation for the RHC program, reimbursement disparities in health coverage, and a drastic increase in Medicare Advantage enrollment without a protection for RHC reimbursement, challenge an already overwhelmed workforce and threaten the delivery of quality and outpatient care in rural America.

I want to thank you for inviting me to share these unique perspectives as part of today's hearing. I am proud to be a voice and advocate for this population. I look forward to seeing the work we can do together for the over 60 million individuals across rural America.

Thank you.

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

Senator CARDIN. Thank you for your testimony.

Ms. Rich?

STATEMENT OF SARA K. RICH, MPA, PRESIDENT AND CEO, CHOPTANK COMMUNITY HEALTH SYSTEM, DENTON, MD

Ms. RICH. Good afternoon, Chairman Cardin, Ranking Member Daines, and members of the subcommittee. Thank you so much for the opportunity to testify today. As president and CEO at Chop-

tank Community Health, I am honored to represent the more than 1,400 health centers that are across this country.

In 2021, health centers provided services to more than 30 million people. Health centers deliver primary health care to the Nation's underserved individuals and families, including one in three people living in poverty, and one in five people living in rural areas.

Choptank Community Health System's mission is to provide access. We want to provide access to exceptional, comprehensive, and integrated health care for all. Since 1980, we have been providing access to quality health care through the delivery of medical, dental, and behavioral health services, now in five counties representing seven locations on Maryland's Eastern Shore. In 2022, we saw more than 30,000 patients, representing 99,000 visits.

In my written testimony, I share several obstacles that rural communities face in accessing health care, and how community health centers are working to overcome those obstacles. This afternoon, I am going to focus on two of these obstacles, workforce and access points for care, and certainly how Choptank is working to overcome those in an innovative way.

So Choptank, along with other rural health centers—and really health-care systems all over the country—is experiencing unprecedented shortages in attracting and maintaining a qualified workforce. At this time, we are recruiting 43 open positions at our health center. Fifteen of those are providers, and those represent medical, dental, and behavioral health, and we have 28 positions open for clinical and support staff throughout Choptank.

So, what do we do? Well, at Choptank we know we need to work on having a robust recruiting effort. We are always working on how we can improve it, tweak it, and make it better. At the same time, we have recognized that we have to have a pipeline of providers and clinical staff. We need to be looking at "grow your own" programs.

And so we are working on that. Some of our efforts include a collaboration with the University of Maryland School of Medicine and the University of Maryland Shore Regional Health to design a rural family medicine training experience for graduate and new physicians.

We know that physicians who train in a health center are nearly twice as likely to begin their careers in a similar setting, providing significant benefits in the rural communities that they serve. We also have expanded a longstanding partnership with NYU/Langone for advanced education and general dentistry. This program is really critical in providing access to oral health care and our health centers, and it does serve as a recruiting resource.

We have hired many of the dental residents that came to Choptank and hired them when they did complete their training. We also have plans in the works to add a pediatric dental residency as well, in partnership with NYU/Langone. We have also partnered with the local community college to address the shortage of clinical support staff. So we have developed a scholarship program to support the certification for medical assistants and dental assistants.

So, meeting people where they are to provide access to care is vital to meeting the mission of health centers, and Choptank is no different. We reach the communities that we serve in a variety of

ways, and one of those is through school-based health centers. We started school-based health centers at Choptank back in 1999, and at this point in time we have 30 health centers that are providing not only medical, but dental, behavioral health, and nutrition services.

Often, these centers are the only method of health care that these students are receiving. We have also had three mobile units that we have added to our access delivery model, that have helped us reach the communities we serve. Outfitted for medical and dental services, the units travel across the Midshore to community events, and they are providing really important health screenings.

Choptank's presence at these events helps to build credibility and increase trust as well. So, new access point funding for new health centers, including funding for mobile health units and school-based health centers, is needed. We certainly recognize that there are budgetary restrictions, but we do know that investing in health centers saves the health system an estimated $24 billion annually in reduced medical expenditures.

Not only that, but expanding our reach as health centers will positively impact America's health outcomes. We know how to provide the access to care. We need funds to continue to do this work, especially with many of the obstacles that we are hearing about this afternoon.

So, thank you for your time today. I really have only scratched the surface of obstacles and opportunities. But I do want to leave you with this: community health centers like Choptank are passionately committed to people. They are very committed to providing quality health care, and we are part of the solution in providing access to medical, dental, and behavioral health services, especially in rural areas.

Health centers are innovative in putting together new programs and services and partnerships, which are really key, and all of this will impact America's health outcomes.

So again, thank you, Chairman Cardin, Ranking Member Daines, and members of the subcommittee. I look forward to your questions.

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

Senator CARDIN. Thank you very much for your testimony.

Dr. Herman?

STATEMENT OF DAVID C. HERMAN, M.D.,
CEO, ESSENTIA HEALTH, DULUTH, MN

Dr. HERMAN. Chairman Cardin, Ranking Member Daines, and members of the Senate Finance Subcommittee on Health Care, thank you for the opportunity to testify at today's hearing on improving health-care access in rural communities. We deeply appreciate your invitation to speak with you today on behalf of Essentia, and about our commitment to value-based care, which has demonstrated significant benefit for our patients.

Essentia Health is an integrated health-care system serving predominantly rural communities in North Dakota, Minnesota, and Wisconsin. We are all too familiar, as my colleagues are, with the unique combination of health-care challenges facing rural residents

across the country. It has been said that value-based care cannot be implemented in rural America, that it just does not work.

In our experience, we have found it is the only thing that really does work. This approach to care focuses on improving overall patient health, with an emphasis on wellness and prevention. It is about connecting patients with the appropriate care at the right time, and providing coordinated care throughout the patient's journey. Through the tools and infrastructure built to support this work, we better manage chronic conditions, reduce avoidable hospital admissions and emergency department visits, and improve the quality of our care. We know that our patients' goal is not to consume health care. It is to be healthy and lead better lives.

Value-based care allows us to provide care in thoughtfully planned ways that result in excellent health outcomes and lower cost. Simply put, value-based care is the best model for rural patients and for all patients. It is neither practical or proper to differentiate the way we care for patients based upon their enrollment in a value-based program. Stratifying patients by their clinical and social needs, rather than by payer, is the most effectable and most equitable. Our approach creates a model of care delivery that is as standard as possible and unique as necessary to meet the needs of our patients and their communities.

Recognizing that this is the best model for all patients, Essentia Health began a shift to value in 2005, when we entered our first value-based contract. This led us to be an early adopter of dual-sided risk models and Medicare Shared Savings Programs, and Minnesota's Medicaid initiative called Integrated Health Partnerships.

Today, we have 23 value-based care programs with both government and commercial payers, with more than 200,000 attributed members. In fact, nearly 40 percent of our health system revenue flows through value-based programs, and we continue to work to grow that number.

So, how did we do this as a health system that serves so many rural communities? Our success starts with a strong clinical and information technology infrastructure made possible by the scale of our integrated health system. Our robust electronic medical record allows us to better understand our patient populations, and to screen for the social determinants of health.

In 2022, more than 144,000 Essentia health patients completed our health-related social needs screening, and more than 20,000 of those patients identified at least one social need related to food insecurity, transportation, or financial difficulties. Informed by that data on our patients, our care teams work together to address needs and care gaps. Yet we realize we cannot do this all on our own. We have implemented an online platform called "Resourceful" that links our patients with a host of community resources. Providers can make referrals right from the electronic health record and then learn through a feedback mechanism if that referral has been completed.

Through this work, we are helping real patients and saving real dollars. From 2018 through 2021, Essentia Health saved the Federal Government more than $42 million, thanks to our Medicare Shared Savings Program participation. We saved $28 million for

the Minnesota Medicaid program. Collectively across all programs, governmental and commercial, Essentia Health has removed over $102 million from the cost of care through our value-based programs. At the same time, the quality of our care continues to improve. In 2021, our providers earned 98 percent of the Shared Savings Program quality targets. In the latest quality report from Minnesota Community Measurement, we were one of two organizations attaining the high-performing status in 13 measures, which is the highest performance in a State with a primarily rural population.

The move to value-based care requires a commitment to a new approach and continuous quality improvement. A shared IT infrastructure to support rural providers in this journey is the key, along with partnerships with community resources. Lawmakers can support this work by aligning financial incentives with value-based care, and protecting critical safety net programs that help rural hospitals.

Thank you once again for the opportunity to share our success with value-based programs in the rural communities we are privileged to serve. I sincerely hope that this can become a premier care model for sustainable health care in rural America.

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

Senator CARDIN. Thank you, Dr. Herman.

We will now go to Dr. Holmes.

STATEMENT OF MARK HOLMES, Ph.D., DIRECTOR, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH; DIRECTOR, NORTH CAROLINA RURAL HEALTH RESEARCH CENTER; AND PROFESSOR, HEALTH POLICY AND MANAGEMENT, GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC

Dr. HOLMES. Good afternoon, Chairman Cardin, Ranking Member Daines, and members of the subcommittee. Thank you for the invitation to appear here today. My bio was read earlier, but I think more importantly, I would mention that having grown up in Caro in Michigan's rural thumb, with family members still there, that I have a deep personal connection to rural health.

I am unable to cover all of the salient issues in rural health today, so I will focus my comments on three main points. First, the rural health-care infrastructure continues to erode, threatening the health and well-being of 60 million rural Americans. Second, Congress can address some specific policy issues in the rural health workforce. Third, rural communities have shown remarkable innovation, and recent policy initiatives have been successful.

Rural-urban health disparities are well known. In the last 2 decades, the rural-urban mortality gap has more than tripled. Rural COVID–19 death rates surpassed urban rates as early as September 2020.

We also need to think about less visible disparities: my family members who had to drive an hour each way or stay overnight to get radiation treatment, facing the expense and the fatigue of long car travel while in the midst of fighting cancer; pregnant people who live in a rural community where the hospital OB services closed will worry about whether they will be able to reach a pro-

vider in time for the birth or go to a hotel and make sure that they are there in time; the frustration and exhaustion of rural residents with opioid problems or issues who must wait in an emergency room for hours or days before a transfer to a mental health facility. Fatigue, worry, and frustration do not show up in official statistics.

Since 2005, nearly 200 rural communities have lost their hospital. Although roughly half of these hospitals have continued to provide some kind of health care to their community, the remainder do not. Because hospitals are typically one of the largest employers in a rural community, closures can have large economic effects.

Hospitals are typically one of the most important health-care providers in a rural community, and many have had weak and declining finances for years. In 2018, roughly half of rural hospitals were unprofitable, and financial distress is one of the leading causes of rural hospital closure.

As hospitals close, residents face a decrease in health-care access. Congress, the Medicare Payment Advisory Commission, and others have long proposed new models of care that focus on a hospital's emergency department services. Senator Grassley's dedication to this issue manifested in the Rural Emergency Hospital provision in the Consolidated Appropriations Act of 2021.

I applaud Congress for acting innovatively to address rural health needs. Continued monitoring of this provider type will be necessary to ensure it is meeting the needs Congress intended.

Rural places have long faced persistent workforce shortages. Many proposed policy solutions to address these workforce challenges focus on one profession, for example, nurses, or one stage of the career, such as graduate medical education. To shore up and grow the rural health workforce, it is critical that we look to solutions that are not siloed in this fashion, and support health-care workers across their entire career trajectory. Health professionals that train in rural areas are five times as likely to remain and practice in rural areas.

Evidence-based investments that increase the number of health professionals training in rural areas, increase the number of preceptors and faculty, provide support to early-career health-care workers, address workplace violence, and focus on retaining mid- to late-career health-care professionals, have been shown to work and could be expanded. By growing the number of rural training opportunities and then ensuring that resources are available to retain that workforce across their careers, we can ensure that the workforce needed to meet the needs of rural areas is there for decades to come.

We commonly hear about rural America being sicker, poorer, and older. These are accurate descriptions of a population that provides much of America's food, fun, and fuel. As much as it describes the health challenges in rural communities, I worry it suggests government is powerless to improve rural health. In fact, when Congress and other policymakers have developed policy to address rural needs, it has improved health in rural communities. There are many examples of rural health-care innovation.

Telehealth, community health workers, expanded scope of practice and task-shifting, drones, new payment models, and leveraging

strong trust in community leaders are all examples where lessons from rural innovation have helped fuel transformation throughout the health-care system. My written testimony provides more examples of creative local-based solutions. This kind of innovation that is responsive to the needs and assets of the community should be fostered and supported.

History has shown that thoughtful legislation designed to address rural-specific challenges and leverage the assets of rural America has been successful in improving the lives of the 60 million rural Americans. Rural health-care systems are different from urban systems, but they can produce similar or better health outcomes when given the opportunity.

The pandemic exposed the fragility of our rural health-care system. Fortunately, Congress has a number of policy opportunities to make real improvements in the health of rural America.

Thank you.

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

Senator CARDIN. Well, thank all four of you for your contribution to this hearing. Each of you have initiated plans in your own community to try to fill the gaps on access to care. So, one of the questions I will be asking you, if we have time during this first round, is what tools at the Federal level have helped you to implement that, and what additional tools would you like to see?

Ms. Rich, you talked about the—and I have been to Choptank many times. The services you are providing are incredible, and you are right: your people are really dedicated to their mission. You talked about mobile facilities or school-based facilities. Senator Stabenow and I worked in regards to the lack of access for oral health care, and we used mobile and school-based as a way to fill that gap, and it worked pretty effectively.

So, what additional incentives do we need in order to provide that type of service in rural communities? As one of you mentioned, some of your community does not have access to the Internet or even telephone service. How do we expand telehealth to rural America? Perhaps broadband is part of that, but how do we make that more effective, and what tools can we provide to make that work in your community?

Dr. Herman, you talked about value-based care. In Maryland, we have a total cost of care model, which is, I think, the ultimate in value-based. What other incentives do we need in order to allow you to move forward in those initiatives?

So, I guess my question to the panel is, what would you like to see us do in order to help you fill—we cannot fill in the rural community. You do not want us to do that, so the population is going to be sparse. What can we do to help preserve your unique way of life?

When you deal with preventive health care and you deal with wellness, it is so difficult if you cannot have more of a presence in a community, particularly with an older population that has more and more challenges.

So, just go down the line, if you have programs that you think we can help you with at the national level to meet your needs locally.

Ms. AUNE. Yes. So as far as telehealth goes, our community, a lot of them are aging populations. So they do not have the Internet, phone, or computer. So that was part of our social determinants of health, that one of the markers that was high was connectivity. So, a lot of cellphone service we do not even have in the area, if they are up north.

So our patients are actually traveling down to our hospital to use our computer to access their telehealth in Billings. So maybe getting them computers or something. And then our telehealth in the Rural Health Clinic is capped at a rate of, I believe, $98.24, around there.

So those appointments are not generating as much income either for us. But the connectivity issue, I think, would be something to address.

Senator CARDIN. And we did some of that in the bipartisan infrastructure bill. But we can look at how we can perhaps build that up more.

Ms. Rich?

Ms. RICH. Well, thank you, Senator Cardin. So, school-based health centers are a powerful tool, and when we think about how we can improve health outcomes in rural areas, it is again, how can we reach people in different ways? And so, we have a lot of tools in our toolbox to do that. The school-based health centers are very powerful, and in fact, one of the things that we have recently done was converted two of our school-based health centers—and I should not say "converted," but expanded their reach.

So, two of them are now open to the community residents as a whole. So not just the school community, but the community around, because they are located a far distance from some of the other health care access points. So additional support, funding for school-based health centers; mobile health units as well.

There was a bill that recently passed to include mobile units as part of the new access point funding if there is some available for health centers. So, moving that forward is great, but we have not had new access point funding to bring more of those mobile health units to life.

And then the other piece regarding telehealth—it was a lifeline. It still is a lifeline, but preserving the reimbursement for that, not only for the virtual visits as we like to call them, but also the audio-only visits, because back to my colleagues' point, having access to Internet, broadband, et cetera does provide some big obstacles for the communities that we serve. So sometimes that phone call, and being able to talk to the patient and connect with the patient that way, makes a huge difference.

Senator CARDIN. And we have bipartisan legislation that would do that.

Dr. Herman?

Ms. RICH. Thank you.

Dr. HERMAN. We believe that our patients really pay us in three types of currency. They pay us with their trust, they pay us with their time and attention, and they pay us, certainly, with money. The challenges of the distances across rural America—we find it necessary rather than to have them come to us, we come to them.

So we have community paramedic programs that actually help people with chronic management of their chronic diseases, post-acute care, and other things that really make a huge difference. Funding for those types of programs, as well as the training for the workforce that can support those types of programs, allows those patients to stay within their community and get their care. It does not need to be always with a doctor or with a nurse.

And when you think about the economic costs that some of my colleagues have mentioned, about having your son or your daughter take a day off work to drive you from Ely, MN to Duluth, MN for a 20-minute visit and then drive back, that could be better served by a community paramedic. It is certainly a challenge for the family and a waste of America's economic vitality.

So, funding those programs where we can actually go to patients, whether it is through telehealth or the community paramedic program, can make a huge difference.

Senator CARDIN. Dr. Holmes?

Dr. HOLMES. I am going to build on Dr. Herman's comment there, which I think is really astute, and extend it to maternal home visits and child home visits as well. But the appeal of all of these is that you are seeing how the population live in their own home, and understanding they need a railing here, for example, if community paramedics can go there, to avoid a fall. And so really understanding more about treating health just beyond health care and the whole complete package.

Senator CARDIN. Thank you.

Senator Daines?

Senator DAINES. Mr. Chairman, thank you.

Ms. Aune, it is good to have somebody officially from the middle of nowhere. That was, by the way, determined by *The Washington Post,* and they had a criterion. It had to be 1,000 residents or more, furthest away from a metro area, and the top three in the Nation were all in northeast Montana. And by the way, number four went to Nevada, some small place.

So you are literally from the middle of nowhere and have the gold medal. So we are glad you are there. I think you bring a very unique perspective. I know your colleagues here, who have shared some testimony, have similar challenges.

In your testimony, you mentioned some of the notable characteristics of providing health care in these very rural and remote areas of the country. And I know when people are sitting in gridlocked traffic, that they are yearning to move to the middle of nowhere sometimes. That is why we are seeing a lot of growth in a lot of parts of Montana.

But we are seeing health professional workforce shortages across the board. Ms. Rich spoke about the acute challenges, the numbers you are facing right now in your facility. But these shortages have outsized effects when you are talking about rural communities where populations, the pool that you can hire from, are limited, small to begin with.

Could you speak a bit more to the rotating provider model that you implemented at your clinic, as well as your recent partnership with Intermountain to facilitate the behavioral health responses in the emergency room?

Ms. AUNE. Yes. So, our rotating providers, that was an organization that we found, luckily found, because we lost our orthopedic surgeon, and if we do not have that, patients have to drive 300 miles to have a hip or knee replaced. So we felt that was a critical need.

So it is 24–7 coverage. We have three full-time providers that rotate in. They live elsewhere in the United States and they fly in for their rotation. They do a 10- to 12-day rotation, and they are on call 24–7. They run a clinic and then they do surgery, and that model worked so well that we achieved that for general surgery, and then OB/GYN as well.

And then we just—unfortunately, our radiologist is moving, so we are possibly looking for that model for radiology.

Senator DAINES. Dr. Herman, thanks for your testimony and highlighting Essentia Health's work serving rural communities. My ancestors who came from Norway stopped in Minnesota for a while, and they heard the mosquitos were smaller out west, so I think they kept going.

You have had some of the most successes in Minnesota, but there are others who are interested, I know, in adopting similar approaches as well.

So maybe for us here as Senators, and for those of us listening to this hearing, what are some observations and best practices that you see that have worked to drive your success? What are some of the barriers you have had in the process of trying to implement value-based care, as you mentioned in your testimony, in more rural areas?

Dr. HERMAN. The challenge that small providers have is the challenge of scale. It is hard to build the infrastructure to support a value-based program when you have two or three providers in a small community. Essentia Health is a conglomeration of more than 30 different practices across northern Minnesota, Wisconsin, and North Dakota, that got together because we have a common mission, and that is to serve our patients better.

I think the Federal Government can provide support just like—when we live in rural areas, we are very familiar with the cooperative model. There is no particular farmer in a small community who can own his or her own silo. But if you can get together and provide that infrastructure, whether it is the IT infrastructure or the care infrastructure, you are much better able to do that.

I also think that some value-based programs are rightly very concerned about the outcomes. But when you are in a small community, you are a slave to the law of small numbers. For many of those communities, the process is more important than the outcomes.

So, if you are measuring the cost of care in a small community, one patient with breast cancer can certainly raise the cost of care, and you end up missing your targets. So how do you get the right process measures to support that particular type of care, and pulling it together with the infrastructure that can support not just a large health-care system, but could support many small health-care systems?

Senator DAINES. So here is a question. Do you get—is there sympathy to your argument in terms of, since the pool is so much

smaller, where one particular patient could drive means and so forth out of whack? How do you deal with that?

Dr. HERMAN. Measurement matters. So what are the things that you are doing that get your average patient healthier? The advantage of those small numbers is, you can take a look at almost every patient, particularly if you have an electronic health record supporting that.

It also allows you to get a fine view of the social determinants of health, and what does the community need other than a health-care provider, to support some of the care of the members of their community? If you are living in a food desert and people are eating high-salt foods, the chance of them being hospitalized for congestive heart failure is very, very high.

So, rather than just taking a look at the patient's path from illness to wellness, what is the patient's path to sustain themselves after they get that? And that is building the community.

Senator DAINES. Thanks, Mr. Chairman.

Senator CARDIN. Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman and Ranking Member. This is such an important hearing, and thank you to all of you for coming.

I specifically have to cite Ms. Rich, coming from Western Michigan University in Kalamazoo. It is so great that you went to school there, and I understand that, Dr. Holmes, you went to school at Michigan State, is that right? Go Green; okay. That is great. And Caro, MI I know well. Very beautiful place, so tell your family "hello."

All of these issues resonate. I grew up in Clare, in the middle of the State, northern Michigan, and my mom was director of nursing at a small hospital. My first job was at the hospital. This is how old I am. My job was cleaning the test tubes in the lab in the basement after school. They just throw them away now so, I know. But that was a long time ago. That was a long time ago.

But I grew up around health care, and rural health care, so I very much appreciate this. There are so many pieces to this, both physical health care, behavioral health care. We have done a lot together to increase community behavioral health clinic access, and I know representing States that include that now through Medicaid funding and others that are applying, in Montana and North Carolina, and so on, to be able to move forward.

But I wanted to zero in for a minute on school-based health centers for a stretch, and talk a little bit more about that. Because so many times children are getting access to health care or behavioral health care through school. That is where it is, and so this becomes so important.

I am leading an effort with Senator Capito, a bipartisan effort, on school-based health care, both funding—we got first-time funding, a line item in the budget last year, but we have Hallways to Health Care, where we are trying to, as I am sure you are aware, increase both children's health insurance funding and Medicaid funding, working with our health centers, working with behavioral health centers, to get into schools.

And we also made some good progress with significant funding, as a part of the gun safety legislation, on school-based health clinic

grants, and behavioral health, and so on. Could you talk a little bit more—you mentioned that your school-based health-care program cares for thousands of patients. Could you talk a little bit more about how accessing comprehensive care right at school expands access both for children and for families?

Ms. RICH. Well, thank you so much for the question, Senator Stabenow. And also, I wanted to add I also went to Michigan State.

Senator STABENOW. Oh, you did go to Michigan State?

Ms. RICH. I just wanted to add that.

Senator STABENOW. You went to two schools in Michigan? Oh, good.

Ms. RICH. Yes, so my apologies. You cannot let that go as a Spartan.

Senator STABENOW. That is right.

Ms. RICH. But you know, school-based health centers are such a wonderful way to provide access to care for our children. When children are in pain, whether it is from a dental infection or they have strep throat, or they are just not feeling well because maybe something happened with some friends and they are feeling down, having that access in the school makes all the difference, and especially for those of us who live in rural areas.

I have used our school-based health centers, and you know, often parents work out of county, for example. They may work 30 or 40 miles away from where their child goes to school. And so, having that peace of mind and knowing that there is a trusted health-care provider, whether it is dental, behavioral health, or medical, is such a relief for families, that they are going to get what they need while they are in school.

We can do lab testing in school. We can take care of acute needs. We can help with chronic conditions such as asthma in school, with dental infections and abscesses, connecting those children with additional services and care that they need. So, it is just a lifeline for many of these children and communities and, if you are not healthy, you cannot pay attention in your math class, you know. You are not going to be able to write an essay.

And so, having that access is a huge relief for the students, for the school team as well, because they want to have healthy students, so they can be healthy learners, and then certainly for families in the community. So I am excited to hear about the work that you are doing to enhance and expand school-based health centers across the country. It is a great tool for accessing health care in rural areas—and certainly beyond.

Senator STABENOW. Great; thank you very much.

Ms. RICH. Thank you.

Senator STABENOW. And one more question for you——

Ms. RICH. Yes.

Senator STABENOW [continuing]. Which is—Senator Daines and I have led a bipartisan working group in the Finance Committee on workforce related to behavioral health. We were able to have some things happen, some additional GME slots for psychiatrists specifically, to be able to do some things around Medicare coverage last time, which was helpful.

But one of the things that did not happen that we had put in our recommendations was talking about how to increase the work-

force by adding a physician bonus payment in shortage areas, and allowing non-physician providers to also receive a bonus payment if they are going into underserved areas.

We do have some of that in school loan forgiveness and so on, but if we were to add a physician bonus payment for rural areas or for other non-physician providers—you mentioned that your clinic is in a mental health shortage area, and so I am wondering how a bonus payment could help clinics like yours attract and retain more providers?

Ms. RICH. Well, thank you for the question. I think that anything that we can do to help and retain providers in our rural areas, especially for behavioral health, is something we need to take very seriously. We do have a lot of National Health Service Corps providers in our organization, and it is a wonderful recruiting tool.

We need to work hard when providers come to our area, to connect them, to help them be part of the community, because once they come, we want them to stay. And so, how do we do that? And that might be a way in terms of that bonus payment. When your service is done with National Health Service Corps, maybe there is an additional payment to continue that service. So, I look forward to hearing more about that. Thank you.

Senator STABENOW. Thank you, Mr. Chairman. I am over time. Thank you.

Senator CARDIN. Senator Blackburn?

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you to each of you for being here. I represent Tennessee, and as you all know, Nashville is the center of much of health care in this country, managing hospitals, and of course many of our companies and our citizens are employed by companies that manage rural hospitals.

In Tennessee, 50 percent of Tennesseans are in a rural area. So we pay quite a bit of attention to what is happening with access to rural health care, and we do what we can to increase that access. And in my work as cochair of the Rural Health Caucus here in the Senate, we spend a good bit of time looking at that.

When I was in the House, I came up with legislation for telehealth, and nobody was interested in telehealth until COVID hit. And then all of a sudden, everybody was saying, "Let us get that bill and pass that bill," and of course it went in under the emergency health order. I have worked with Senator Crapo to try to decouple that, so that we can continue with telehealth.

In the behavioral health arena, it makes a tremendous difference. When I am talking to our community health centers, it makes a tremendous difference. We have one county in Tennessee, Hardeman County Community Health Center, which has access to a cardiologist through e-consults and ConferMED. Now, they have never had that access in this county, but now they do, and it is showing tremendous gains and benefit into this service area.

So, Ms. Rich, let me just stay with you. If you would talk about, very quickly, how you all have used telehealth, and then why parity in that payment is important for telehealth?

Ms. RICH. Well, thank you for the question, Senator Blackburn. And certainly, telehealth was something we knew that we needed to implement, and certainly with the COVID pandemic, we imple-

mented it basically overnight—and needed to do so if we wanted to provide care to our patients. So telehealth has allowed us to reach our patients when they could not come into our health centers during the pandemic, but certainly now it is another tool in the toolbox to be able to provide access to care.

It is wonderful, because we have patients who have transportation issues. They live long distances from the health center, and again, it is another way for them to access care.

In terms of reimbursement parity, I think that is going to be really critical as we move forward. It has become integrated into service delivery models at our health center, at other health centers, and patients need it. Patients want it.

Senator BLACKBURN. Yes, they do need it. I have a rural healthcare agenda that I have worked on for the last 3 years. Senator Durbin and I have a bill that focuses on workforce and would incent, even further than the National Health Corps, getting people into rural areas, health-care professionals. Also, a component of it is on innovation in delivery of care. And the third component is something Senator Warner and I are working on for an appropriate national minimum to address the area wage index. We think that that is important. You are not going to get innovation in rural health care without these things, and we think that it is so important.

We are concerned about the closure of rural hospitals. Dr. Herman, I would like to ask you about that, if you all are looking at this, and then the way the community health centers are coming in and helping fill that void, because we are facing closures.

Dr. HERMAN. We believe that no rural hospital should have to stand by itself. I think many of the ones that are closing are hospitals that have had to stand by themselves. So we have hospitals within our system that, if they were not part of a system, would not be able to stand by themselves.

But providing that integrated care that surrounds it, whether it is a health system or another entity, taking responsibility for the care in the area, not just a particular community, I think makes a tremendous difference. From a telehealth standpoint, one of the challenges that we have is, we certainly do not want anyone to practice fraud from a telehealth standpoint.

But I use the bird feeder analogy. Sometimes you are so concerned about keeping the squirrels out of the bird feeder that the birds cannot get in either. I think when we start looking at some of the regulations we are building around telehealth, sometimes it really impedes the provider's ability to care for a particular patient.

Senator BLACKBURN. And thank you for that.

I know I am over time, but I am working on community healthcare access for veterans, and one of the components that we're working on right now is allowing these veterans to immediately access care in their local community.

And just a thumbs-up or thumbs-down, would your facilities be able to handle veterans coming in, showing their card, getting that health care? And then our responsibility would be making certain that there is a way for you to bill that back quickly, and of course be quickly paid. Not 180 days out, right? Absolutely. Thank you.

Senator CARDIN. Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you.

Coming from Nevada, telehealth is key for our rural communities as well. I am curious if anybody is opposed to audio-only visits as well?

Ms. RICH. I am very much in favor of audio-only visits.

Dr. HERMAN. Right, because a lot of the areas do not have the broadband capability to have anything other than an audio visit.

Senator CORTEZ MASTO. That is right, and that is why we really should be pushing both of those together. And we can address the fraud concerns always.

Let me jump to another issue I am hearing about from our providers in Nevada. They are experiencing challenges contracting with Medicare Advantage, and clearly we have more and more beneficiaries choosing to enroll in Medicare Advantage.

We want to make sure that we take a look at this relationship between the plan coverage and the patient access. So, Ms. Aune, let me ask you this. How do Medicare Advantage payments for Rural Health Clinics differ from traditional Medicare, and do these payment differentials, if they do occur, really create access issues in rural areas?

Ms. AUNE. Yes. So, at our facility, we are not a contractor with Medicare Advantage. But for our other Rural Health Clinics, there has been a drastic increase in the Medicare Advantage enrollment, and it threatens the rural health safety net.

So, while Rural Health Clinics receive enhanced traditional Medicare payments in comparison with their fee-for-service, their counterpart, says Congress, "recognizes the increased costs of providing care in rural America, and the high value of care in these communities." So there is no statutory requirement around RHC Medicare Advantage reimbursement. With that, oftentimes there is less negotiating power as one of the providers in a rural area. So many RHCs across the country are facing the financial stability concerns due to the low Medicare Advantage reimbursement rates; reimbursements differ.

Senator CORTEZ MASTO. Is that what you guys are seeing? Thank you. And is everybody else seeing the same thing?

Dr. HERMAN. Yes, and prior authorization becomes a challenge with some Medicare Advantage plans as well.

If you drive some 200 miles and you are at the clinic and you can get that service right now, and then your Medicare Advantage plan says, "Well, we need to take another 2 weeks to take a look at this," even though when they do say "yes," you have gone back 200 miles and you have got to come back another 200 miles and go back another 200 miles.

Senator CORTEZ MASTO. Right, right. Yes, and let me just add to this, because I appreciate Senator Daines's and your comments. In northeastern Montana, Elko, NV, it takes 4 hours to get to a medical facility, either in Salt Lake or into Reno, NV. And so we see these similar concerns about how we address health care and bring that health care to our communities.

So, Dr. Herman, I am really interested in this tri-state cooperative that you have, and you talked about it, obviously the value-based payment strategy. But you also talked about shared IT and

community partnership programs. How did you get that up and going? How did that start?

Dr. HERMAN. First of all, you have to build the relationships, and you have to build the trust. But we are on the Epic platform, and we have our Epic platform in hospitals that are not our hospitals. But we have the clinic within that community. If we have a different health-care record, we do not know enough about our patients to be able to take good care of them.

So literally, putting that health-care record within hospitals that we do not own, or within clinics that we do not own, helps the population that we are all privileged to serve by coordinating that care.

Senator CORTEZ MASTO. And let me ask you this: just in 2020, Congress created a new designation for rural hospitals, the Rural Emergency Hospitals, and it went into effect in January of this year. I know it is still being rolled out. But what is unique about the Rural Emergency Hospital designation that makes it an attractive option? Is it an attractive option for rural providers?

Dr. HERMAN. We are still taking a look at that. We would like to thank Senator Grassley and the rest of the Senate for the great work that they did on that. One of the advantages of that program is, you do not have to have an inpatient part of your hospital. You can move it to an outpatient and still be able to qualify for funding that supports the hospital within that. We are fortunate enough within our thing that our—those beds are really needed, even with the 96-hour rule, which we could talk about some other time as well, because we have seen an expansion of the ability for these hospitals to care for patients through the pandemic.

But for a place that does not have the need for that inpatient care, but needs something within the community, we think it is a very constructive model.

Senator CORTEZ MASTO. Thank you.

And then finally, we talked a little bit about the mobile health units. The Mobile Health Care Act was passed; are there any impediments that you are seeing that we need to address after the implementation of this law?

Ms. RICH. Well, I know it is a fairly new law.

Senator CORTEZ MASTO. Right.

Ms. RICH. Thank you for the question. I think it has a lot of opportunity for community health centers to expand that access and take mobile health units on the road. I think the challenge with it is, it goes along with new access point funding that would be available to health centers, and there has not been new access point funding in a number of years.

Senator CORTEZ MASTO. Okay; thank you.

Ms. RICH. Yes, thank you.

Senator CARDIN. Senator Grassley?

Senator GRASSLEY. Yes. I am going to ask Dr. Holmes—but let me lead in with this. I have helped pass the voluntary Rural Emergency Hospital program, and I thank the Senator from Nevada for bringing this up. Since January, several hospitals have become Rural Emergency Hospitals. An article from St. Mark's Medical Center in Lagrange, TX was titled, quote, "Texas Hospital to Keep Doors Open With Rural Emergency Hospital Designation."

Another article about the Holly Springs, MS hospital quoted a hospital official saying, "We expect the new designation to improve both the financial and the outpatient capability for citizens of Marshall County." There are several more examples.

So, Dr. Holmes, what hospitals are prime candidates to become Rural Emergency Hospitals, and what would be the alternative for hospitals if a Rural Emergency Hospital did not exist?

Dr. HOLMES. Well, the alternative is, for many of them, closure. And so, at least the REH program offers them an opportunity to provide emergency department care to their community. That is usually one of the first instances that we notice when a hospital closes, is someone needs an ED service and, within 3 to 4 days, it is not there during a closure.

Dr. Herman, I think, touched on the main points for which hospitals would be strong candidates for REH conversion. These would be places that have low inpatient use, probably a low ED volume as well, and have been financially struggling.

Senator GRASSLEY. For you and Dr. Herman: I support the Rural Community Hospital Demonstration program. It is a key tool to support rural hospitals and maintain access. Currently, the Centers for Medicare and Medicaid Services are underutilizing the program by leaving five of its 30 spots open. So do you two, do you think that we should be underutilizing a cost-effective rural hospital program like the Rural Community Hospital Demonstration?

Dr. HERMAN. Certainly not. Certainly, the need is there. I think what we would need to do is go back and take a look and say, "Why haven't five other hospitals been put into that?" Sometimes the regulatory hurdles are so complex that they are either hard to understand or, if there are 20, you can meet 19 of the 20 requirements, and you cannot meet that last one.

My suggestion would be to have an outreach program from CMS to many of these rural hospitals, and try to facilitate the application, rather than just sending it out.

Senator GRASSLEY. Do you have anything to add, Doctor?

Dr. HOLMES. I do not. That was a great answer.

Senator GRASSLEY. Okay. Then let me go to you two again. I have championed efforts to ensure Iowa physicians get paid fairly for the health-care services that they do. Iowans pay the same amount of money on Medicare as everyone else in the country.

Yet rural States like Iowa get shortchanged when Medicare pays Iowa physicians less than a lot of other States, and I will use New York and California as examples. Lower reimbursement has several impacts, influencing physicians practicing in our State. The labor shortage of physicians is not local but national, especially in the age of telehealth.

There are many unforeseen costs physicians face by working in rural areas, namely travel time, transportation costs, and broadband. Congress has established this Geographic Practice Cost Index that we call around this town the GPCI. That floor is to ensure rural State physicians receive fair reimbursement.

At the end of 2023, this is going to sunset. How does the GPCI floor protect access to physicians in rural areas?

Dr. HOLMES. I will take that one first, I guess, and you can build on it. I think an important thing to remember about where the

GPCI comes from is, it is based on historical and longstanding patterns prior to its introduction. So a State that has low wages gets a lower GPCI, which means lower revenue, which means they pay lower wages.

So, there is a cycle there that is sort of self-fulfilling, and I think we have seen some examples where CMS in particular has tried to up some of those price indexes, and it will be interesting to see what kind of impact that has had.

Senator GRASSLEY. Do you have anything to add to that?

Dr. HERMAN. Yes. I would say that it used to be, in the 1960s, when you evaluated a physician's standard of care, it was based upon the community. Now a physician's standard of care is based upon the broader community of the United States. The health-care costs to run a practice are much more reflective of the broader health-care costs across the United States than something that happens in Osage, IA. So I think there needs to be something done with that.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator CARDIN. Thank you.

When Senator Lankford came in, he actually bumped Senator Grassley, but I did not know that. So let me defer now to Senator Lankford, and then I will pick up after him.

Senator LANKFORD. No one on our side of the aisle bumps Senator Grassley, so just for the record on that.

Let me add one other comment here about what Senator Grassley was talking about on the GPCI issues and the reimbursement for physicians. When Oklahoma is competing with New York City for rates on cardiologists, the devices cost the same no matter where you are. Costs of everything are the same.

So, this process of punishing doctors if they practice in rural America, or even just not in the largest cities in America, has got to be resolved long-term. Shockingly to some folks outside this building, there are some areas where we can work together.

Last week, Senator Durbin and I actually dropped a bill on the Rural Hospital Closure Relief Act. It is the same bill that we actually had in the last session that we felt we were very close to dealing with, and this deals with the Critical Access Hospital designation.

The rural emergency designation does not work for every location, and we are trying to fix this 35-mile perimeter. We literally have hospitals in Oklahoma that are 34½ miles, and trying to be able to work through the process has become a pain on it.

So there are areas where we are trying to work together practically to be able to resolve some of these in very practical ways on this. Oklahoma State University has had a process for a while of trying to attract people out of rural Oklahoma, so that they would return to rural Oklahoma to be able to practice medicine. OU has been very aggressive in trying to be able to train physicians as well, nurses, other practitioners. So there is some practical work that is ongoing on this, but clearly, we have a long way to go in several areas on this. I do want to talk about some of the workforce issues, because this is a significant issue in attracting workforce into rural hospitals.

Duncan Regional Hospital in my State has done a lot of work in partnering with local universities, even reaching into high schools, doing programs there and then helping them through their education to be able to then return back to Duncan Regional on that.

Have you seen success—and any of you can answer this—have you seen success like that in other areas, because that has been very successful for Duncan Regional? Anyone else seen success in recruiting workforce long-term?

Ms. RICH. Yes. Thank you for the question, Senator. I would say that partnering with universities' academic medical centers has helped us a great deal in providing greater access to health care in rural areas. We have a partnership with NYU/Langone for general dentistry residents. We are working to establish another residency for pediatric dental care, and we are working with the University of Maryland School of Medicine to establish a rural training track for physicians in the area.

I think what the challenge is, is that some of these initiatives that we have taken on, they take time and you have to be proactive to plan and to get them into place. And I think right now, in terms of workforce, we are in two stages. We are in reactive and proactive, and so, how do we bring all those together so we can address these challenges?

Senator LANKFORD. Yes. It takes a while to be able to raise it up. The Federally Qualified Health Centers in my State—we have a phenomenal group of leaders and groups that are doing it, almost 200 in my State, scattered around the State. They are the primary caretaker for a very large percentage of so many folks in our State, and it has been a very, very successful model now for several decades.

So, very grateful for them. They have raised the issue to me about 340B, and I know that is not in our committee. But for contract pharmacies, are you dealing with the contract pharmacy issues, Ms. Rich, at the Federally Qualified Health Centers in trying to be able to deal with that pricing model? Is that something you are dealing with right now?

Ms. RICH. Yes. Many community health centers across the country are 340B participants, and it certainly is an important tool that we have to assist our patients and provide additional care in rural areas.

Senator LANKFORD. That has been a big issue on the pharmacy side of this as well. This has been one of my frustrations, and I know none of you are pharmacists in that sense, but you are interacting with those folks in a lot of our rural settings. That local pharmacy in many areas is the only really health-care professional that is in that area.

I have a lot of concerns. Our committee has talked about this quite a bit. I am going to continue to be able to raise the issue of the DIR fees, especially for our rural pharmacists and those independent pharmacists.

Literally, PBMs are driving our rural pharmacies out of business for their benefit, but not to the benefit of health-care advice for many of these folks in rural areas, to be able to come to someone and just say, "Hey, just mail order this, and it is going to be fine."

But that is not fine for a lot of folks who just need some counsel, who have multiple medications and need just somebody to be able to talk to. Are any of you all dealing with individual pharmacies and the DIR fees in particular?

Dr. HERMAN. One of the things that concerns us, particularly for rural health care, is white bagging, where as an example, chemotherapy is provided in a small community, but the insurance company makes sure they get the medication from the insurance company, rather than from the local care provider.

What people do not understand is that some of the money that comes from getting that medication in that particular area pays for the care and the infusion center where the patient is getting it, particularly in a rural area like Deer River, MN. When that goes away and white bagging goes away, that site goes away because there is no way to fund the site.

Senator LANKFORD. Yes. Mr. Chairman, I appreciate your holding this hearing and going through this. It is an incredibly important issue for us. I would love to be able to spend more time, but I am out of time on this. But the issue about Medicare Advantage—we have quite a few Medicare Advantage carriers that are advertising to rural America to get Medicare Advantage.

People are signing up for it and finding out that there are not actually providers in their area, and they have to travel very long distances. That is a different conversation for a different day, but that is definitely affecting rural America as well.

Senator CARDIN. It is a conversation we need to have, because we have also had Medicare Advantage plans leave some of our rural areas without much notice.

Senator Whitehouse?

Senator WHITEHOUSE. Thanks very much, Mr. Chairman, and thank you to this panel. We do not have as much rural going on in Rhode Island as many of these States, but I very much appreciate the work that you all have done.

I am particularly interested in what, Dr. Herman, you think about the ACO model. I worked very hard to get that into the Obamacare bill. I have been a harasser and shepherd of it, as CMS people have tried various—I thought not particularly helpful—things to strip revenues out of ACOs as soon as they get them, and set the new standard low so that you are competing against yourself in ways that are ultimately fruitless.

I would love to hear from you if there is anything that you think is immediate, that would help advance the ACO program. And to the extent you want to reflect on it, if you could take that as a question for the record. Because I am eager to spread ACO incentives as broadly as possible, and to try to make sure that——

In Rhode Island, we had two spectacular ACOs, I mean, killer. They were just fabulous. They made a ton of money for Medicare. Their patients just loved them. So I have seen it at its best, and I want to make sure that that gets——

Dr. HERMAN. We are strong proponents and strong practitioners of value-based care and the ACO model. We are probably one of the only Level 3 ACOs in rural America. We believe it is the best way to care for patients. I agree that when you look at the Medicare Shared Savings Program—my colleague, Dr. Holmes, is a mathe-

matician. But if you integrate that over time with the model of the Shared Savings Program, somewhere along the line you are giving perfect care free.

So the question becomes, what is the floor on that, and what is a reasonable amount to do that? There are many different ways to set up these programs. I think a lot of the programs are set up without the knowledge of the people that they serve, particularly from the regulatory side.

And what I would suggest is that you partner with people who want to do it, have a commitment to do it, and do it well, and see how they do it. And then work with colleagues like Dr. Holmes, Ms. Rich, and Ms. Aune, who are really committed to providing great care for their patients, because it is a great model, not just in rural America, but anyplace in America, because it takes really three things. You know who your patients are, you know what they need, and then you can get it to them before they really need it. That promotes health, wellness, and well-being, and it also decreases the cost of care.

Senator WHITEHOUSE. Well, I still have scars from years of engagement with CMS on this subject, and I hope they have a few too. I think we have learned to respect one another, and I would love to work with you going forward. So let us stay on this.

Dr. HERMAN. Perfect; thank you.

Senator WHITEHOUSE. And, Ms. Rich, you are in the Maryland Primary Care Program, which is a statewide program that we do not have. I think it is unique to Maryland?

Ms. RICH. Yes, it is.

Senator WHITEHOUSE. So I would really like to get your take on how that works. One of the things that I think bedevils the healthcare system—we have talked about it—is the burden of prior authorizations, claims denials, payment delays, the payment warfare that takes place between payers and providers, which at the end of the day, I think, is a net loss to the system.

It does not actually add value. If it does, it is negligible. But I think it is actually negative. It just eats up costs and time and effort. Once you go to the Maryland model and you get away from fee-for-service, which I think encourages those kinds of behavior, have you seen that architecture of obstruction diminish in your company or in the State generally?

Ms. RICH. Well, so I want to start out by saying the Maryland Primary Care Program certainly is under the Maryland Total Cost of Care Model that really focused in on hospitals. And so, primary care components came in in about 2019, and following the community health centers. Choptank just joined the Maryland Primary Care Program in January, so I do not have a lot of——

Senator WHITEHOUSE. So you are still in the beginning process?

Ms. RICH. We are. So I do not have a lot of experience to speak to it, but I am very excited about the transformation that it will be doing in our health center, to provide greater access to service to wrap around our patients, and work on healthier outcomes as a whole.

Senator WHITEHOUSE. Well, to me it stands to reason—and I have 30 seconds left, so let me make this a question for the record to any of you who care to engage. It strikes me that this whole

claims denial measure, claims pursuit countermeasures, that whole back and forth, is completely unhelpful and very expensive, and ultimately, I think, bad for patients.

To the extent that we can get off of the fee-for-service model that encourages it, I think that is likely to diminish, which will be good for the costs in the system, good for patients, good for providers, good for everybody. So, if anybody has observations on that point, in addition to what we should do to help ACOs, I am all ears and, I look forward to hearing from you.

Thank you.

Senator CARDIN. Senator Whitehouse, let me just point out that the Maryland Total Cost of Care Model is really very much what you want to see. You reward the overall health-care costs of an individual, rather than stove-piping the different types of needs.

It is also an all-payer rate structure, so that you are not rewarded by having private pay versus Medicare or Medicaid. They all pay the same rates at the hospitals. So it is a system that is rather pure in that regard.

Senator Casey, you get the total 5 minutes. Those 29 seconds are not going to be held against you.

Senator CASEY. Mr. Chairman, thanks very much. Thanks for having this hearing. I just have one question, in the interest of time, for Dr. Holmes, but I wanted to start by just laying a little bit of the groundwork for the question.

I live in a State that has 67 counties, and 48 are rural. And the primacy of rural hospitals in so many counties cannot be, cannot be overstated in terms of health-care access, the good quality of care they provide, as well as the job base that they provide.

And, Dr. Holmes, you said in your testimony that since 2005, I guess it is a little more than 190 rural hospitals have closed, about 193 I guess it is, and I am told that 150 of those are just since 2010. It is hard to comprehend the scale of that. I guess some continue to provide health-care services, but roughly half of them do not provide health-care services.

These closures lead to a decrease in the labor force in the population living in the community. I have seen that in Pennsylvania, and as I said, they are so important to the stability of a community. I pushed for a 2-year extension of the enhanced payments for the Medicare-Dependent and Low-Volume Hospital adjustment payments in the so-called omnibus, the appropriations bill last December.

I am proud to reintroduce a bill with Senator Grassley to make both of these payment adjustments permanent, in order to provide certainty surrounding the funding for these hospitals, including 27 of which are in the State of Pennsylvania.

Dr. Holmes, can you speak to how permanent funding such as the Medicare-Dependent Hospital program and the enhanced low-volume Medicare adjustment payments would provide predictable funding and help protect the financial solvency of rural hospitals?

Dr. HOLMES. Yes; thank you for the question. I think this kind of goes back to the question that Senator Grassley asked as well about RCHs, in that you are asking hospitals to move to a new program or to make decisions about investments on something that

might be here in 2 years, might not. And you know, let's face it, MDH and SCH have been continuously extended.

And so, while it is fair to believe that they probably will keep being extended, you are asking executives and administrators to make decisions on something that looks like it will end. So I think a permanent extension of these programs will be beneficial.

It will allow them to have certainty and make investments, rather than looking at, well, we cannot do too much because we do not know what it is going to look like in the next year or two; to really say, "All right, we think this program is permanent. We can make decisions planning on having a certain revenue flow."

Senator CASEY. Doctor, thanks, and I want to thank the panel as well. I have to run, but thank you, Mr. Chairman.

Senator CARDIN. Thank you.

Senator Carper?

Senator CARPER. How many counties do you have?

Senator CASEY. Sixty-seven.

Senator CARPER. And how many are rural?

Senator CASEY. Forty-eight.

Senator CARPER. We only have three counties, and two out of the three are rural, and the other aspires to be, but probably without success. [Laughter.]

Senator CASEY. And those three used to be in Pennsylvania.

Senator CARPER. And they used to be in Pennsylvania. And so we know who the first State is. It is Delaware.

So, I have a question I want to start off with you, Miss Rich, if I may—we are grateful that you are all here—dealing with federally qualified community health centers with respect to increasing access to behavioral health care. I am a huge proponent, have been ever since I was Governor, even before I was Governor, a huge supporter of federally qualified community health centers.

We have one in each of our counties, and they do wonderful work in a variety of ways. But I call them federally qualified community health centers—I do not even use the acronym—I always have. But they play a critical role in our State in increasing access to care. My notes say here "to everyone." Not to everyone, but to a whole lot of people.

And that is particularly in rural communities, but not entirely; not entirely. There are many rural communities in the State of Delaware, and I am proud to serve as cochair of something we call the Senate Community Health Centers Caucus that you may have heard of, along with my fellow cochairs—listen to this: Senator Cardin, Senator Cornyn, Senator Cassidy, and Senator Carper. What is similar to all those people is the letter C—the letter C; there you go.

I would like to say the letter C defines, I tell other people, the secrets to a happy marriage: communicate and compromise. But also, the letter C can be used to apply to getting things done here in the Senate, and the four names that I have just mentioned are people who like each other, bipartisan, bicameral, and we get a lot done.

But the services that are provided by federally qualified community health centers go beyond one's physical health. They also pro-

vide crucial services, as you know, for mental health care and treatment, not only in Delaware but in the other 49 States as well.

I oftentimes say, as Senator Cardin will attest, "find out what works and do more of that." I said that just this morning in the hearing on the permitting processes. But find out what works; do more of that. In that spirit, Ms. Rich, could you just share with us some of the best practices from centers that are doing an especially good job providing mental health services and addressing behavioral health needs of rural communities, so that the rest of us can learn from their success? Find out what works; do more of that. Go ahead.

Ms. RICH. Well, thank you so much for the question, and thank you for your support of community health centers. So we have just implemented behavioral health at our health center about 2 years ago.

Senator CARPER. Again, tell me a bit more. Where is your health center?

Ms. RICH. Eastern Shore, Maryland. So Caroline County is our headquarters.

Senator CARPER. Okay.

Ms. RICH. And you know, when we think about our mission, providing that access to the comprehensive care that is integrated, not providing that behavioral health service was a barrier for our patients. So bringing behavioral health into the health center was very important because we ensured that it was integrated with primary care.

And so, through the course of the patient care day, if one of our medical providers was treating a patient and did some of the screening tools that we use—the SBIRT screening for substance abuse disorder, depression screenings, et cetera—we connect the patient with a behavioral health therapist, right then and there, through a warm transfer.

And so what we have found with that warm transfer process is the patient is in a place where they are ready to get into treatment. They likely show up for their appointments, and they are getting better. That is what we want to do, and also take away some of the stigma too, that the behavioral health is right there colocated with our medical, with our dental as well.

So I think that integration is really key, and then ensuring that we do those warm transfers as well during the course of the visit. So those are some of our lessons learned as we have moved forward with behavioral health care at Choptank.

Senator CARPER. Well, that is good.

I have about 30 more seconds. That is probably not enough time to ask another question, so I will just sit back and listen to Senator Barrasso, Dr. Barrasso's questions.

Senator CARDIN. Do you have any Delaware patients who come into your facilities?

Ms. RICH. Yes.

Senator CARDIN. I thought Senator Carper would like to know that.

Senator CARPER. I would like to know that.

Senator CARDIN. Senator Barrasso?

Senator BARRASSO. Thanks very much, Mr. Chairman.

Dr. Holmes, if I could, for over 20 years I practiced as an orthopedic surgeon in Wyoming, a State where we are always trying to recruit and retain physicians in rural areas—sometimes pretty remote—to just get the health care that we need. I think we are running more and more into the fact of recruitment being a challenge, especially since so many residency programs for training are done in the big cities. You know the correlation where people are more likely to then set up a household, where they decide to live and practice, based on where they trained, or within a radius of 50 miles from there. So I see that as a disadvantage to rural communities, because the training is from a distance.

So, Senator Tester and I have a bipartisan bill called the Rural Physician Workforce Production Act of 2023. It addresses the current Medicare-funded residency program problem for entire States. The bill would solve some problems by lifting resident caps and removing Medicare limits on rural resident training growth; providing equal funding to rural hospitals for residency training, because so much of that funding is disproportionate; increasing Medicare reimbursements for urban hospitals that send residents to rural health-care facilities; and creating an elective per-resident payment initiative to ensure rural hospitals have the resources to bring on additional residents.

So, the approach to solving workforce shortages to empower rural health-care providers, I think, is something we should try to implement. So, can you explain how legislation geared toward rural physician workforce development could impact health outcomes and access in rural America?

Dr. HOLMES. Great. Thank you for the question. I am glad you brought this up. As you mentioned, we know that two of the strongest predictors for rural practice are being from a rural area and being trained in a rural area. And so, addressing the paucity of physician training—but also more generally, workforce training—in rural areas is critical.

Rural areas have shortages of just about every workforce, and so an initiative to boost training in rural areas has a twofold effect. The first is, in the short run, you have trainees out there providing more care. But also, in the long run, you are going to generate a workforce that is more rural-aware and likely to continue to practice there.

Senator BARRASSO. And then, Dr. Herman, in terms of the local community hospitals, nursing homes in a place like Wyoming, if there is a loss of one facility, the impact on the entire community can be devastating. Not only do closures impact the services and the care provided; they impose additional challenges in terms of attracting teachers to the community, attracting small businesses to the community, all of those sorts of things.

Recently, the Wyoming Hospital Association conducted a statewide study to determine the economic impacts of hospitals and nursing homes, and it is very significant, the number of jobs that are supported.

Do you see Federal policies that you think are most needed to protect against closures of these critical facilities in rural areas? Because I think, over the last 15 years, whether it's a Republican

administration, a Democrat administration, the great number of hospital facilities that have closed are rural.

Dr. HERMAN. That is right, and I think you said "one facility." It can be one person that causes one facility to close. So I think Dr. Holmes addressed a lot of that. One thing that we found successful in recruiting providers to rural communities and retaining them is, it is not the health system that recruits and retains the providers; it is the community that recruits and retains the providers.

So we get our communities very involved in the recruitment, the retention. When you are part of a community and you recognize that you are a very critical part of the community, I think it is very gratifying as a provider. I think you are much more likely to come, and you are much more likely to stay.

Senator BARRASSO. Yes.

So, Ms. Aune, following that, we had a community in Wyoming a number of years ago when I first started to practice, where we had a physician and a physician assistant, and at the time they were tied together, where the physician had to observe and be in the same facility.

So the physician was tragically killed in a wreck, in an accident. He was the only physician in the community, and at that point there was no way for the physician assistant—the community tried to recruit a physician to then supervise the physician assistant, because they were going to lose everything.

But we actually were able to change the law in Wyoming to then have the physician assistant report and work under a physician at a remote location in an emergency room 100 miles down the road. Not as ideal, but it reflected a need that was going to be met, and legislatively we stepped in.

Have you seen similar things like that, where legislation has to be done at a local level or statewide to try to help put health care in communities?

Ms. AUNE. I do not have anything to answer towards that. We do have PAs and nurse practitioners in our facility, which is great. But I do not have anything legislatively.

Senator BARRASSO. Because I know that, Dr. Herman, Dr. Holmes, you have seen a change in how physicians and physician assistants, nurse practitioners, additional care providers, have evolved since kind of our days in medical school, if you will.

Dr. HERMAN. We have advanced providers that actually staff some of the emergency rooms in our smaller hospitals, supported by the physicians in our Level 1 trauma center, and also transportation from the people there. So I think it is a very good model that can be done.

I think it does have some limitations. You are probably not going to get an emergency-trained physician in every small community. But we have a lot of resources that regulations sometimes get in the way of. What we can certainly do is get back to you on that, because we can look at the regulations and say where the barriers are.

Senator BARRASSO. Okay, because what we are seeing—yes, Dr. Holmes?

Dr. HOLMES. They are recognized as team-based health care, which I think is where we need to be headed.

Senator BARRASSO. Thank you, Mr. Chairman.

Senator CARDIN. Ms. Aune, you mentioned transportation as being one of the challenges. Do you have transportation available for those who need it in your community, and if you do, how is it financed? If you do not, what are your recommendations for filling this void?

Ms. AUNE. So currently, we are working on a transportation project within the hospital and the community. We do not have hospital-based transportation that we have at our hospital to bring patients to their appointments.

But we do have a county transit, and so we are working together with the transit on marketing them and helping patient awareness, and then asking patients when they do call to make an appointment if they have transportation needs, and then hooking them up with that transportation service so they are aware of it.

Because I think a lot of people are not aware of it. We do have huge transportation needs. So also, collaborating with the Tribes on how to get those patients over to our community, because we do have a lot of people in our area who do not have a ride, either to their appointments or to outpatient surgeries, or even like I had mentioned before, when they come to the ER, they do not have a ride home.

So we are working on our transportation efforts and trying to come up with a system so we have different phased approaches to that, how we are going to come up with that.

Senator CARDIN. And, Ms. Rich, I know some of our local governments are providing some of the needs, I know on the Eastern Shore, on transportation. Let me ask you about patients who have chronic conditions, and the regular follow-up care. If they live far away from a provider, how do you deal with someone who is in that position?

Ms. RICH. Well, that is a wonderful question. Thank you, Senator Cardin—and it is a challenge. Certainly, transportation continues to impact us all in rural areas. There is, you know—the counties contribute to that. We have public transportation, but again, there is often not enough of it.

We are grateful for the Medicaid coverage for transportation, and my understanding is there is some movement to also provide coverage for transportation for dental patients as well, which is very important. But you know, for the chronic care management piece, patients come in, they see their provider multiple times a year, depending on what the condition is and what their health looks like.

But this is where some of the efforts of the Maryland Primary Care Program come in and what we term population health, where we wrap around the patient and we work with the patient and their family to ensure that they are taking the medication correctly, that they understand how to do that, that they understand their care plan.

So, going over a lot of those health factors and assessing health literacy, looking at the social determinants of health, all of those pieces are critical, especially in rural areas when we are looking at getting people back in for care.

Senator CARDIN. As you can see by the number of Senators who have participated in this hearing, there is a great deal of interest on our committee in regards to rural health care. There have been lots of initiatives, and we have tried to include them in some of the major bills around here. I think this hearing has been very helpful for us to focus in on the areas where we really still need to make progress, and providing the right incentives at the Federal level, in partnership with the other stakeholders we have, in order to fill the needs that are out there.

I really congratulate each of you for innovative ways to deal with rural health care in your service areas, because you have all come up with ways to help fill the void, knowing full well there are areas that you just are going to be frustrated about: getting enough providers in your community, getting enough training facilities in your community, knowing that that is where people like to stay.

But it is encouraging to see what you are able to provide for your communities. So I congratulate each one of you for your commitment to the health care of your communities.

Senator CARPER. Mr. Chairman?

Senator CARDIN. Senator Carper?

Senator CARPER. Before we adjourn, I want to touch on workforce one more time, if I may.

Senator CARDIN. Certainly.

Senator CARPER. If I could. I asked my staff if this question has been asked already and was told that it has not, so I want to go ahead and ask it. We have a major health-care provider in our State. It is called Christiana Care, and it is huge for a little State. And we have any number of smaller hospitals and federally qualified community health centers.

I stay in close touch with almost all of them, my staff does, and one of the things I recently discussed with the people who run Christiana Health Care, a large health-care provider—among their challenges is workforce. It is not just the federally qualified community health centers; it is just about everybody.

And we find that almost every employer that we talk to—I do a lot of customer calls with businesses large and small throughout my State, and we hear this all the time. Let me just—if I can, Dr. Holmes, based on your research background, could you just give me some idea of ways in which expanding provider training at rural health facilities has demonstrated success in increasing the rural health workforce?

Again, I like to say "find what works; do more of that." Just give us some examples of that.

Dr. HOLMES. Yes, sure. Thank you for the question. So, I think the first one I will come up with is the Rural Residency Planning and Development Program, which was rolled out by HRSA, I think 3 years ago, to help spur physician residency programs in rural areas and give them the technical assistance to launch them.

There have been more rural residency slots created in the last 3½ years than in the prior 6 years, I think it was. So it really shows that intentional and Federal investments in expanding that can really pay a dividend. We have talked a few times about this notion that having training in rural areas is more likely to keep

you practicing there subsequently, so there is a through line between those two that really directly connects that.

Senator CARPER. Good; thanks for that. Anyone else want to comment on this? Please.

Dr. HERMAN. One quick comment——

Senator CARPER. Yes, Dr. Herman.

Dr. HERMAN [continuing]. Is that we built this health-care system on the largest group of high school students and college students that ever went through in America. And that workforce is not available anymore. Unless we get a disproportionate share to go into health care, we will never be able to staff health care like we have before.

So it will require a lot of different innovations for us to not only treat people more efficiently and more effectively, but to find ways to keep people well to reduce the burden on the health-care system, and more importantly, reduce their burden of illness.

Senator CARPER. Say that again: find ways to help people. Could you say that again, to keep them well? Go ahead and say that again. I am a big believer in that. Go ahead. Just repeat it.

Dr. HERMAN. What I just said?

Senator CARPER. Yes, just the last part of what you said. It was a great truth.

Dr. HERMAN. In order for us to really meet the needs of the population, the population has to be well. And making the investments up front to keep people healthy and to decrease the burden of their disease, decrease our need for health-care providers, decrease the cost for health care most importantly, keeps people well. People do not want to be consumers of health care. People want to be well.

Senator CARPER. Where does obesity fit in that, if at all?

Dr. HERMAN. Obesity is huge. We have just done a study of our health-care system—largely rural. When we look at the number of the patients who are hospitalized, more than 40 percent of the patients who are hospitalized at any given time in the 14 hospitals across our system have a diagnosis of diabetes.

That may not be why they were admitted to the hospital, but the comorbidities associated with diabetes are likely the thing that brought them in for a hospital admission.

Senator CARPER. All right. Thank you very much. Thank you all very much. Great to see you.

Senator CARDIN. We know that Senator Thune was tied up in another committee. He was planning to come by, so we are going to keep the—right on cue. He has been out there for 15 minutes waiting for me.

Senator Thune, the floor is yours.

Senator THUNE. Mr. Chairman, thank you. Thank you for making it possible for me to get here, and to Senator Daines for having a very important hearing to discuss access to health care in rural communities, which is critical in, certainly, my home State of South Dakota. And I want to thank our panelists for joining us today and for the work that you are doing in your communities to improve access to health care.

We had a lot of strains put on rural health-care providers by the pandemic, and in some very difficult circumstances. The challenge

of attracting and retaining workforce has become even a more significant issue that they have to deal with.

Providers in South Dakota worked really hard to find innovative solutions on how to reach patients, but there are still barriers. I look forward to working with my colleagues on this committee to advance solutions that will meet some of those challenges.

Let me just say, I have heard from many of the hospitals in South Dakota about the impact the workforce shortage has on their ability to discharge patients from the hospital. Often, even though a patient is ready to be discharged to a long-term care facility, because the long-term care facility has a shortage of staff, they are not able to take these patients.

In South Dakota, these patients are waiting as much as 45 days in the hospital to be discharged. In one recent case, a patient waited 150 days before being placed in a facility, and then it was to a facility in a different State, far from his family.

Further, I am concerned this issue could be exacerbated by a potential requirement from CMS that would mandate staffing ratios in nursing homes, something we have heard a lot about. So, we need to ensure that burdensome regulations do not get in the way of providing high-quality care for patients, and instead we need to work on tailored solutions for our rural communities.

So, Dr. Holmes, you mentioned that in order to grow the rural health workforce, we need to support health-care workers across their entire career. At the Federal level, there are grants to support training and loan relief to recruit providers to certain areas. What other ways can we help support providers to both train and remain in rural areas?

Dr. HOLMES. We talked about the bonus program earlier. So that would be another option to continue to make it more financially sustainable to practice in rural areas. It is not just getting them there, but keeping them there to that point.

We know that workplace violence has been on the uprise for a while in terms of, I guess really, anger at many health-care workers. And what can be done in that space?

Senator THUNE. We have—and I am sure you guys have covered this already—but this mandated staffing nursing ratio issue. You have talked about that, exhausted that at some length, if you have already talked about that. If you have not talked about that, I would love to get your reaction to that.

Senator CARDIN. That is the first time that has been raised.

Senator THUNE. Okay.

Dr. HERMAN. I believe it is about the care of the patient rather than mandating a particular ratio. It depends upon the acuity of the patient, the illness of the patient, and what the patient needs at that particular time. I think it is a very coarse tool that is unlikely to be completely successful.

We have nursing professionals within each one of our facilities who know what it takes to care for a patient. I do think that if you are not caring for patients well, there are certainly regulations that allow for that to be addressed. But to mandate a ratio, I think, is a blunt tool that will, number one, inhibit hospitals from being able to provide the care they need to provide, and will not have the intended outcome of patient safety.

Senator THUNE. And I hope they will take that into consideration and relook at that. Unfortunately, increasing the pipeline of providers in rural areas is not going to happen overnight, and telehealth has been as good a bridge as we have for getting there.

I continue to work with my colleagues on the CONNECT for Health Act, which would eliminate barriers to telehealth in Medicare, including allowing Rural Health Clinics to provide access to services through telehealth.

Ms. Aune, during the pandemic, Rural Health Clinics were able to act as distant sites for telehealth services, enabling many patients to have access to health services. Could you tell us more about your experience using this flexibility during the pandemic, and how making this permanent could benefit patients?

Ms. AUNE. Yes. So it was very beneficial to patients. Like everyone else on the panel has said, we use a lot of audio-only because our community may not have a computer or Internet. So, if we could integrate that some way within the payment system, that would be great. We have a lot of providers that will just call the patient because the patient will call day of appointment and say they cannot make it because they do not have a ride to the appointment; they may be 60 miles away.

And so, the provider will actually just do a telephone visit with them, and a lot of times those are not even billed because a provider does not bill them for their call with their results.

Senator THUNE. Yes. And the CONNECT for Health Act does permanently add Rural Health Clinics as a distant site, and we have 58 Rural Health Clinics in South Dakota.

Do I have time for one more, Mr. Chairman? Sorry, I know you are—so anyway.

We have 39 Critical Access Hospitals across the State of South Dakota, and these hospitals serve as essential health-care providers in areas where there may not be another health-care facility. Dr. Herman, you highlighted the challenges that Essentia's Critical Access Hospitals face with arbitrary regulatory requirements like the 96-hour rule.

As you know, this rule was waived during the pandemic health emergency. Could you describe how the waiver of this rule during the health emergency helped Critical Access Hospitals better serve patients, and what challenges are those hospitals now going to face if the rule is back in place?

Dr. HERMAN. We firmly believe that the best care a patient can get is the care that they can get closest to home. You have the support of your family, and you have the support of your community, and we know that those are incredibly important in promoting the wellness and the healing of the patient.

What we saw during the pandemic is that waiver of the 96-hour rule did several different things. First of all, it allowed those Critical Access Hospitals to retain their staff. When you have a widely fluctuating census, it is hard to keep the staff because people work Monday and Tuesday, and then they do not work for the rest of the week.

Number two, it allowed them to really build their capabilities to take care of sicker patients. They became more confident in their ability to do that, and it allowed them to keep those patients closer

to home. Our concern is, and the other part of it was that we did not have the capability in the larger hospitals to take care of those patients.

A lot right now towards the post-acute care—there are about 2,000 patients every day in Minnesota hospitals who are waiting to get to a skilled nursing facility or post-acute care. Where do those patients go? If we can stabilize the staff and build the capabilities of those Critical Access Hospitals, I believe it will go a long way to their success in the future.

Senator THUNE. Okay. Well, we look forward to working with you on that.

And, Mr. Chairman, I thank you again for giving me the time.

Senator CARDIN. Sure.

Senator THUNE. Thank you.

Senator CARDIN. Thank you, Senator Thune.

Senator THUNE. Thank you all very much.

Senator CARDIN. We want to thank the entire panel. These have been extremely helpful presentations that will be used by our committee dealing with these issues.

The record will remain open until next Wednesday for members to ask questions for the record. And again, with our thanks to our witnesses, this hearing will now be adjourned.

Thanks.

[Whereupon, at 4:28 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ERIN AUNE, MBA, CRHCP, VICE PRESIDENT OF STRATEGIC PROGRAMS, FRANCES MAHON DEACONESS HOSPITAL; AND BOARD OF DIRECTORS MEMBER, NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

On behalf of my roles with both Frances Mahon Deaconess Hospital (FMDH)[1] and the National Association of Rural Health Clinics (NARHC),[2] I thank the subcommittee for their attention to the obstacles and opportunities facing rural health. During my testimony, I hope to take you on a journey of what it is like to access and help to provide health care while living in the heart of rural America.

The Rural Health Clinics program[3] was created in 1977, and remains the oldest Federal program aimed at improving access to outpatient care in rural, medically underserved areas. The RHC program, as a whole, serves approximately 37.7 million patients per year—more than 11 percent of the entire population and approximately 62 percent[4] of the 60.8 million Americans who live in rural areas. Rural Health Clinics are a separate and distinct program from the Federally Qualified Health Center program, also represented on today's panel, and both serve a critical role in our country's health-care safety net. RHCs receive enhanced Medicare and Medicaid reimbursement but are not grant-funded.

I feel fortunate to represent one of those Rural Health Clinics, located in Glasgow, MT. If you are picturing mountains, we are not that side of the State! Glasgow lies in the northeast corner of Montana and is an agricultural community with big skies and wheat fields as far as the eye can see. Glasgow has been deemed the "middle of nowhere"[5] by *The Washington Post,* as it the most geographically isolated area, taking 4.5 hours in any direction to get to a city.

As a provider-based RHC attached to a Critical Access Hospital, we have no choice but to be very strategic on how we can best serve our community and the surrounding areas. Glasgow has a population of about 3,500 residents, 7,600 people live in the county, and about 15,000 in the two neighboring counties. Fort Peck Indian Reservation is also located 15 miles to the East of us. With the closest larger hospital over 300 miles away, we work very hard to provide our service area with as many service lines as possible to relieve some burdens for our patients. Our RHC provides a wide range of services including primary care, behavioral health, general surgery, orthopedics, and OBGYN. We are especially proud that we recently achieved 24/7 coverage in general surgery, OBGYN, and orthopedics. Our RHC serves approximately 8,600 patients annually, roughly 33 percent Medicare, 22 percent Medicaid, and 37 percent commercial pay.

My testimony today will focus on specific challenges and solutions in workforce, telehealth, access to care barriers, and the educational pipeline. Through my role as a board member with the National Association of Rural Health Clinics, I will also share insights into other opportunities and obstacles facing my colleagues in the over 5,300 other RHCs across the country.

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[1] *https://www.fmdh.org/.*
[2] *https://www.narhc.org/narhc/default.asp.*
[3] *https://www.cms.gov/center/provider-type/rural-health-clinics-center.*
[4] *https://www.narhc.org/News/29910/Sixty-Percent-of-Rural-Americans-Served-by-Rural-Health-Clinics.*
[5] *https://www.washingtonpost.com/news/wonk/wp/2018/02/20/using-the-best-data-possible-we-set-out-to-find-the-middle-of-nowhere/.*

WORKFORCE

As is the case for many other rural areas, recruitment challenges are significant in the "middle of nowhere." After years of provider turnover and unfilled openings, we strategically found a staffing model which would allow us to provide specialty services locally. In 2020, we contracted with a company that provides 24/7 orthopedic coverage. The providers are a team of three, full-time employees, and the same team covers the entire month on a rotating basis. This model worked so well we explored the idea for general surgery and OBGYN as well and are considering it for radiology, another specialty where we are facing recruitment challenges. Being able to offer these services locally provides better patients outcomes, continuity of care, a better work life balance and helps prevent provider burn out. This model has worked well for those specialties, but we struggle with accommodating the behavioral health needs of the community. We currently staff one psychologist and one Licensed Clinical Social Worker Candidate. Our LCSWC is a local resident who was interested in furthering her career in the field, and we were able to support her in this. This still does not meet the needs of our communities, and access to behavioral health services remains a nationwide crisis in need of significant attention. Our staffing plan shows a shortage of three behavioral health providers, but a recent study shows there is a need for 60 in our region alone. To help bridge many of these gaps in access, we have pursued telehealth options for behavioral health, pain management, and maternal fetal medicine. We recently partnered with Intermountain Health to provide immediate tele-crisis services through our emergency room to our patients that are having a behavioral health crisis. While new, this service has been working well.

The ability to serve as a distant site telehealth provider has much potential for Rural Health Clinics and other providers, as shown throughout the COVID–19 pandemic, and I thank Congress for seeing the value in telehealth. Offering telehealth services, particularly in rural communities, does present challenges of its own, however. The majority of our patient population does not have access to a computer, the Internet, or a phone according to the Social Determinants of Health Index, we were provided with from Cynosure for our pilot project. The connectivity measure for the area was listed as high in many of the communities we serve at FMDH. Telehealth services may seem like a great solution to help bring care to the patient, but when they cannot access the care, it becomes more of a burden and frustration to those we're seeking to help. Many of our patients travel 50–100 miles one way to attend an appointment at our facility and do not have the ability to utilize telehealth services. Further, RHCs and FQHCs are reimbursed for telehealth services through a "special payment rule" at $98.27 per visit. While traditional outpatient offices that bill fee-for-service Medicare receive reimbursement parity between in person and telehealth services, safety net providers like us are paid significantly less for telehealth visits than our in-person encounters, disincentivizing investments in telehealth technologies and obscuring the claims data as to exactly which services are offered through telehealth. I ask that as the committee considers long-term Medicare telehealth policy, it takes into account rural provider perspectives, including the value of adequate reimbursement and audio-only flexibilities to reach patients with connectivity challenges.

EDUCATION PIPELINE

FDMH seeks to inspire our youth to follow a career in health care based on the quality of care they receive from our organization. From my generation alone we currently have seven providers and multiple nurses on our staff that were born and raised in Glasgow and have moved back to provide care in rural America. My 12-year-old son wants to pursue a career in medicine because of the care he has received here. We strive to introduce our youth to the health-care field, this year we will be hosting the first Med Camp for kids in grades 6–8, introducing them to multiple areas of the hospital and clinic. With many clinics and hospitals being at staffing crisis levels, we need to be proactive with our youth and getting them to think about the future. We are also proud participants and supporters of the WWAMI education program[6] through the University of Washington School of Medicine, through which Washington, Wyoming, Alaska, Montana, and Idaho expose medical students to an increased variety of clinical settings throughout their training, including RHCs like ours. Many of our local students have participated. Investing in our youth now helps both our present and our future.

[6] *https://www.uwmedicine.org/school-of-medicine/md-program/wwami.*

TRANSPORTATION

The greatest barrier that our community is facing is transportation. We strive to provide our community and surrounding communities with as much access to health services as we can provide locally, whether we provide them in house, provide outreach to other facilities, bring in specialty outreach clinics, or provide telehealth services. The services we cannot provide are 300 miles away and can cause patients stress and financial burdens. Impacts of no-shows and canceled appointments, resulting from high gas prices, lack of a reliable vehicle or a vehicle entirely, inability to take time off work or have a friend or family member transport them, include lapses in or delayed care, poor adherence to provider recommendations, lack of surgical follow-ups, and much more, all resulting in negative health outcomes and more expensive, higher-level care needs. This is only exacerbated when patients need higher-level care at a facility hours away. When patients are transferred to a larger facility for this care, they are at least 300 miles away from home. Many families struggle to get to their loved ones as well as how to get them back home after discharge. I can share many stories with you, but one that stands out is from this winter when a patient presented to the ER by ambulance, a non-emergency ride which was denied by Medicaid. After the patient was discharged, they were planning to walk/hitchhike 30 miles home to Frazer, in a temperature of −17 below and −35 windchill. While staff were able to help this individual and consistently seek partnerships and other solutions to address these significant barriers, we need more comprehensive solutions.

My clinic is just one of 5,300 RHCs across the country, providing critical services in innovative ways to serve the needs of their patients. The unique structure of the RHC program comes with significant regulatory requirements and oversight, intended to protect the integrity of the RHC benefits. However, many provisions of the RHC statute written in 1977 have never been updated. For example, RHCs are required to have lab equipment within the square footage of the clinic for specific laboratory services. At FMDH, our patients go across the hall to our full-service lab for these services, meaning that our expensive equipment is unused for all purposes except meeting survey and certification requirements. Requirements like these increase cost and administrative burden, challenging an already overwhelmed workforce and threatening the delivery of quality, outpatient care in rural communities. Finally, the drastic increase in Medicare Advantage enrollment across the country, including in rural communities, threatens the rural safety net. While RHCs receive enhanced traditional Medicare payments in comparison with their fee-for-service counterparts as Congress recognizes the increased costs of providing care in rural America and the high value of care in these communities, there is no statutory requirement around RHC Medicare Advantage reimbursement. With oftentimes lessened negotiating power as one of few providers in a rural area, many RHCs across the country are facing financial stability concerns due to low Medicare Advantage reimbursement.

In conclusion, I want to thank you for inviting me to share these unique perspectives as part of today's hearing. We often forget our "why," and this experience has reminded me of why I do what I do. I am proud to be a voice and advocate for this population. I thank the subcommittee for their continued leadership on these critical issues, and I look forward to seeing the work that we can do together for the over 60 million individuals across rural America. Thank you.

QUESTIONS SUBMITTED FOR THE RECORD TO ERIN AUNE, MBA, CRHCP

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. Our Nation's maternal mortality rate is too high and has increased 47 percent since 2018. At the same time, over 80 percent of pregnancy-related deaths are preventable. These challenges impact women of color and women living in rural areas the most. There's a lot we can do, but aren't. My bipartisan Healthy Moms and Babies Act would help address these maternal health challenges. It takes best practices from across the country to improve care, including care coordination, telehealth, and supporting community-led efforts. What actions should we take to improve the maternal mortality rate, especially among women of color and women living in rural America? Do you have a best practice you can share that is helping address these challenges?

Answer. Many patients in our rural area have to travel 300 miles to receive a higher level of obstetrical care. Not only is it 300 miles, there is very limited cell

phone coverage and little to nothing in between, making it very risky for our patients. We are very proud that we have achieved our goal of providing our area with 24/7 OBGYN coverage. We have achieved this with a rotating provider schedule as I mentioned in my written testimony. We are also setting up an outreach clinic with maternal fetal medicine, so our high-risk patients don't have to travel as much or as far for care. Many of our patients travel the 300 miles and then will stay there for multiple weeks before delivery. This causes the patient and their families a lot of stress as it is a huge financial burden. As a facility we are very proactive with this issue but it still could be greatly improved, we can only do so much with the resources that are available. Many other rural areas struggle as they don't have access to resources or education. Providing rural areas access to resources will help with improving care.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. The burden of prior authorization and disputes between providers and payers about claims and payment denials are time-consuming, expensive, and ultimately bad for patients. Can you discuss the extent that transitioning from the fee-for-service (FFS) model to value-based care could help diminish these administrative disputes?

Answer. Value-based care pushes clinical documentation improvement to indicate the complexity of the patient, therefore eliminating the need for peer to peer, only if documentation doesn't support medical necessity. In my opinion, I believe it would still pose administrative burdens, not diminish them. There could potentially be a shift in the administrative burden, more on the providers documentation and coding and less on the AR follow-up staff. However, high-deductible health plans will cause a shift from insurance reps to self-pay collectors. The same problems can be foreseen that we have now with payers having their own set of guidelines. Standardization will be key in EMRs, by payers, etc. before we see diminished administrative disputes.

PREPARED STATEMENT OF HON. STEVE DAINES,
A U.S. SENATOR FROM MONTANA

Thank you, Mr. Chairman. It's great to be here this afternoon to discuss rural health care. It's also a pleasure to be joined by Ms. Erin Aune from Glasgow, MT. We'll have a more formal introduction soon, but thank you for making the trip to be here representing our State and Rural Health Clinics. We're glad to have you.

Rural health is a key component of America's health-care conversation and greatly important to my State of Montana, as more than 720,000 Montanans live in designated rural areas. Most every State in the Nation has some semblance of a rural population, and in frontier States like mine, we are all too familiar with the challenges that come with living where we do—including the challenge of accessing health care.

When we consider health care in a rural setting, one of the defining characteristics of access to care is distance and transportation. The majority of people in rural America live great distances from their nearest health-care provider. A trip to a hospital or doctor's office often requires traveling several hours one way.

Not only is this highly inconvenient and straining, but also very dangerous in emergencies. Extreme weather and unpredictable terrain only add to the challenges rural folks face.

Other threats to access that we see disproportionately affecting rural communities are the increasing number of hospital closures and service line erosions. As our witness Dr. Holmes can attest, we've seen nearly 150 rural hospital closures over the past 13 years.

While closures briefly stalled in 2021, this can largely be attributed to Provider Relief Funds and other assistance to keep providers afloat during COVID–19. As we move beyond the pandemic, the number is sadly on the rise again.

I also hear too often about the erosion of service lines in rural America. In these areas, one of the first services to be eliminated is obstetric and maternity care. GAO issued a report last year which found that access to these services has been in steady decline, and more than half of rural counties do not have these services available at all.

I recently learned of a woman in Montana who traveled from her home several hours away to Billings in the weeks leading up to her due date. She moved into a hotel so that when she went into labor, she would be able to get to the hospital for her delivery. Preparing for labor, delivery, and a newborn is difficult enough. No expectant mother should feel the need to go to such drastic lengths to receive routine prenatal and delivery care.

This is just one example of how service line erosion impacts rural residents, but it is illustrative of the challenges we need to help address. We must find sustainable ways to keep health care accessible in our rural communities. To that end, I am looking forward to the discussion today with our colleagues and witnesses, and hearing their perspectives.

The last time the Finance Committee had a robust conversation about rural health was in 2018. I'm glad we are revisiting the conversation today—post pandemic—to examine the difficulties and progress over the past 5 years.

The difficulties often receive more attention than the successes, and I'd like to acknowledge the recent efforts of my colleague, Senator Grassley, who has long been a champion for rural health issues. Thanks to Senator Grassley's leadership, in January of this year, the first new Medicare rural provider designation went into effect since the Critical Access Hospital designation was created in 1997.

We're very proud of the Montana leadership which led to this designation—a designation spearheaded by Senator Max Baucus—but it's great to see Senator Grassley and others working to implement new and creative ways to serve the changing needs of our rural hospitals today.

Rural health care has long enjoyed robust bipartisan collaboration and support, and I look forward to continuing that tradition.

Thank you to our witnesses for being here today. We appreciate your expertise on this subject and all the work you are doing to promote rural health and access to care.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF DAVID C. HERMAN, M.D.,
CEO, ESSENTIA HEALTH

INTRODUCTION AND BACKGROUND

Chairman Cardin, Ranking Member Daines, and members of the Senate Committee on Finance, Subcommittee on Health Care, thank you for the opportunity to testify at today's hearing: "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." We are pleased the subcommittee is interested in learning more on how to improve health care across rural communities and appreciate the invitation to tell you about our journey to value-based care.

Essentia Health is an integrated health system serving patients primarily in rural communities throughout Minnesota, Wisconsin, and North Dakota. Headquartered in Duluth, MN, Essentia Health combines the strengths and talents of 15,000 employees, including 2,200 physicians and advanced practitioners, who serve our patients and communities through the mission of being called to make a healthy difference in people's lives. The organization lives out this mission with a patient-centered focus at 14 hospitals, 77 clinics, six long-term care facilities, six assisted and independent living facilities, seven ambulance services, 25 retail pharmacies, and a rural health research institute.

On behalf of Essentia Health, we are pleased to highlight our ongoing efforts to serve our patients and rural communities through value-based care models. Our experience has shown that delivering care through these models can be successful in rural communities. Our remarks will focus on:

- The unique challenges providing care in our rural communities.
- How we embarked on value-based care models.
- What we've learned along the way.
- How these models serve as a pathway for the future of rural health care.

Addressing the Needs of Our Rural Communities and the Social Determinants of Health

Providing access to health-care services across rural communities presents unique challenges in addressing the social determinants of health. Our rural patients across Minnesota, North Dakota, and Wisconsin tend to be older, bear greater burdens of chronic disease, experience higher levels of poverty and substance abuse, and have lower rates of education and insurance coverage compared to urban areas.[1, 2, 3] In these rural States, financial insecurity further perpetuates these challenges, as many of the counties we serve fall below statewide median income[4] (Appendix A).

Access to care is the largest, most complex issue currently facing rural health. Patients with access to a primary care physician spend less time in the hospital, have fewer visits to the emergency department, achieve better outcomes and have lower health-care costs.[5, 6] But rural residents face significant barriers in simply accessing care. Patients across rural Minnesota face more challenges in securing appointments and establishing a patient-doctor relationship with primary care providers.[7] Rural counties are more likely to face shortages of primary care doctors and mental health-care providers.[8] Over 40 percent of rural counties are underserved in primary care and over 80 percent of rural counties in America lack local access to behavioral health services.[9]

Residents in rural Minnesota need to travel greater distances to access inpatient services, particularly mental health and obstetrics.[10] Furthermore, over 25 percent in Wisconsin[11] and almost 20 percent in rural Minnesota[12] lack reliable broadband Internet for use in video visits, a barrier to accessing virtual services that were critical during the COVID–19 pandemic.

Rural hospitals and health-care systems significantly impact their local communities, both on health and economic sustainability.[13] As anchor institutions, rural hospitals and clinics play critical roles in the economic and social vitality of their

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[1] Minnesota Department of Health, Division of Health Policy. Rural Health Care in Minnesota: Data Highlights, 2022, *https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf* (accessed May 12, 2023).

[2] University of North Dakota School of Medicine and Health Sciences Advisory Council. Health Issues for the State of North Dakota, Seventh Biennial Report, 2023, *https://med.und.edu/about/publications/biennial-report/_files/docs/seventh-biennial-report.pdf* (accessed May 10, 2023).

[3] Sarina Schrager, "Rural Health in Wisconsin—Looking to the Future," *Wisconsin Medical Journal,* 117, no. 5 (2019), 192–193, *https://wmjonline.org/117no5/schrager/* (accessed May 13, 2023).

[4] Minnesota Department of Health, Division of Health Policy. Rural Health Care in Minnesota: Data Highlights, 2022, *https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf* (accessed May 12, 2023).

[5] David P. Glass, Michael H. Kanter, Steven J. Jacobsen, and Paul M. Minardi, "The impact of improving access to primary care," *Journal of Evaluation in Clinical Practice,* 23, no. 6 (2017), 1451–1458, *https://doi.org/10.1111%2Fjep.12821* (accessed May 12, 2023).

[6] Barbara Starfield, Leiua Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly,* 83, no. 3 (2005), 457–502, *https://doi.org/10.1111%2Fj.1468-0009.2005.00409.x* (accessed May 12, 2023).

[7] Minnesota Department of Health, Rural Health Care in Minnesota.

[8] Elizabeth A. Dobis and Jessica E. Todd. 2022. "The Most Rural Counties Have the Fewest Health Care Services Available." *Amber Waves, The Economics of Food, Farming, Natural Resources, and Rural America,* Economic Research Service, U.S. Department of Agriculture, August 1, 2022, *https://www.ers.usda.gov/amber-waves/2022/august/the-most-rural-counties-have-the-fewest-health-care-services-available/*.

[9] Dobis and Todd, "The Most Rural Counties Have Fewest Health Care Services Available."

[10] Minnesota Department of Health, Division of Health Policy. Rural Health Care in Minnesota: Data Highlights, 2022, *https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf* (accessed May 12, 2023).

[11] Danielle Kaeding, "Report: Rural Areas of Wisconsin Suffer From Major Gaps in Broadband Access," Wisconsin Public Radio, January 4, 2021, *https://www.wpr.org/report-rural-areas-wisconsin-suffer-major-gaps-broadband-access* (accessed May 12, 2023).

[12] Minnesota Department of Health, Division of Health Policy. Rural Health Care in Minnesota: Data Highlights, 2022, *https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf* (accessed May 12, 2023).

[13] University of North Dakota School of Medicine and Health Sciences Advisory Council. Health Issues for the State of North Dakota, Seventh Biennial Report, 2023, *https://med.und.edu/about/publications/biennial-report/_files/docs/seventh-biennial-report.pdf* (accessed May 10, 2023).

communities.[14] In 2022, Essentia Health invested $430.3 million in community contributions [15] across our organization's geographic footprint.

ORGANIZATIONAL COMMITMENT FROM VOLUME TO VALUE

Building an Organizational Culture and Infrastructure to Embrace Value-Based Care

Nationwide, health-care spending grew to $4.3 trillion in 2021, accounting for 18.3 percent of the gross domestic product.[16] This spending growth was fueled by the status-quo approach of paying for medical services based upon volume—an approach that is simply unsustainable. Traditional fee-for-service (FFS) models pay for specific, itemized care delivered by clinicians. Adverse effects of the FFS approach include:

- Rewarding the volume rather than the quality of care and outcomes.
- An emphasis on treatment at the expense of prevention and wellness.
- Providing no incentives for integrating and coordinating care.
- Discouraging practice transformation and clinician-driven innovation.

Recognizing the failure of volume-based reimbursement to meet the needs of patients, Essentia Health committed to transforming our care model to prioritize patient outcomes and overall value. Our volume-to-value journey started with the shared understanding of the need for strategic change, which helped create an environment and forward-thinking culture that embraces continuous improvement and innovation. Effective care transformation relies upon leadership support and engagement from physicians and providers, all aligned in agreement that a new model is required to best care for our patients and communities. At its core, value-based health care emphasizes prevention and wellness, in addition to treatment. This approach focuses on:

- Improving overall patient health.
- Connecting patients with the appropriate care at right time.
- Providing access to integrated care through the entire patient journey.
- Investing in practice transformation and quality improvement.

Value-based care is cost-effective and improves care for all patients, particularly those with chronic illnesses, by improving patient outcomes, experience, and quality of life by:

- Limiting duplicative testing.
- Avoiding medication mistakes and overuse.
- Reducing avoidable emergency department visits and hospital admissions.
- Increasing patient engagement and adherence to care plans and medication.

As we face significant workforce challenges, value-based care supports our clinicians and care teams. Provider wellness has been at risk in our Nation's health-care system, and the pandemic heightened these challenges further. Implementing value-based care programs enhances the care clinicians can provide through care coordination and other services that connect patients with the resources they need to be healthy. A team-based approach to care allows clinicians to spend valuable time with their patients and to contribute their own innovations. Value-based care provides opportunities to make the delivery of health care more rewarding and fulfilling.

The model of care developed to improve outcomes in value-based programs leads to the implementation of best practices for all patients. Because it is neither practical nor proper to differentiate the way we care for patients based on whether they are enrolled in a value-based program, we are creating a best practice standard for all patients. It is the right thing to do for our communities to ensure that health care is sustainable. **Simply put: value-based care delivery is the best care model for *all* patients.**

Essentia Health's commitment to engage in value-based programs and contracts has the added benefit of improving health care for our rural populations. That is

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[14] "Leveraging Position as an Economic Anchor to Improve Health Equity," Rural Health Information Hub, accessed May 13, 2023, *https://www.ruralhealthinfo.org/toolkits/health-equity/2/organizational-capacity/economic-anchor.*

[15] *https://www.essentiahealth.org/about/facts-figures/.*

[16] "NHE Fact Sheet, Historical HE, 2021," Centers for Medicare and Medicaid Services, National Health Expenditure Data, accessed May 15, 2023, *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.*

why our organization entered into our first value-based payment contract in 2005, paving the way to make a substantial leap into value as an early adopter in the Accountable Care Organization (ACO) Medicare Shared Savings Program (MSSP). Embarking on a new way of measuring and providing care in partnership with the Federal Government was a challenging decision for our organization, yet it was a necessary step in moving away from a fee-for-service model. We advanced these efforts when the Minnesota Department of Human Services (DHS) launched a managed Medicaid program called Integrated Health Partnerships (IHPs) in 2013. In the IHP program, Minnesota DHS contracts with ACOs to achieve cost and quality targets. Essentia Health has remained in both of these programs, moving to dual-sided risk-bearing models in 2016 for MSSP and 2018 for the IHP program. Today, we participate in 23 value-based care programs with more than 200,000 attributed members. Nearly 40 percent of our revenue flows through value-based programs.

HOW WE DID IT: ANALYTICS, ACTION, AND ACCOUNTABILITY

Create a Model of Care Delivery That Is as Standard as Possible and as Unique as Necessary to Meet the Needs of our Patients and Communities

Our strategy for success focused on three "As": Analytics, Action, and Accountability. Each of these helps to support a value-based care system with an emphasis on continuous improvement. Strategies for value-based care success include:

- Identifying the patients.
- Determining patients' care needs.
- Managing chronic illness.
- Providing care needs in a proactive and coordinated way.
- Driving appropriate utilization—lower health-care spending.
- Addressing social determinants of health.
- Partnerships with government, private payers, and community organizations.

Analytics

Clinical and information technology infrastructure is a fundamental building block to invest in and maintain value-based care programs. Robust electronic health record (EHR) functionality and data collection systems are necessary to understanding patient populations and screening for the social determinants of health. Payer partnerships are also critical to the success of value-based programs. Payer and EMR data are integrated into clinical data registries to stratify the populations. The results of the analysis support the development of population-specific and actionable cost containment and health improvement strategies, such as:

- Risk stratification.
- The evaluation of utilization patterns.
- Care gap identification.
- Referral management.

Health is created through social, economic, and environmental factors in addition to health-care access and individual health behaviors, and Essentia Health's social needs screening data collected over the past several years highlights the widespread barriers that have impacted inequities across the region. For example, in 2022, 144,000 Essentia Health patients completed a health-related social needs screening, with more than 20,000 (14 percent) patients identifying at least one social need related to food, housing, or transportation. The percentage of patients with social needs varies by clinic locations, with the highest-need communities having more than half (53 percent) of patients identifying at least one need. However, this need is not evenly distributed across race and ethnicity. We found that 22 percent of American Indian/Alaskan Native patients and 17 percent of Black or African American patients reported food insecurity compared to 7 percent of White patients and were also more likely to report financial strain and transportation barriers than white patients.

Actions: Implementation of the Strategies

Informed by data on our populations, nurses, physicians, pharmacists, and community care associates work together to develop programs that address the needs of our patients. Clinical data registries are created to integrate EHR and payer data. The registries stratify the population, identifying those with the highest level of needs. Using this information, the team can engage with the patient to develop an individualized care management plan. As an example, through pharmacy care management, pharmacists review medications with patients to ensure they have the information needed to manage their medications and work with prescribers to iden-

tify the most cost-effective medication options. These efforts result in improved health outcomes, better patient experience, and lower overall utilization and cost.

The approaches used to serve patients have evolved along our journey. Changes in the population require new strategies, including:

- Use of alternative care delivery models, such as virtual care and remote monitoring.
- Improving transitions of care, such as after hospital discharge or when leaving the emergency department.
- Addressing social factors influencing health and well-being.
- Closing care gaps.
- Chronic illness management.

Patient-centered primary care encompasses strategies and services oriented around the patient to achieve their best health. Clinical and non-clinical experts support the care needs of the population working together in team-based care. Community care associates in rural areas are critically important to improve care outcomes by facilitating access, adding value to the health-care team, and enriching the quality of life for their patients, including those who are poor, underserved, and in racial and ethnic minority communities.

At the core of patient-centered care is connection via the EHR. This critical tool allows providers to facilitate care with closed loop referral processes to ensure patients receive timely access to specialists and that the primary care provider remains involved in the patient's care throughout their journey. Several tools connected to the EHR support timely, efficient communication between patients and providers, including Essentia's online patient portal, our Nurse Care Line program, and Virtual Visits on Demand. This improves the patient's journey and engages them in the continuum of care. Care coordination identifies and supports patients with high-risk conditions by helping to arrange services and communicate with multiple providers while transitional care management services help patients transition between hospitalization and community setting.

While collecting data on social determinants of health helps to establish intervention plans, creating connections to community-based organizations is critical in addressing the social factors influencing health. Essentia Health has implemented the FindHelp platform, branded as Resourceful across our service area, and launched a campaign to encourage community organizations to input data and enable referrals. Having the information in a centralized location improves access for all patients and stakeholders. By building relationships with key community partners through outreach and engagement, we are facilitating stronger coordination between agencies and building a network of social care providers ready to help people in need across the region. Essentia Health has embedded access to the Resourceful platform in our EHR to enable providers, care managers, and community care associates to make direct referrals to community-based organizations. Additionally, we also have the ability to determine if the patients received help from the community-based organization. In the two years since launching the program, there have been more than 10,000 referrals with 30 percent patients verified to have received services they need to support their health and well-being.[17]

Expansion to New Partners and Payers

Much like health-care providers, government and commercial health plans are at varying levels of maturity in the value-based care journey. While through the years our government payer programs have been primarily in Medicare and Minnesota Medicaid, we are pleased that the North Dakota Department of Health and Human Services (ND HHS) has embarked on the journey to implement a value-based model to replace fee-for-service Medicaid. Being in full support of advancing value-based care, Essentia Health has engaged with ND HHS and the governor's office to promote the benefits of outcomes-based models. This new program starts out rewarding for process and engagement (pay for reporting) and ramps up over time toward rewarding health outcomes (pay for performance). We appreciate the partnership and willingness to seek input from providers to create a model with short-term and long-term goals.

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[17] Anthony Matt, "Essentia Health-supported program reaches 10,000 referrals for vital programs, services," Essentia Health Newsroom, April 12, 2023, *https://www.essentiahealth.org/about/essentia-health-newsroom/essentia-supported-program-reaches-10000-referrals/* (accessed May 12, 2023).

While the government remains a key part of value-based payment strategy, private payer partnerships are just as fundamental to success. Essentia Health has established criteria to evaluate payer programs and determine alignment with system strategy through financial, systematic, and joint accountabilities. From a financial perspective, models with a glide path to increased risk/reward allow the payer and provider to create a long-term program together. Payer models that offer providers options on levels of risk allow the necessary time for providers to build the infrastructure needed to be successful. Access to timely data is part of the foundation of value-based care. Payers that are engaged in advancing value-based care provide detailed membership and claims data to providers to support the analytics and care interventions needed. Finally, agreeing to fair terms and joint accountabilities will help ensure success with government programs and private payer plans as well.

Accountability

Oversight and accountability are key to advancing the journey from volume to value. We have developed a governance model with oversight committees with clinical and administrative leaders within Essentia Health and also with key payer partners to monitor performance. Through this governance structure we establish goals and provide oversight on performance.

Transparency on performance brings everyone together to identify improvement strategies that support the achievement of standard work through process and care design. We set targets for achievement that can measurably improve outcomes, and we have developed the tools needed to track progress. Examples include dashboards to monitor clinical quality metrics, surgical outcomes, and hospital inpatient length of stay.

SUCCESS IN VALUE-BASED CARE

From 2018 to 2021, Essentia Health Removed Over $102 Million From the Cost of Care Across All Value-Based Programs, While Being Recognized as a Top Performer for Quality, Cost, and Equity

Value-based care is a continuous journey as we learn, evolve, and expand our efforts across our organization. Essentia Health has achieved success in both Medicaid and Medicare value-based programs, saving tax dollars while maintaining a high level of quality and patient satisfaction. We are pleased and proud of our achievements, yet we know we can do more.

Outcomes from our value-based care programs include:

- Medicare Shared Savings Program (MSSP) savings $42.4 million from 2018–2021.
- Minnesota Integrated Health Partnership (IHP) savings of $28 million from 2018 2021.
- Nearly 40 percent of our revenue flowing through value-based programs.
- Approximately 80 percent of value-based contracts having downside risk.

We have demonstrated our commitment to providing affordable, high-quality health-care services for our patients and communities. As a participant in MSSP since 2013, Essentia Health transitioned from shared savings only into the risk-sharing track in 2016. Since then, we have demonstrated consistently high performance. In fact, our providers met 98 percent of the quality targets, earning full quality points for performance year 2021 and generated a 4 percent savings rate, or $13 million for the Medicare program. **From 2018 through 2021, Essentia Health has generated cumulative savings to the Federal Government of over $42 million as an MSSP ACO** (Appendix B). We have also demonstrated success in Minnesota's Integrated Health Partnership (IHP) as well. **From 2018 through 2021, Essentia Health achieved savings of $28 million for the Minnesota State Medicaid program.** Through this work, we have proven that investing into value-based care models can be successful and have brought forward a pathway to the future of providing care in rural areas. We must, however, continue to evolve the way we deliver care to ensure long-term sustainability for our patients and the communities we are privileged to serve.

Quality of care has not been comprised but enhanced in our journey. While focusing on care coordination, appropriate utilization, improving outcomes and lowering cost, our quality of care has continued to increase. This year, Essentia Health was named one of the top-performing health-care systems in the State from Minnesota Community Measurement (MNCM), a statewide resource for timely, comparable in-

formation on health-care quality, costs and equity (Appendix C).[18] Essentia Health scored significantly above statewide averages on 13 of 21 eligible clinical-quality measures for 2021. We have continued to expand our value-based program portfolio with government and commercial payers with more than 200,000 attributed members in 23 programs with 53 percent in government programs and 47 percent are in commercial payer arrangements.

LEARNINGS AND RECOMMENDATIONS TO RURAL HEALTH-CARE PROVIDERS

We Have Implemented a System and Created a Culture That Supports Value-Based Care to Many Communities and Care Sites That Have Joined Essentia Health During Our Journey

To be successful in value-based care, it starts with a desire and commitment to start the journey and achieve the goals. A culture of teamwork and care management is key to building a value-based care program. For small and rural practices, a foundation of EHR and other IS systems support likely cannot be implemented in small practices alone. Shared infrastructure that supports clinics, hospitals, and other sites of care will provide a network to reach populations across a region and coordinate across primary and specialty care services.

A common electronic health record with strong population health capabilities is necessary to understand social determinants of health and preventative care interventions. Health care providers must also be able to access measurement and data resources to track progress and develop local insights in care successes and care gaps to be addressed. They also benefit from tools for standardizing metrics across programs.

In rural areas, health systems must extend their capabilities by partnering with community resources to address local non-medical needs. Connecting to other social services is a critical part of population health improvement, including access to healthy food, transportation, and housing.

Other key learnings include:

- Set short-term goals that reward development and implementation of the infrastructure with a path to more complex models in later years.
- Align all payers within the same model redesign so rural value-based care participants do not have the burden of managing multiple different systems.
- Design models to accommodate lower patient volumes in rural settings to assist with setting benchmarks and targets and in the management of outlier cases.

PUBLIC POLICY RECOMMENDATIONS

What Policymakers Can Do To Advance Value-Based Care to the Next Level

Policymakers play an important role in supporting value-based care. Essentia Health asks Congress to support critical resources for health-care providers, reduce regulatory burden, and enhance the design of value-based payment models.

Continued Support for Critical Resources

Extend the Bonus Payment for Advanced Alternative Payment Models (APMs)

Enacted in the Medicare Access and CHIP Reauthorization Act (MACRA), Congress provided a 5-percent incentive bonus for APMs with downside performance risk. This incentive payment has been important for Essentia Health to continuously invest in program management to participate in MSSP. Appropriate financial incentives will help attract providers to participate in these models to reduce cost and support their transition to value. We appreciated that Congress enacted an extension of the 3.5-percent incentive bonus for 2023.[19] We urge policymakers to reinstate a 5-percent Medicare bonus payment for new and existing advanced APM participants.

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[18] Anthony Matt, "Essentia Health ties for first atop rankings of high-performing health-care systems in Minnesota," Essentia Health Newsroom, January 12, 2023. *https://www.essentiahealth.org/about/essentia-health-newsroom/report-ranks-essentia-among-top-performing-health-care-systems/* (accessed May 12, 2023)

[19] Consolidated Appropriations Act, 2023, Pub. L. 117–328, *https://www.congress.gov/bill/117th-congress/house-bill/2617* (accessed May 13, 2023).

Protect the 340B Prescription Drug Discount Program

The 340B Prescription Drug Discount Program helps rural hospitals stretch limited Federal resources and is used to support health services and programs throughout our communities. Protecting this program is crucial for rural hospitals. The savings help provide essential services to their communities, but unfortunately the program is also coming under attack from drug manufacturers placing unlawful restrictions on covered entities, negatively impacting hospitals and the ability to acquire prescription drugs under the program.

Reduce regulatory burden

The COVID–19 pandemic brought unprecedented challenges and strain on Essentia Health and our Nation's health-care delivery system. However, the pandemic also provided a unique opportunity. Under the emergency, HHS invoked their authority and waived hundreds of regulatory requirements placed on health-care providers. This alleviated barriers that resulted in rapid innovation to meet the challenges brought on by the pandemic.

Continue to Remove Regulatory Barriers To Improve Access to Telehealth

Throughout the pandemic, telehealth and virtual platforms has increased access and safely provided appropriate levels of care. Essentia Health strongly supports enhanced access to telehealth and digital health services and encourages Congress to alleviate regulatory barriers and enact policies to increase access to care through these modalities. Congress needs to consider ways to maximize access for patients, especially those who reside in rural and underserved areas. We thank Congress for enacting legislation to extend certain telehealth flexibilities issued during the public health emergency through 2024 [20] and urge a comprehensive bill to permanently extend telehealth flexibilities made available during the pandemic.

Extend the 96-Hour Rule Waiver for Critical Access Hospitals (CAH)

CAHs are required to maintain an average patient length-of-stay under 96 hours, which was waived during the PHE.[21] With the PHE now expired, CAHs are faced with compliance risk of the 96-hour rule while continuing to provide services to patients that cannot be discharged in a timely manner. Essentia Health will face challenges to meet the 96-hour rule due to very tight health-care system capacity driven by high acuity and lack of post-acute care discharge availability. Continued flexibility and stability will allow hospitals to provide access for their patients closer to home. Essentia Health recommends extending the 96-hour rule waiver through 2024 to align with the extension of various PHE telehealth waivers previously enacted by Congress.

Enhance Value-Based Payment Models

Enact the Value in Health Care Act

Introduced in the previous Congress, the Value in Health Care of 2021 [22] would make a number of positive changes to the ACO program. The bill would modify risk adjustment criteria, improve benchmarking, alleviate barriers to program participation, and extend the advanced Alternative Payment Model (APM) bonus payment. We ask Congress to re-consider introducing and advancing this legislation to help providers nationwide move to value-based care.

Incentivize Participation in Alternative Payment Models (APMs)

To incentivize APM participation, it is essential to remove barriers and give additional flexibility and tools to innovate care. Specifically, Congress should remove distinctions that penalize safety net providers; improve financial methodologies so APM participants are not penalized for their own success; reduce regulatory burdens by offering increased flexibilities and waivers for clinicians moving to risk; and provide technical assistance for new participants.

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[20] Consolidated Appropriations Act, 2023.

[21] Department of Health and Human Services, Changes to FY 2000 Hospital Inpatient Prospective Payment System (PPS) Policies as Required by the Medicare, Medicaid, and State-Child Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. 106–113, Transmittal No. A–00–17, April 2000, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/A001760.pdf* (accessed May 15, 2023).

[22] Value in Health Care Act of 2021, H.R. 4587, *https://www.congress.gov/bill/117th-congress/house-bill/4587* (accessed May 12, 2023).

Establish Alignment and Parity Between Alternative Payment Model (APM) and Medicare Advantage (MA) Program Requirements

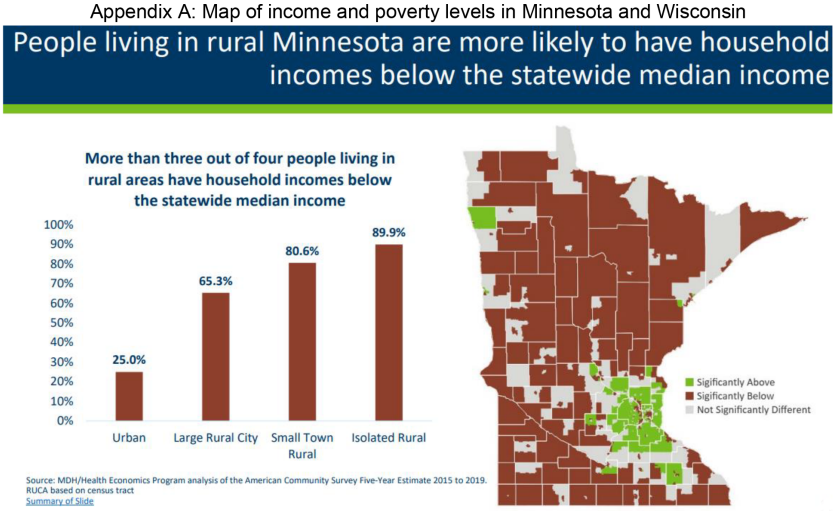
Overall, we support increased alignment between APMs and the MA program to ensure that APMs are not disadvantaged. This includes establishing parity between program flexibilities and network adequacy requirements including telehealth to reduce clinician burdens and improve patient access to care. Additionally, Congress should encourage more multi-payer value-based arrangements and examine how APM incentive payments and shared savings payments, which are incorporated into MA benchmarks, are equitably passed on to physicians and other clinicians.

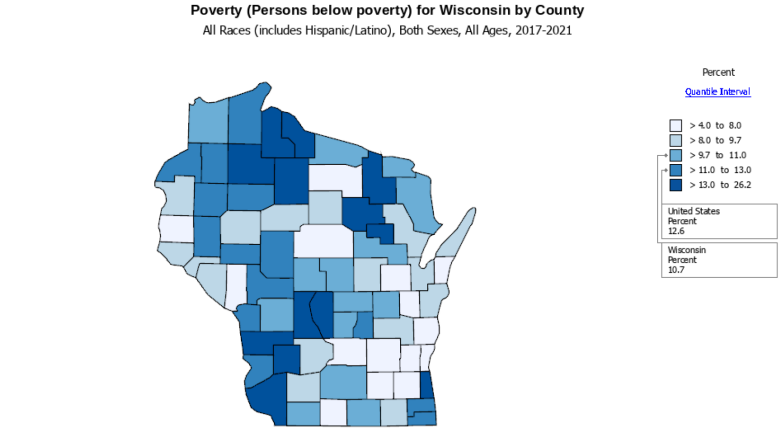
CONCLUSION

On behalf of Essentia Health, we thank Chairman Cardin, Ranking Member Daines, and members of the Senate Committee on Finance, Subcommittee on Health Care, for the opportunity to testify on today's hearing: "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." We are honored to share with members of the subcommittee our value-based care journey, which has significantly lowered health-care spending while increasing the high quality of care and improving patient outcomes. Based on our journey, we hope our testimony today has demonstrated that value-based care is not only a possibility—it is a necessity to achieve health and vitality in rural areas of our country.

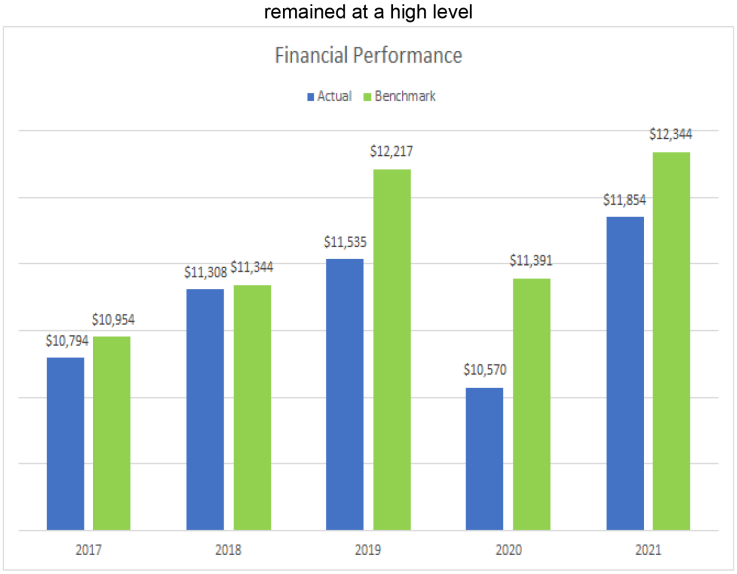
[23] HDPulse, An Ecosystem of Minority Health and Health Disparities Resources, National Institute on Minority Health and Health Disparities, Created May 15, 2023, *https://hdpulse.nimhd.nih.gov*.

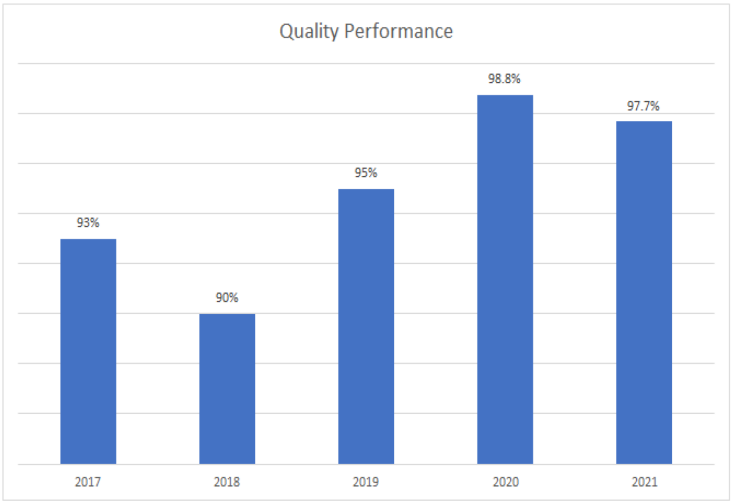
Appendix A: Map of income and poverty levels in Minnesota and Wisconsin



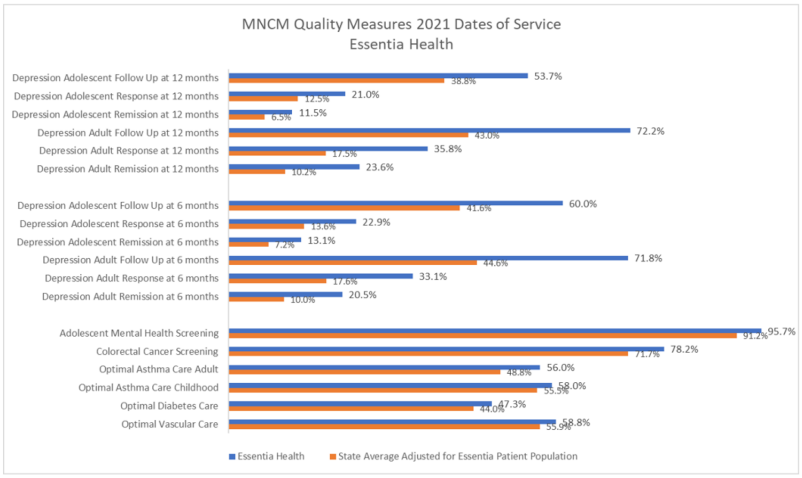


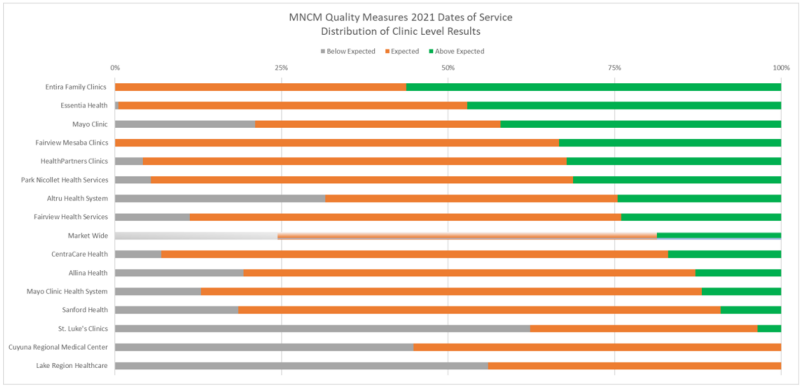
Appendix B: Financial performance indicates savings achieved under benchmark while quality remained at a high level





Appendix C: Minneosta Community Measurement Results





Questions Submitted for the Record to David C. Herman, M.D.

Questions Submitted by Hon. Chuck Grassley

Question. I'm the lead sponsor of the bipartisan Pharmacy and Medically Underserved Areas Enhancement Act. The bill would allow pharmacists to be paid by Medicare for services they're licensed and trained to perform. This will improve seniors' access to wellness screenings, diabetes management, and treatment, and more. Currently, 90 percent of Americans live 5 miles or less from a community pharmacist. Given the access and workforce challenges facing health care in rural America, why is it important to expand access to pharmacist services for seniors?

Answer. Access to pharmacy services plays an important role in the continuum of care. In rural areas, community pharmacies offer access to over-the-counter medications (OTC) and prescription drugs, yet they also provide an important role in education, including medication management. Through these valuable services, a pharmacist will work directly with the health-care team to help patients manage medications and achieve health-care goals.

Local community members who need medications for an acute illness or injury can receive assistance from a pharmacist to select the most appropriate OTC medication or supplies for treatment at home. Furthermore, community pharmacists help patients navigate financial barriers and identify alternatives to make care more affordable. To further help provide services in rural areas, tele-pharmacy can also reach patients closer to home. At Essentia Health, our tele-pharmacy program is deployed across the organization to help patients with multiple medications manage their care. Our pharmacists are members of the clinical care team and provide access to patients with comprehensive opioid addiction treatment, hypertension, hyperlipidemia, and transitions of care. Through the tele-pharmacy diabetes care management program, this program has led to improvements in health outcomes and reduced hospital readmissions. However, these services are not reimbursable unless they are provided in a clinic. Reimbursing these services through telehealth delivery by the system that cares for the patient longitudinally would allow for further rural expansion of this critical health sustaining service.

Pharmacists providing services in rural areas were instrumental during the COVID–19 pandemic. By connecting patients with access to COVID–19 testing and vaccinations, pharmacists provided public health services and helped alleviate the burden on hospitals that were facing high patient volumes due to the pandemic. Simply put, rural pharmacists are known by members of their community as a trusted resource.

Question. Over 600 rural hospitals stand to benefit from my bipartisan Rural Hospital Support Act. The bill would permanently extend the Medicare-Dependent Hospital and Low-Volume Hospital programs, along with establishing a new rebasing year for Sole Community Hospitals. Each of these rural hospital programs offer much needed flexibility and support for rural communities. Why is it important to maintain these rural hospital programs?

Answer. Essentia Health supports provisions of the Rural Hospital Support Act that would permanently extend the Medicare-Dependent Hospital and Low-Volume Hospital programs. We appreciate your leadership to sustain access to services in rural communities and provide resources to hospitals that meet these criteria.

Congress established the Medicare-Dependent Hospital (MDH) program in 1987. This program allows hospitals with 100 or fewer beds that serve a high proportion of Medicare patients to receive a slightly enhanced reimbursement compared to the normal payment rate larger hospitals receive. Similarly, Congress established the Low-Volume Hospital adjustment (LVH) in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This law was enacted in response to a report from the Medicare Payment Advisory Commission (MedPAC) that warned about a widening gap between rural and urban hospital financial viability. However, due to only a very limited number of hospitals benefitting from the program, Congress expanded the program eligibility in 2010 and reauthorized it again in the Consolidated Appropriations Act, 2023. The LVH program provides rural hospitals with low volumes a 0–25-percent payment increase on a sliding scale based on their inpatient volumes. The current improved low-volume adjustment better accounts for the relationship between cost and volume, improves equity across low volume hospitals, and maintains access to care in rural areas.

Rural hospitals are essential access points for care, economic anchors for communities, and the foundation of rural health infrastructure. These hospitals have maintained their commitment to ensuring local access to high-quality, affordable care in spite of unprecedented financial and clinical challenges. In 2022, this program has helped provide approximately $1.6 million in supplemental payments for our hospitals in Virginia and Detroit Lakes, MN, which goes toward maintaining vital services for these communities. We thank Congress for continuing this program and strongly support legislation that would make this program permanent.

Question. Is our health-care system, including the Federal Government as a payer, doing enough to move to value? Are there actions that need to be taken within the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) to speed up the transition to value?

Answer. Essentia Health commends Congress and the Centers for Medicare and Medicaid Services for their commitment to value-based care. The existing fee-for-service system prevalent across health care is financially unsustainable. Currently, there exists a myriad of policies and payment adjustments embedded into Medicare fee-for-service for providers and hospitals. These include quality reporting programs, value-based purchasing, hospital readmissions reduction, health-care acquired con-

ditions penalty, and the Merit-based Incentive Payment System. These policies are all aimed to provide some incentives for providers and hospitals to deliver value-based care.

Since its creation, the Center for Medicare and Medicaid Innovation (CMMI) has developed a variety of payment models. Essentia Health made a substantial leap into value-based care in 2012 as an early enrollee in the Medicare Shared Savings Program (MSSP). Embarking on a new way of measuring and providing care in partnership with the Federal Government was a challenging decision for our organization, yet it was a necessary step in moving away from a fee-for-service model. We advanced these efforts when the Minnesota Department of Human Services (DHS) launched a managed Medicaid program called Integrated Health Partnerships (IHPs) in 2013. In the IHP program, Minnesota DHS contracts with ACOs to achieve cost and quality targets. Essentia Health has remained in both of these programs, moving to risk-bearing models in 2016 for MSSP and 2018 for the IHP program.

Essentia Health applauds efforts from CMMI to create new payment models for organizations to choose. While we have demonstrated success in the MSSP ACO model, it is not suited for all types of providers and health system arrangements. We appreciate and support the acceleration of new models of care for providers and hospitals, yet this work should not come through compromising existing MSSP ACO participants. We understand the challenge of balancing flexibility and simplicity with new models of care that are often at odds with traditional care models.

Much like health-care providers, government and commercial health plans are at varying levels of maturity in their value-based care journey. While our value-based government payer programs have been primarily in Medicare and Minnesota Medicaid, we are pleased the North Dakota Department of Health and Human Services (ND HHS) has embarked on the journey to implement a value-based model to replace fee-for-service Medicaid. Based on our experience with the Minnesota IHP, Essentia Health has engaged with ND HHS and the governor's office to promote the benefits of outcomes-based models. This new program starts by rewarding process and engagement (pay for reporting) and ramps up over time toward rewarding health outcomes (pay for performance). We appreciate the partnership and willingness to seek input from providers to create a model with short-term and long-term goals. Essentia Health remains committed to partnering with the North Dakota Medicaid program in the transition to value-based care.

While the government remains a key part of value-based payment strategy, private payer partnerships are just as fundamental to success. Essentia Health has established criteria to evaluate payer programs and determine alignment with our system strategy through financial, systematic and joint accountabilities. From a financial perspective, models with a glide path toward increased risk/reward allow the payer and provider to create a long-term program together. Payer models that offer providers options on levels of risk allow the necessary time for providers to build the infrastructure needed to be successful. Access to timely data is part of the foundation of value-based care. Payers that are engaged in advancing value-based care provide detailed membership and claims data to providers to support the analytics and care interventions needed. Finally, agreeing to fair terms and joint accountabilities will help ensure success with government programs, along with private payer plans.

There is a point where value-based care provides a better overall approach than fee-for-service across all payers. As an integrated health system, we have learned that participating as an MSSP ACO provides a broad level model across our organization to invest in preventive care and disease management. Some models that are narrowly focused, such as for a certain type of services (*i.e.,* cardiology, oncology) may be appropriate for some providers based on their size and scope. However, it becomes challenging to manage dozens of value-based care models with different performance measures, benchmarks, and targets across a payer portfolio for an integrated system.

Congress and CMS need to provide a viable pathway for entry into risk-based APMs while also providing the right support and resources for participants that have been in risk-based models for several years. To that end, the following are recommendations to policymakers that would accelerate the adoption of value-based care models:

- **Reduce administrative burden.** Being successful in risk-based APMs requires significant investment in administrative functions. We believe new

models should focus on reducing administrative requirements as a way for new providers to participate. For example, CMS requires MSSP ACOs to develop and implement electronic clinical quality measures (eCQMs). This is a significant investment of resources with little benefit to patient care. Furthermore, there is active movement toward streamlining quality measurement through digital quality measures (dQMs) that would extract data directly from an electronic medical record. This would allow for rapid measurement of quality without unnecessarily requiring participants to invest in significant resources to build eCQMs.

- **Financial viability.** Models need to have a clear path that identifies success and financial viability built within the model. Furthermore, Congress needs to enact legislation to maintain the 5-percent advanced APM incentive payment that was originally enacted in the Medicare Access and CHIP Reauthorization Act (MACRA). This is important for new and existing participants to have a financial incentive to help with costs associated with managing the program.
- **Health inequities and social needs.** We strongly support efforts to advance health equity and address social needs through population health models. Payment models should include a focus on health equity and social determinants of health.
- **Data improvements.** Data is the bedrock of managing a value-based model and is critical to developing strategies to improve population health. This could be enhanced with improvements to timeliness, standardization and performance benchmarks.
- **Reward existing advanced APM participants.** We support pathways for new participants that provide a ramp to risk-based arrangements. However, we caution that new models should not compromise existing risk-based ACO participants.

Question. You mentioned in your written testimony the successes of Essentia Health removing $102 million from the cost of care over a 3-year period through value-based arrangements. Is this work bending the cost curve? Is it doing enough?

Answer. Value-based care is a continuous journey as we learn, evolve, and expand our efforts across our organization. Essentia Health has achieved success in both Medicaid and Medicare value-based programs, saving tax dollars while maintaining a high level of quality and patient satisfaction. We are proud of our achievements to improve quality and help to bend the health-care cost curve, yet we know we can do more. Nationally, we all need to work toward the same goal of improving quality and lowering cost. If more providers get involved in value-based arrangements—public and private—the opportunity for improved care is exponential.

Outcomes from our value-based care programs include:

- Medicare Shared Savings Program (MSSP) cumulative savings of $42.4 million from 2018–2021.
- Minnesota Integrated Health Partnership (IHP) savings of $28 million from 2018–2021.
- Nearly 40 percent of our revenue flowing through value-based programs.
- Approximately 80 percent of value-based contracts having downside risk.

We have demonstrated our commitment to providing affordable, high-quality health-care services for our patients and communities. As a participant in MSSP since 2013, Essentia Health transitioned from shared savings into the risk-sharing track in 2016. Since then, we have demonstrated consistently high performance. In fact, our providers met 98 percent of the quality targets, earning full quality points for performance year 2021 and generated a 4 percent savings rate, or $13 million for the Medicare program.

We have demonstrated success in Minnesota's Integrated Health Partnership (IHP) as well. Through this work, we have proven that investing into value-based care models can be successful and have brought forward a pathway to the future of providing care in rural areas. We must, however, continue to evolve the way we deliver care to ensure long-term sustainability for our patients and the communities we are privileged to serve. As was also mentioned by other panel members during testimony, support for community based programs which address health-related social factors is critical to improving health and further reducing the cost of care.

Question. I'm committed to improving access to care by expanding our health-care workforce. A key way we can do that is by modernizing Medicare so that health-care workers are being paid at the top of their license and training. My efforts don't

change State licensing laws, but rather reflect the decisions States have already made. I'm the sponsor or cosponsor of several bills to improve access to pharmacists, audiologists, and physical therapists under Medicare. Last Congress, we improved access to marriage and family therapists and mental health counselors under Medicare. You mentioned the shortages among our health-care workforce in your written testimony. Is modernizing Medicare to pay for services that pharmacists, audiologists, and physical therapists are licensed to perform an important step to addressing the workforce shortages?

Answer. As we face significant workforce challenges, value-based care supports our clinicians and care teams. Provider wellness has been at risk in our Nation's health-care system, and the pandemic heightened these challenges further. Implementing value-based care programs enhances the care clinicians can provide through care coordination and other services that connect patients with the resources they need to be healthy. A team-based approach to care allows clinicians to spend valuable time with their patients and to contribute their own innovation. Value-based care provides opportunities to make the delivery of health care more rewarding and fulfilling. Paying for services provided at the top of a provider's license is important and allows them to be appropriately reimbursed for their services. This supports team-based care.

Medicare should evaluate the extent to which existing policies that arbitrarily restrict education and training programs and coverage of certain services by specific providers limit access to care. Unfortunately, CMS and the Medicare Area Contractors (MACs) are inappropriately re-interpreting existing rules that does not appropriately recognize an integrated health-care system. Specifically, in their view, if a hospital is part of a system CMS will no longer reimburse the hospital for their Nursing and Allied Health Educational costs (42 CFR 413.85). This includes our Pharmacy and Pastoral Care residency programs provided at Essentia Health. This reinterpretation of outdated regulations needs to be modernized with the transition of many hospitals being part of a health system. A hospital should not be penalized for being part of an integrated delivery system that provides training opportunities for our next generation of workforce

Congress and CMS need to also recognize the care team of certified and trained professionals. Under existing rules, Medicare will not cover services provided by certified Tobacco Treatment Specialists provided by registered nurses for tobacco cessation. This is similar to an RN who is a certified diabetic educator providing counseling and education to patients to manage their diabetes. This unnecessarily limits access to care that would otherwise be provided by an appropriately trained professional. These are just a few examples of how regulations inappropriately restrict access to care to professionals that are trained and certified to deliver care. We greatly appreciate the work done by Congress to improve access to therapy services by appropriately trained professionals.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Many providers and health systems have correctly identified the benefits to participating in APMs like the Medicare Shared Savings Program, but still many high-cost providers continue to find traditional fee-for-service to be too financially attractive for them. Could you outline what more can be done to improve incentives within APMs to increase participation?

Answer. While we applaud efforts made thus far to encourage value-based care, Congress and CMS can do more to accelerate this journey. Specifically, policymakers need to provide a viable pathway for providers and hospitals to enter into risk-based APMs while also providing the right support and resources for participants that have participated in risk-based models for several years. To that end, the following are recommendations to policymakers that would accelerate the adoption of value-based care models:

- **Reduce administrative burden.** Being successful in risk-based APMs requires significant investment in administrative functions. We believe new models should focus on reducing administrative requirements as a way for new providers to participate. For example, CMS requires MSSP ACOs to develop and implement electronic clinical quality measures (eCQMs). This is a significant investment of resources with little benefit to patient care. Furthermore, there is active movement toward streamlining quality measurement through digital quality measures (dQMs) that would extract data directly

from an electronic medical record. This would allow for rapid measurement of quality measurement without unnecessarily requiring participants to invest in significant resources to build eCQMs.

- **Financial viability.** Models need to have a clear path that identifies success and financial viability built within the model. Furthermore, Congress needs to enact legislation to maintain the 5-percent advanced APM incentive payment that was originally enacted in the Medicare Access and CHIP Reauthorization Act (MACRA). This is important for new and existing participants to have a financial incentive to help with costs associated with managing the program.
- **Health inequities and social needs.** We strongly support efforts to advance health equity and address social needs through population health models. Payment models should include a focus on health equity and social determinants of health.
- **Data improvements.** Data is the bedrock of managing a value-based model and is critical to developing strategies to improve population health. This could be enhanced with improvements to timeliness, standardization and performance benchmarks.
- **Reward existing advanced APM participants.** We support pathways for new participants that provide a ramp to risk-based arrangements. However, we caution that new models should not compromise existing participants.

Question. The burden of prior authorization and disputes between providers and payers about claims and payment denials are time-consuming, expensive, and ultimately bad for patients. Can you discuss the extent that transitioning from the fee-for-service model to value-based care could help diminish these administrative disputes?

Answer. Prior authorization is a requirement established by health insurance plans for patients to obtain preapproval of a medical service, procedure, or medication. Health plans use criteria such as medical guidelines, utilization, cost, or any other elements in rendering a coverage decision. This process can be challenging for health-care providers because the standards are often opaque. Certain health plans often classify their medical necessity criteria as proprietary and do not share specifics with medical providers.

The process for obtaining prior authorization varies by insurer and involves submission of administrative and clinical information by the treating physician and sometimes the patient. Yet the lack of transparency is a frequent reason that prior authorization and claim submissions are delayed or denied. Essentia Health highlighted these issues in public comments submitted earlier this year to CMS regarding Medicare Advantage Organizations (MAOs) in response to proposed regulations that would increase health plan oversight and better align with traditional Medicare policies.

Improving the prior authorization process can be part of the learning journey in value-based care. For payers waiving prior authorization, the responsibility for total cost of care resides with the provider in a value-based care arrangement. The provider is accepting financial accountability to ensure medically necessary care is being delivered. This balance of oversight and allowing physicians to practice medicine helps to advance value-based care while alleviating administrative burden. Empowering physicians to work with patients on the best options for care without the need for prior authorization barriers helps to provide timely access to care.

PREPARED STATEMENT OF MARK HOLMES, PH.D., DIRECTOR, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH; DIRECTOR, NORTH CAROLINA RURAL HEALTH RESEARCH CENTER; AND PROFESSOR, HEALTH POLICY AND MANAGEMENT, GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA

Chairman Cardin, Ranking Member Daines, and members of the committee, my name is Mark Holmes. I am director of The Cecil G. Sheps Center for Health Services Research and North Carolina Rural Health Research Center at the University of North Carolina at Chapel Hill. I am also a professor in the UNC Gillings School of Global Public Health. I have been a rural health researcher for 25 years; my expertise is in hospital finance and health policy, especially Federal public insurance payment policy. Growing up in Caro in Michigan's rural thumb, I witnessed firsthand some of the health challenges facing our rural communities.

The Cecil G. Sheps Center for Health Services Research is one of the Nation's leading institutions for health services research. Our interdisciplinary researchers undertake innovative research and program evaluation to understand health-care access, costs, delivery, outcomes, equity, and value. The Sheps Center has a long-standing reputation for conducting high-quality, objective research that informs science, practice, and policy. The Center's program on Rural Health Research is one of many Sheps Center programs which are very active in generating the evidence needed to inform pressing challenges facing State and Federal policymakers as they seek to ensure access to health-care services. I am delighted to speak on this important topic. I am unable to cover all the salient issues in rural health today, so I will focus my comments on three main points:

1. Rural health-care infrastructure continues to erode, and this threatens the health and well-being of the 60 million Americans who live in rural areas.
2. Congress can improve the health of rural communities by addressing some specific policy issues in rural health workforce.
3. The common narrative of rural places as sicker, poorer, and older is mostly accurate, but is too fatalistic—rural communities have shown remarkable innovation, and recent policy initiatives have been successful.

THREATS TO A ROBUST RURAL HEALTH-CARE SYSTEM

Since 2005, nearly 200 rural communities have lost their hospital.[1] Although roughly half of these hospitals have continued to provide some kind of health care to their community, the remainder do not—they become condominiums, a car wash, or more often completely abandoned. We also know how important hospitals are to rural economies; recent research has shown that closures can lead to decreases in the size of the labor force and the population living in the community.[2] Those hospitals that do survive have steadily gotten smaller. Rural hospitals have cut services like maternity care and home health services,[3] and inpatient care in rural hospitals has fallen by 13 to 20 percent in the last decade,[4] with most of this decrease driven by rural residents being increasingly likely to receive inpatient care at urban hospitals.[5] Approximately 20 percent of Americans live more than 60 minutes from a medical oncologist,[6] and the financial burden of increased travel time reduces the use of lifesaving treatments and, paradoxically, *increases* the cost of care; geographic barriers to care actually lead to higher costs in the long run.[7] Rural residents who drive an hour a day—each way—for 5 weeks in a row to get their radiation treatment are facing fatigue of long car travel while fighting cancer.

This diminishing access has led to increasing rural-urban disparities in health outcomes. In 1999, the death rate in the most rural counties was 6 percent higher than it was in large urban counties; in 2019, it was 28 percent higher.[8] Meanwhile, research led by experts at the Centers for Disease Control and Prevention (CDC) found that communities served by closing rural hospitals experienced an increase

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[4] Malone, TL, Pink, GH, and Holmes, GM (2021), Decline in Inpatient Volume at Rural Hospitals. *The Journal of Rural Health,* 37: 347–352. *https://doi.org/10.1111/jrh.12553.*

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[6] Levit, LA, Byatt, L, Lyss, AP, Paskett, ED, Levit, K, Kirkwood, K, Schenkel, C, Schilsky, RL. Closing the Rural Cancer Care Gap: Three Institutional Approaches. *JCO Oncol Pract.* 2020 Jul;16(7):422–430. doi: 10.1200/OP.20.00174. Epub 2020 Jun 23. PMID: 32574128.

[7] Rocque, GB, Williams, CP, Miller, HD, Azuero, A, Wheeler, SB, Pisu, M, Hull, O, Rocconi, RP, Kenzik, KM. Impact of Travel Time on Health Care Costs and Resource Use by Phase of Care for Older Patients With Cancer. *J Clin Oncol.* 2019 Aug 1;37(22):1935–1945. doi: 10.1200/JCO.19.00175. Epub 2019 Jun 11. PMID: 31184952; PMCID: PMC6804875.

[8] Analysis of United States Department of Health and Human Services (U.S. DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Multiple Cause of Death 1999–2020 on CDC WONDER Online Database, released 2021. Data are compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

in preventable admissions.[9] Death rates from COVID–19, while initially higher in urban areas, became higher in rural as early as September 2020.[10]

The rural health-care system consists of a wide variety of health-care providers, such as Federally Qualified Health Centers and Rural Health Clinics (RHCs). There are several technical fixes that would allow RHCs to play a more expansive role in rural health care, such as correcting eligibility caused by a change in the definition of rural used by the Census Bureau, removing the historical requirement that RHCs cannot "be a facility that is primarily for mental health treatment," and expanding use of home health by RHCs.

Hospitals are typically one of the most important health-care providers in a rural community, and they have had weak and declining finances for years. In 2018, roughly half of rural hospitals were unprofitable, and financial distress is one of the leading causes of rural hospital closure. As hospitals close, residents face a decrease in access to health care. Facing this decline in access, Congress, the Medicare Payment Advisory Commission, and others have long proposed new models of care that focus on a hospital's emergency department services. Senator Grassley's dedication to this issue manifested in the Rural Emergency Hospital (REH) provision in the Consolidated Appropriations Act of 2021. This model has some appealing elements, and at least five rural hospitals have officially converted to REHs, but interest has been muted due to some program design elements that can only be addressed legislatively. I applaud Congress for acting innovatively to address rural health needs. Continued monitoring of this provider type will be necessary to ensure it is meeting the needs Congress intended. Meanwhile, rural hospitals are becoming increasingly part of a larger health-care systems, and this can lead to further service erosion—work by researchers out of the Agency for Healthcare Research and Quality has found that rural hospitals that merge are more likely to close their obstetric and surgical units.[11]

RURAL AREAS ARE FACING ACUTE HEALTH WORKFORCE SHORTAGES

Rural places have faced persistent workforce shortages and over the past 20 years, it has become even more difficult to recruit, retain and sustain rural health-care workers ranging from doctors to nurses to EMS personnel in rural areas.[12] Without an adequate health workforce, it is becoming more difficult for individuals in rural areas to access health care.[13] Many proposed policy solutions to address these workforce challenges focus on one profession, for example nurses, or one stage of the career, such as graduate medical education. To shore up and grow the rural health workforce, it is critical that we look to solutions that aren't siloed in this fashion and support health-care workers across their entire career trajectory.[14]

Evidence-based investments that increase the number of health professionals training in rural areas, increase the number of preceptors and faculty, provide support to early career health-care workers, address workplace violence, and focus on retaining mid- to late-career health-care professionals can be further scaled. Health professionals that train in rural areas are five times as likely to remain in practice in rural areas.[15] By growing the number of rural training opportunities and then

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[14] Fraher, E, Brandt, B. Toward a system where workforce planning and interprofessional practice and education are designed around patients and populations not professions. *J Interprof Care.* 2019 Jul–Aug;33(4):389–397. doi: 10.1080/13561820.2018.1564252. Epub 2019 Jan 23. PMID: 30669922.

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Continued

ensuring that resources are available to retain that workforce across their careers we can ensure that the workforce needed to meet the needs of rural areas is there for decades to come.[16]

Decades of research have taught us that one of the most effective ways to boost health workforce in rural and underserved areas is to *train* them in rural and underserved areas.[17] Efforts to expand physician training have paid great dividends; for example, during the 4 years of the Rural Residency Planning and Development program, there have been more new rural residency slots (463) than were established during the prior decade (418).

Congress has enacted legislation to address rural physician shortages via training. The Consolidated Appropriations Act of 2021 included a number of provisions that expand rural resident training opportunities. Section 126, for example, increased the number of physician residency slots, to be phased in over a number of years. To qualify, training programs must meet one of four criteria, including being located—or being *treated* as being located—in a rural area. Legal decisions have led to a rapid increase in the number of urban hospitals who reclassify as rural; this means that, under current legislation, they are treated as rural hospitals in all respects, including eligibility for residency slots. Despite a 10-percent floor on the number of expanded residency slots allocated to rural hospitals, only 6 percent of slots were allocated to hospitals located in rural areas; another 42 percent were allocated to urban hospitals that have been reclassified as rural.[18] This may not have been Congress's intention.

RURAL CAN INNOVATE AND LEAD WHEN POLICIES ARE RURAL-APPROPRIATE AND SUPPORTIVE

We commonly hear about rural America being sicker, poorer, and older. It is also relatively well-known rural residents are less likely to have health insurance,[19] travel farther for health care,[20] and have more chronic diseases. The CDC has found that rural residents are more likely to die of the five leading preventable causes of death.[21] These are accurate descriptions of a population that provides much of America's food, fun, and fuel. As much as it describes the health challenges in parts of the country that have fewer physicians, nurses, and hospitals, I often worry that it suggests government is powerless to improve rural health. When Congress and policymakers have developed policy to address rural needs, it has led to dramatic improvements in conditions for typically relatively small expenditures. In the early 1990s, rural hospitals were closing at a dramatic pace, and Congress introduced the Critical Access Hospital program in 1996. That program has helped stabilize the rural health-care system for over 1,300 rural communities. Although roughly one quarter of acute care hospitals are CAHs, the program only accounts for five percent of total hospital outlays by Medicare.[22]

Perhaps because of the more limited resources in rural communities, there are many examples where rural health-care innovation has led the way. Telehealth, community health workers, expanded scope of practice and task shifting, drones, new payment models, and leveraging strong trust in community leaders (faith lead-

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[17] *E.g.,* Holmes, GM. Increasing physician supply in medically underserved areas. *Labour Economics.* Volume 12, Issue 5, 2005, pages 697–725, ISSN 0927–5371, *https://doi.org/10.1016/j.labeco.2004.02.003.*

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ers, agriculture, other community organizations) are all examples where lessons from rural innovation have helped fuel transformation throughout the health-care system. Community paramedicine is a promising model that leverages existing rural resources to meet uniquely rural needs.[23] By tailoring the design to its specific environment and resources, a Critical Access Hospital in North Carolina found a path to expanding maternity services in the rural community it serves.[24] Others in the rural Southeast have designed programs ensuring access to maternity care, addressing substance use using peers, high risk pregnancies using telehealth networks, and providing family planning counseling using rural-specific messaging. During the pandemic we saw rural hospitals adapt, often working with urban hospitals to absorb excess demand when there was more rural capacity. This kind of innovation that adapts and is responsive to the needs and assets of the community should be encouraged.

CONCLUSION AND FUTURE DIRECTIONS

Although rural residents—and those who visit rural communities—face real barriers to achieving their full health opportunities, there are policy strategies that Congress can consider in order to mitigate some of the barriers. History has shown that thoughtful legislation designed to address rural-specific challenges and leverage the assets of rural America has been successful in improving the lives of the 60 million who live in our rural communities. It is important to continue to recognize that rural health-care systems are different, and not simply "small versions of urban" and can yield similar outcomes, when given the opportunity.[25] The pandemic exposed the fragility of our rural health-care system. Fortunately, Congress has a number of policy opportunities to make real improvements for rural America.

QUESTIONS SUBMITTED FOR THE RECORD TO MARK HOLMES, PH.D.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. Pharmacists play an important role in ensuring access to care for patients across the country, especially in rural communities. During the COVID–19 pandemic, pharmacists were crucial access points for communities to receive COVID–19 testing and vaccinations.

Having seen how pharmacists' knowledge and skill sets were leveraged during the COVID–19 pandemic to increase access to care, how can we use lessons learned from the COVID–19 pandemic to continue this access to care for other conditions through the use of pharmacists?

Answer. Although this is not my area of expertise, the studies below may be helpful. Additionally, the RUPRI Center for Rural Health Policy Analysis out of the University of Iowa is an expert in this area. Some research has shown that because pharmacists are more geographically dispersed than physicians, they may be an underutilized and viable strategy for delivering certain health-care services, such as vaccines (*e.g.,* Shah et al., 2018). An article in the *Journal of Rural Health* (Adunlin et al., 2021) discussed the potential role of rural pharmacies for COVID and other infection disease management. An article from *Vaccine* (AlMahasis et al., 2021) showed that rural pharmacies continued to provide other vaccination services at about the same rate before and after pandemic onset.

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QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. You stated in your written testimony that nearly 200 rural communities lost their hospital since 2005. The Rural Emergency Hospital (REH) designation became available in 2023. If the REH program was available at the time, how many hospitals could have been saved?

Answer. The Rural Emergency Hospital (REH) designation is an important innovation in America's efforts to maintain access to hospital care in rural areas. The intent of the REH is to provide a new model of care that is financially and operationally viable over the long term. For communities faced with imminent closure of their acute care hospital, the REH could be a compelling option for maintaining local access to emergency and outpatient services—an option that wasn't usually viable before REHs. Currently seven hospitals (and an eighth imminent) have availed themselves of this new Medicare designation. Although it is impossible to know how many closed hospitals could have been replaced by a REH, it is likely that many of the 196 hospitals that closed since 2005 *(https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/)* would have considered the REH as a strategy to maintain services in the community. It will be important to monitor the implementation of REHs and to assess their impact on access, cost, and quality of care. As has been the case for other Medicare payment designations, it will also be important to evaluate whether changes to REH design, eligibility, reimbursement, and services are warranted to meet the goals of the legislation.

Question. I'm the lead sponsor of the bipartisan Pharmacy and Medically Underserved Areas Enhancement Act. The bill would allow pharmacists to be paid by Medicare for services they're licensed and trained to perform. This will improve seniors' access to wellness screenings, diabetes management, and treatment, and more. Currently, 90 percent of Americans live 5 miles or less from a community pharmacist. Given the access and workforce challenges facing health care in rural America, why is it important to expand access to pharmacist services for seniors?

Answer. Research has shown that because pharmacists are more geographically dispersed than physicians, they may be an underutilized and viable strategy for delivering certain health-care services, such as vaccines (*e.g.,* Shah et al., 2018). Despite the documented return on investment for clinical pharmacy services such as medication management and chronic disease management (*e.g.,* NASEM report 2021, Tran et al., 2022, Chisholm-Burns et al., 2010), reimbursement for clinical services is complex (Pollack et al., 2023). Payment for clinical pharmacy services is not systematically covered by Medicare and Medicaid and payment strategies varies widely by State. Coupled with transportation challenges in rural areas, proximity to pharmacists implies that expanding scope and reimbursement of appropriate services may increase access to critical health-care services in rural areas, especially those where the population is medically underserved and faces a shortage of health-care providers.

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Question. Over 600 rural hospitals stand to benefit from my bipartisan Rural Hospital Support Act. The bill would permanently extend the Medicare-Dependent Hospital and Low-Volume Hospital programs, along with establishing a new rebasing year for Sole Community Hospitals. Each of these rural hospital programs offer much needed flexibility and support for rural communities. Why is it important to maintain these rural hospital programs?

Answer. Our rural health research center regularly tracks the profitability of rural hospitals. In a pre-COVID study *(https://www.shepscenter.unc.edu/download/19974/)*, we found that rural PPS hospitals with 0–25 beds and Medicare-Dependent Hospitals (MDHs) had the lowest profitability compared to other hospitals—these were the only hospitals with negative median total margins. We also found that MDHs are smaller and are more likely to be located in more rural areas with a higher percentage of elderly—both of these factors increase the risk of financial distress. In a forthcoming brief focusing on COVID years, we find that MDHs were the only Medicare payment designation for which median profitability was lower in 2021–22 than 2018–19.

In another pre-COVID study *(https://www.shepscenter.unc.edu/download/13871/)*, we found that Low-Volume Hospitals (LVHs) are typically smaller, more geographically isolated, and have lower total and operating margins than other rural hospitals. In a forthcoming brief focusing on COVID years, we find that LVHs had lower total, operating, and Medicare inpatient margins than other rural hospitals, and that LVHs would have substantially lower profitability margins without the LVH adjustment, with the largest impact on Medicare inpatient margins.

The implication of both of these research studies is that LVHs and MDHs are types of rural hospitals that face extraordinary financial pressure. They are among the most financially fragile rural hospitals, and the LVH or MDH designations and continued support are necessary to avoid jeopardizing the long-term sustainability of hospitals with these designations.

Question. Is our health-care system, including the Federal Government as a payer, doing enough to move our health-care system to value? Are there actions that need to be taken within the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) to speed up the transition to value?

Answer. A transition to value-based care is largely predicated on having sufficient volume over which to manage the variability of individual health outcomes and costs. Rural communities are often challenged to meet these volumes. Furthermore, given high rates of "bypass" of hospital and other types of health care, rural providers may have less influence over the health care their residents receive than urban, larger providers. Many Federal (as well as non-Federal) value-based designs face difficulties in implementing the urban designs in rural areas. Smaller volumes mean the statistical precision of measures is lower, meaning incentives are based on "noisier" values. The specifics of some payment mechanisms more common in rural areas (*e.g.,* all-inclusive rates in rural health clinics; cost-based reimbursement in critical access hospitals) means that value-based designs utilizing PPS claims as a backbone for attribution and total cost of care calculation need to be tailored to rural areas. Two-sided risk models may be more challenging for rural providers with lower liquidity and ability to manage the financial risk. Prioritizing rural-centric design, rather than urban-centric tweaked for rural specifics, has shown to be more effective in transitioning rural areas to value.

Question. I'm committed to improving access to care by expanding our health-care workforce. A key way we can do that is by modernizing Medicare so that health-care workers are being paid at the top of their license and training. My efforts don't change State licensing laws, but rather reflect the decisions States have already made. I'm the sponsor or cosponsor of several bills to improve access to pharmacists, audiologists, and physical therapists under Medicare. Last Congress, we improved access to marriage and family therapists and mental health counselors under Medicare. You mentioned the shortages among our health-care workforce in your written testimony. Is modernizing Medicare to pay for services that pharmacists, audiologists, and physical therapists are licensed to perform an important step to addressing the workforce shortages?

Answer. Many of the principles supporting increased use of pharmacists in my earlier response apply here. In general, ensuring that the health workforce practices to the top of their training will increase access.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. The burden of prior authorization and disputes between providers and payers about claims and payment denials are time-consuming, expensive, and ultimately bad for patients. Can you discuss the extent that transitioning from the fee-for-service model to value-based care could help diminish these administrative disputes?

Answer. A primary tension in our health-care payment system is that the payers and providers have misaligned incentives. Traditional fee-for-service designs often use prior authorization and other utilization management tools to discourage the use of low-value care. One promise of value-based care designs is that they better align the incentives: providers are accountable for cost. As incentives for eschewing low-value care and instead focusing on high-value care are incorporated into value-based designs, through (for example) total cost of care, quality metrics, or other objectives, are recognized by providers, the importance of utilization management reduces. An article in *HFM* (Butcher, 2019) discusses this principle in one commercial plan: as it shifted to value-based payment, it eliminated PA for many services. Of course, it is important to recognize that value-based payment may change the dynamic of the patient-provider relationship; facing these new incentives, do *providers* use utilization management type-approaches, replacing the *payer*-based utilization management tools?

There are, of course, other opinions. For example: "Part of the appeal of VBP contracting is that it promises to free provider organizations from the complexities of FFS payment. In reality, however, the mechanics of claims and denials are still baked into the VBP system. The bottom line is that denials management will remain a critical function in health care financial management for the foreseeable future. . . . A strong denials management program is critical to calculating accurate cost-of-care benchmarks and therefore ensuring the best chance of hitting cost targets and securing shared savings incentives."

HFM, March 2021, *https://www.hfma.org/cost-effectiveness-of-health/financial-sustainability/denials-management-an-underrated-tool-for-optimizing-value-base/*.

PREPARED STATEMENT OF SARA K. RICH, MPA, PRESIDENT AND CEO, CHOPTANK COMMUNITY HEALTH SYSTEM

INTRODUCTION AND BACKGROUND

Chairman Cardin, Ranking Member Daines, and members of the committee, thank you for the opportunity to testify on obstacles that rural communities face in accessing health care and how community health centers are overcoming those obstacles.

Choptank Community Health System's mission is, "to provide access to exceptional, comprehensive and integrated health care for all." Choptank teams focus on providing access to care for the communities we serve each day and continuously develop innovations and solutions to ensure our mission shines through all our endeavors.

As a private, nonprofit community health center, we provide access to quality health care through the delivery of comprehensive medical, dental, and behavioral health-care services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties on Maryland's Eastern Shore. Choptank opened its first primary care office in Caroline County in July 1980 and has been providing quality health care in this rural area continuously for 43 years. Choptank is a Federally Qualified Health Center (FQHC) with oversight from a community board.

In the U.S., nearly 20 percent of residents live in rural areas, but only 10 percent of health-care providers work in these areas. Twenty-five percent of Maryland's total population lives in an officially designated rural area, all five counties in the Choptank service area are designated as rural.

The region also includes some of the most medically underserved counties in the State. Caroline, Dorchester and Kent Counties have a Health Professional Shortage Designation (HPSA) for dental, mental health and primary care. In addition, Talbot County has HPSA designation for dental care.

Through program development and expansion, Choptank has grown to seven medical office locations, five dental locations, and seven behavioral health service sites. All dental and behavioral health services are co-located with medical services. All Choptank care locations and program sites are accredited by The Joint Commission and have achieved Primary Care Medical Home (PCMH) distinction.

In 2022, Choptank provided care to 29,777 patients representing 99,205 visits, with 7,950 being virtual via phone or video. Eighteen percent of the patients seen were Hispanic or Latino/a. In terms of reported race, 1 percent of patients were Asian, less than 1 percent were Native Hawaiian, 3 percent were Other Pacific Islander, 23 percent were Black/African American, 2 percent were American Indian/Alaskan Native, 59 percent were White, less than 1 percent were more than one race, and 13 percent chose not to disclose. More than 4,000 patients were best served in a language other than English.

Choptank is committed to providing equitable access to quality care for all residents of our service area. We provide sliding fee coverage to those patients who are uninsured or under insured. Patient-reported income shows that 23 percent of patients were at or below Federal Poverty Levels (FPL) of 100 percent; 12 percent were 101–150 percent of the FPL; 6 percent were 151–200 percent; and 8 percent were over 200 percent. Thirty-three percent of the patients seen were children under age 18; 24 percent were ages 18–29; 28 percent were ages 40–64; and 14 percent were age 65 and up. Forty-four percent of 2022 Choptank patients had Medicaid, 15 percent Medicare, 28 percent private insurance, and 13 percent had no insurance.

Choptank served 646 veterans in 2022, an increase from the prior year. Nearly 2,600 patients were seen in our school-based health program. Three hundred and seventy-three agricultural workers or dependents were seen through our migrant health program. Choptank provided care to 191 homeless patients in 2022.

My testimony will identify obstacles to accessing care in rural areas and show how Choptank is overcoming those obstacles. I will close with some recommendations on how this committee and Congress can support health centers and other providers' work in this area.

OBSTACLES AND OPPORTUNITIES TO ACCESS

Rural areas often share similar characteristics that are unique from other geographic designations. These include distance to obtaining services, lack of transportation, health-care access and availability and poorer health outcomes. For example, in the Choptank service area, rates of smoking, obesity, excessive drinking, children in poverty, and teen births are higher than State of Maryland rates.

Workforce Shortages

On the Eastern Shore, the workforce shortage has been exacerbated by the closure of large service providers for behavioral health and women's health. In response, Choptank and their board of directors committed to rapid expansion of the new behavioral health service line. To date, Choptank has a behavioral health therapist at each location and has added this service in the school-based health centers. A part-time child and adolescent psychiatrist has also been hired. Recruitment efforts continue to fill the remaining vacancies.

> A Choptank physician facilitated a warm hand-off with a 71-year-old White female struggling with depression. The therapist was able to work with her during the warm hand-off; however, due to Medicare not accepting Licensed Clinical Professional Counselor (LCPC) licensure, we could not connect her with the therapist in her health center. The patient had no transportation to a site with an LCSW–C and no computer or Internet at home to access telehealth services. Choptank has to refer this patient to another organization, which is equally as difficult due to the obstacles the patient faces. LCPCs have been approved for Medicare reimbursement, but this does not begin until 2024.

Choptank also committed to expanding prenatal care and women's health offerings by hiring a certified nurse midwife to rotate throughout the health centers. This is in addition to two family medicine physicians offering prenatal care in their

practice and the multiple medical providers providing women's health services. Choptank ensures that our family practice providers are trained in various women's health services.

> A 29-year-old White single-parent female initially had a routine pregnancy. It was complicated by high sugar levels during her diabetes screening test. She stopped drinking soda and her follow-up test to verify diabetes was negative. An ultrasound showed a tumor on the baby's hand with an extremely large blood vessel tracking up his arm. Mom was transferred to Maternal Fetal Medicine locally and ultimately to Baltimore. After delivery, we followed up on mom's well-being, because the baby has required 2+ months in the NICU in preparation for surgery. When mom developed postpartum depression, our co-located behavioral health therapist was able to start therapy for her right away while her primary care provider started her on medication. Mom plans to bring her baby to Choptank for pediatrics once he is discharged home.

Access to dental care has been a high priority in Maryland for many years because of the death of 12-year-old Deamonte Driver due to a dental infection. Choptank's robust dental program has expanded to include specialty care for pediatrics and oral surgery. At this time, the oral surgeon position has been vacant for a year and a half with recruitment continuing.

> Our mobile health school-based dental team was providing care in Dorchester County. They were parked in front of the school, when there was a knock on the van door. A parent was bringing her daughter to school late because of tooth pain. Mom didn't know what to do. The family was new to the area and the daughter, an 8-year-old African American female, wasn't enrolled for our program but she came in, and our dental hygienist saw the patient and provided an evaluation immediately. The patient had an abscess on a baby tooth that was painful to the touch. The dental hygienist reached out to our dental case manager and the patient had an emergency visit at our Cambridge dental center that same day.

Maryland recently expanded coverage for adult dental Medicaid patients. This is a huge need, especially on the Eastern Shore. The obstacle is that most private practices do not accept Medicaid, leaving Choptank care for more patients than ever before.

> A 39-year-old White male was referred to Choptank for oral surgery. He drove 90 minutes for a consultation at our Federalsburg dental center. Instead of referring him to an oral surgeon, our dental team took additional x-rays to determine if we could do the needed extraction in- house. Our dentist was able to perform the procedure, which meant the patient did not have to travel further or pay additional charges. Oral surgery is a huge need on the Eastern Shore.

Recruitment for dental hygienists has been difficult with vacancies open for more than a year and a half. At this time, the Eastern Shore does not have a training program for dental hygienists. Clinical support staff are critical in the ability of our health centers and providers to take care of the patients that need health-care services. For dentists to work at an optimum level, two dental assistants are needed per provider. Often, dentists are working with one assistant and have had to share an assistant with another provider. The same holds true for medical providers. Medical assistants also represent a workforce shortage for Choptank. This reduces access to health care for patients. Developing a pipeline of new providers and clinical support staff is critical for health care especially in rural areas.

Efforts to expand the Choptank service area's rural primary care workforce include a partnership with the University of Maryland School of Medicine (UMSOM). UMSOM received a planning grant from HRSA in 2019 to explore the development of a rural residency training track in collaboration with Choptank and the University of Maryland Shore Regional Health (SRH). The funding allowed for the design of a rural family medicine training experience for graduated new physicians. Physicians who train in an FQHC are nearly twice as likely to begin their careers in a similar setting providing significant benefits to rural communities. In recognition and support of addressing the health-care needs on the Eastern Shore of Maryland, the Maryland State legislature passed a bill allocating $1.5 million in funding for the rural residency track.

Choptank has a longstanding partnership with NYU/Langone for Advance Education in General Dentistry (AEGD) residents. This program has been critical in

providing access to dental care in our health centers and served as a recruiting resource as we have hired many of the residents to join Choptank as a dentist when they have completed their training. Historically, Choptank would train 2 residents each year. In 2023, Choptank has 4 residents from NYU/Langone. Plans are underway to bring a pediatric dental residency to Choptank with NYU/Langone. Choptank has hired a pediatric residency director to build and lead the new program.

To address the shortage of clinical support staff, Choptank partnered with a local community college, Chesapeake College, which has health-care training programs and a with a state-of-the-art facility for mock patient care experiences. Thanks to American Rescue Plan funds, Choptank developed a scholarship program to support certification for medical and dental assistants who chose to work at Choptank.

New providers are hired and must relocate to the Eastern Shore, they often face barriers in securing housing. Recently, a dentist was hired and was unable to move into a rented apartment for nearly 3 months. She stayed in a hotel until more permanent housing was available. Choptank is exploring partnerships with the local chambers of commerce and economic development to strategize how housing can be more accessible, especially to health-care professionals coming to the area.

Broadband Access

The need for reliable Internet services became even more critical, especially in rural areas during the COVID–19 pandemic. Health providers across the country had to pivot to virtual visits overnight to provide access to care for their communities. During that time, 65–70 percent of medical visits were provided virtually, representing more than 9,000 patients seen. Obstacles were rampant as many patients did not have reliable Internet in their homes and couldn't access it elsewhere. Often, the planned virtual visit was converted to a phone visit so that the provider could connect with their patient. Audio-only visits are a life-line to some of our most vulnerable patients who face multiple obstacles in obtaining health care including chronic disease, transportation and Internet access.

Transportation

Through the work of the Maryland Mid-Shore Rural Health Collaborative, transportation continued to be identified as the most common barrier to accessing health care in rural Maryland for all types of health-care services. Obstacles identified include lack of broad bus routes, limited hours of operation/ schedule and limited medical transportation services. Some communities do not have any public transportation available. Due to the large geographic area of the Eastern Shore, travel times can be extensive.

Choptank utilizes community health workers to assist patients in planning for transportation to and from their medical and dental appointments to reduce this barrier to accessing care. Telehealth including audio-only visits helps reduce the need for travel in some cases. Medicaid transportation is limited and does not yet include coverage for dental visits.

Redetermination

With the unwinding of the COVID–19 public health emergency, States will now have to begin eligibility redeterminations for Medicaid enrollees after nearly 3 years. National estimates from Geiger Gibson indicate that up to 15 million Medicaid enrollees will lose coverage. This will impact community health centers that provide care for one in six Medicaid beneficiaries. According to the National Association of Community Health Centers, Medicaid beneficiaries who are patients at health centers have lower overall costs to Medicaid than non-health-center patients while also having better health outcomes. Medicaid redetermination is estimated to impact health center revenue and reduce patient access and staffing. According to the Maryland Health Benefit Exchange, estimates indicate that approximately 80,000 residents could lose coverage.

States, including Maryland, are partnering with community health centers to provide outreach and education to patients who need to renew coverage depending on their eligibility or to find new coverage. It is important for these patients to not stop accessing primary care services during this transition period so that they can continue their partnership with their providers' care team and make progress on their treatment plans. Choptank is developing messaging to share with patients at check in and have members of the population health department reaching out to patients who are due to reapply for coverage.

Opportunities through non-traditional delivery models

Providing health care in a rural area requires thinking outside the traditional health-care delivery models. Community health centers thrive in this area, and Choptank is no exception.

School-Based Health Centers

Since 1999, Choptank has been providing school-based health center services. In partnership with the school systems, and health departments, Choptank provides medical and dental services in nine schools in Caroline County, five in Talbot County, three in Queen Anne's, and one in Kent County. There are 14 sites providing dental only, including four in Kent County. These centers are open every school day and provide in-person, virtual, and curbside services as well urgent care to enrolled students and school staff. Other services include health education and risk assessment, physical exams, dietary support, asthma management, and sick/acute care. School-based dental services are provided by a dental hygienist at all our schools throughout the school year. Services may include a screening, cleaning, dental sealants, fluoride treatment, and referrals when needed.

> Our school-based team in Queen Anne's County were connected with two Hispanic middle school students—aged 12 and 14, siblings—by the school guidance counselor and school nurse. The families' resources were limited—no insurance, transportation, or housing—and they had not been seen by a medical or dental provider in several years. Our medical and dental provider were able to see the students immediately and evaluate them for health and dental needs, provide education, and prescribe antibiotic for a dental abscess. The children are scheduled for appointments to establish primary medical and dental care at our Goldsboro Health Center. They have been connected to transportation services, and our population health team for assistance with connection to insurance and other needed resources.

Expansion of School-Based Health Center's Scope

To further meet the need for health care, two of the school-based health center sites are now community health centers located in a school. These centers are at Tilghman Elementary and Rock Hall Elementary. With the support of the local school systems and their understanding of community need, they agreed to partner with Choptank and open the school site to residents in the community.

Population Health and the Maryland Primary Care Program

Choptank and most other Maryland community health centers are part of the Maryland Primary Care Program (MDPCP). The program recognizes primary and preventive health investments as key to bending the cost curve and avoiding costly health-care use. The program aims to reduce avoidable hospitalization and emergency department visits and build a robust primary care delivery system to identify and respond to medical, behavioral, and social needs. Accomplishing these goals lowers the total cost of care across all provider settings.

Through the MDPCP, CMS's Center for Medicare and Medicaid Innovation provides needed funding to community health centers (and other primary care practices) corresponding to Medicare-attributed beneficiaries. The funding supports positions that would otherwise not be possible such as care navigators to ensure timely screenings, data analytics to close care gaps, and care coordinators that train and assist patients in monitoring and managing chronic conditions outside the center's walls. Choptank is new to MDPCP, having started in January 2023. Maryland community health centers that began the program in 2021 acknowledge that investments were needed to facilitate care delivery transformation, supporting patient engagement and better health outcomes. This program helps health centers follow patients beyond the time that they spend with their provider.

> A 37-year-old White male was diagnosed with diabetes in October 2022 with an A1C of 14.3. Normal range is 5.7–6.4. He had not seen a doctor in 5 years. The Choptank provider referred the patient to one of our care coordinators. She called the patient to discuss checking his blood sugar twice a day and to provide additional education. She learned that the patient had poor health-care literacy. The care coordinator provided an introductory discussion about the overall impact of food, activity, proactive self-management, and potential damage from poorly controlled diabetes. He had weekly calls with a case manager, and as of March, his A1C is down to 7.0.

The Power of Partnerships

Partnerships that focus on innovation and creativity are instrumental tools for health centers as we continually look for ways to provide access to underserved populations. Choptank is proud of the partnerships we have developed to help us meet our goals of equity outreach.

Community partners like Building African American Minds, the Multi-Cultural Resource Center, and the Avalon Foundation have provided opportunities for us to participate in festivals and events that help us meet our community where they live. Choptank's presence at these celebrations builds credibility and breaks down the trust barriers often found in these communities.

Our towns and municipalities have provided support in helping us identify and reach populations geographically challenged. This has especially been helpful for us with our recent expansion to Kent County. The local elected officials, fire departments, EMS, and even police departments have been instrumental in sharing and helping spread the word about our services expanding to the area. We are working with many of these departments to implement a grant from the Maryland Community Health Resources Commission that will help us provide quality care to our patient population with mental health and substance use treatment and unable to access care in our site. Along with our services, we will collaborate with community programs to provide access to technology (*i.e.,* tablets, computers, Internet) for telehealth services for those unable to connect to telehealth in their own residence. And a local police department is providing us with parking for our mobile health unit when it is not in service.

Local health departments and public school systems partner and collaborate with us to support our school-based health centers. With their support, we opened five new centers including four in two new counties last year. These new centers serve both students and staff and for many rural families provide the only medical and dental services they have access to. We are proud to share that Choptank was recently recognized as the Business Partner of the Year by one of the school systems we serve.

Businesses also play a role in our ability to break down the barriers of access. Just 2 weeks ago Talbot County Economic Development recognized Choptank as a 2023 Community Impact Award Winner. It is because of partnerships with local businesses that we can impact the communities we serve. While exploring ways to reach our communities, we approached Preston Motor Group to see about helping us with a mobile health unit. Through grant funding received by HRSA, and a discount from Preston, we were able to purchase a transit cargo van. Outfitted for medical and dental services, the unit allows us to meet our patients where they are. The unit travels across all the Mid-Shore communities we serve and visits community events providing health screenings. The mobile unit provides school-based medical and dental services during the school year. And, in the summer months, the unit provides a platform for Choptank's migrant program team to visit various farms, agricultural nurseries, and crab houses across the Shore. Through our continued partnership with Preston, we now have three mobile health units helping us provide increased access to our services.

> In March, our MHU traveled to Rock Hall, MD to support other community partners in providing screenings for local watermen. Many of the residents in this area do not routinely access medical care- specifically preventative and wellness services. Screenings provided included lab evaluation for diabetes, a skin screening, blood pressure, and hearing screenings. One gentleman we connected with was a 74-year-old waterman who had not seen a provider in years and had an elevated blood pressure. He stated that he didn't go to the doctor because "he didn't see the need to leave Rock Hall." Fortunately, one of the providers at the screening was the primary care provider at our newly opened Rock Hall Elementary School health center. After our provider explained that he didn't need to leave Rock Hall for care, he agreed to schedule a follow-up and has been seen for treatment.

Choptank Community Health System has community in our name for good reason—community is at the core of everything we do. When local agencies and community partners work together, the result is healthier communities.

OPPORTUNITIES TO INCREASE RURAL HEALTH ACCESS

Providing access to health care in a rural area presents obstacles; however, we are fortunate to have several available resources to make a difference in the lives

of patients, families, and the communities we serve. The following are actions needed to continue and enhance access to care in rural areas:

- Reimbursement for population health services: This will enhance the health-care system's ability to provide ongoing services outside the health center's walls to impact health outcomes.
- Make permanent reimbursement for telehealth patient care, including audio-only visits: Telehealth and audio-only visits are a lifeline for patients in rural communities. By limiting reimbursement, access to care is also limited.
- Safeguard the Prospective Payment System (PPS) to ensure access to quality health care: Health centers are good stewards of the PPS system and are able to provide services to patients that impact health equity including interpreters, community health workers, and other assistance.
- New Access Point Funding for new health centers including mobile health units: Health centers make a difference in rural and urban communities. Expanding their reach will impact America's health outcomes.
- Reauthorize Federal 330 funding: This funding serves as the foundation and backbone for health centers, and many would not be able to continue providing the level of service that they currently are without this support. This funding has not kept up with inflation and in real terms has actually declined by 9.3 percent since 2015. The result is that health centers struggle to compete with salaries being offered by larger and wealthier competitors.

CONCLUSION

Community health centers are the key to providing access to high-quality, affordable, and equitable health care. The investments made in America's health centers have made a difference in the lives of millions across the country. Community health centers, like Choptank, work to figure out how we can best meet the needs of the communities we serve and are constantly reinventing how we provide access to care so we can meet our mission.

Chairman Cardin, Ranking Member Daines, and members of the committee, thank you for the opportunity to share the obstacles impacting health care in our rural communities on the Eastern Shore of Maryland. With all of us working together, we will continue to improve health-care outcomes for those we serve.

On behalf of Choptank Community Health System, we appreciate the committee's interest and commitment to rural health care.

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QUESTIONS SUBMITTED FOR THE RECORD TO SARA K. RICH, MPA

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. Since my time as Governor of Delaware, I have been focused on making sure kids can get the care they need, where they're at—in schools. During that time, we were proud to put a wellness center in every public school. Last Congress, I in-

troduced the Kickstarting Innovative Demonstrations Support (KIDS) Health Act of 2022 with Senator Sullivan. This legislation works to improve coordination between mental health and community health care providers to better support children's needs through a "whole-child health care" model. It is clear we share an understanding on the value of school-based services. During your tenure as CEO, Choptank has increased the number of school-based health centers offering services to children in two additional counties.

How are the social determinants of health considered when implementing these programs in rural communities and what policy should Congress—in particular this committee—consider for improving access to whole-child health in rural communities across the Nation?

Answer. Maryland school-based health centers provide education and preventive care services such as vaccines, acute/sick care, and ongoing care for children with behavioral health needs and chronic conditions such as asthma and diabetes. School-based health center providers and students often develop trusting relationships critical to the child's health and wellness. School-based health centers are uniquely positioned to address social determinants of health through strong student relationships and local partnerships. For example, during the COVID–19 pandemic, the strong collaborative relationship between Choptank and school systems increased community access to testing, education, and vaccination.

The State of Maryland recently issued a recommendation that school-based health centers should be reimbursed by Medicaid at a higher rate to support school-based health-care providers and allow them to expand services further. Congress should consider policies and initiatives to increase reimbursement and support a wider range of school-based health-care services, such as behavioral health, oral health and nutrition services to improve access in rural communities.

Question. Pharmacists play an important role in ensuring access to care for patients across the country, especially in rural communities. During the COVID–19 pandemic, pharmacists were crucial access points for communities to receive COVID–19 testing and vaccinations.

Having seen how pharmacists' knowledge and skill sets were leveraged during the COVID–19 pandemic to increase access to care, how can we use lessons learned from the COVID–19 pandemic to continue this access to care for other conditions through the use of pharmacists?

Answer. The COVID–19 pandemic demonstrated the vital role of pharmacists in expanding access to care and maintaining continuity of care during a crisis. Expanding pharmacists' scope of practice will allow patients to access a broader range of services. Maryland passed a bill expanding reimbursement for pharmacists in 2023. Increased reimbursement will enable health-care providers to support and integrate more pharmacists into care teams.

Integrating pharmacists into care teams benefits health systems, regardless of practice setting, by providing medication reconciliation, education to improve medication adherence, and developing and implementing infectious disease protocols. Patients may also interact with a pharmacist before their next medical appointment, strengthening patient access and support addressing the full range of health needs for patients. Other care team providers also gain knowledge from pharmacists, further increasing patient safety and enhancing care coordination.

The PREP Act allowed pharmacists, pharmacy interns, and pharmacy technicians to administer COVID–19 and seasonal flu vaccines during the COVID–19 pandemic. This flexibility increased their workforce capacity and ability to deftly administer more vaccines. While this flexibility has been extended until December 2024, making this successful flexibility permanent will better utilize the whole pharmacy teams' skillset and meet more patients' needs. As with other health-care solutions, telehealth has proved instrumental in connecting pharmacists with socially and physically isolated patients during and after the COVID–19 pandemic. Supporting telepharmacy and digital health solutions will extend pharmacists' reach, especially in underserved areas.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. Our Nation's maternal mortality rate is too high and has increased 47 percent since 2018. At the same time, over 80 percent of pregnancy-related deaths are preventable. These challenges impact women of color and women living in rural

areas the most. There's a lot we can do but aren't. My bipartisan Healthy Moms and Babies Act would help address these maternal health challenges. It takes best practices from across the country to improve care, including care coordination, telehealth, and supporting community-led efforts. Given your experience with the National Center for Child Death Review, are most pregnancy-related deaths preventable? What actions can we take to prevent these deaths in rural America? Additionally, what actions should we take to improve the maternal mortality rate, especially among women of color and women living in rural America? Do you have a best practice you can share that is helping address these challenges?

Answer. There is a growing recognition that non-obstetric health-care professionals play a large role in reducing maternal morbidity and mortality. In 2022, the American Conference for Obstetrics and Gynecology, the American Academy of Family Physicians, and other national health-care associations announced a multidisciplinary effort to identify and manage obstetric emergencies during pregnancy and the postpartum period. As of 2022, FTCA-deemed Federally Qualified Health Centers are required to train all clinical staff that see women of reproductive age on identifying obstetrical emergencies.

In recent years, Maryland has passed several laws to address and expand access for mothers through Medicaid. The laws include free doula coverage for Medicaid beneficiaries, Medicaid coverage for undocumented women and children, and guaranteed extension of Medicaid benefits 12 months postpartum. The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine reported that the continuous presence of a doula during pregnancy is one of the most effective tools to improve labor and delivery outcomes. Further, extending postpartum Medicaid coverage is known to reduce maternal mortality for women of color and those living in rural America by extending access to affordable care.

QUESTION SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. The burden of prior authorization and disputes between providers and payers about claims and payment denials are time-consuming, expensive, and ultimately bad for patients. Can you discuss the extent that transitioning from the fee-for-service (FFS) model to value-based care could help diminish these administrative disputes?

Answer. Moving toward per-member per-month risk-adjusted payments, rather than fee-for-service, promotes appropriate, preventive, and timely care delivery. While billing for services remains essential to track usage, the threat of denials is diminished. At the center of most value-based care programs are attribution methodologies that assign patients to providers. While attribution of FQHC patients is typically straightforward, disengaged patients who need care quickly don't always understand which center they should go to. Because FQHCs turn no one away, it will be necessary for payers to work with providers to inform attribution and not deny claims related to attribution. All care delivered to a Medicaid MCO patient should be paid for in an FQHC, irrespective of unknown primary care provider assignment.

As we move towards more value-based care arrangements, there are myriad ways patients can be attributed. According to a 2023 *JAMA* article,[1] in the last 20 years, more than 170 different attribution models have been developed, with at least 30 methods implemented. Attribution accuracy varies widely between 20 percent to 69 percent accuracy. If not correctly attributed, this could place undue administrative burden on providers trying to resolve the issue and hurt overall patient care coordination efforts. Moving towards value-based care has the opportunity to increase efficiency while positively impacting patient care, but if issues with attribution are not remedied, patient care will be impacted.

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[1] *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2802660#:~:text=Patient%20attribution%20methods%20are%20used,%2C%20track%2C%20and%20improve%20care.*

COMMUNICATIONS

ALLIANCE FOR RURAL HOSPITAL ACCESS
The McDermott Building
500 North Capital Street, NW
Washington, DC 20001
https://ruralhospitalaccess.org/

U.S. Senate
Committee on Finance
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

The Alliance for Rural Hospital Access (ARHA, or the Alliance) appreciates the opportunity to submit this statement for the record on the "Improving Health Care Access in Rural Communities: Obstacles and Opportunities" hearing held by the Health Care Subcommittee on May 17, 2023.

The Alliance is comprised of hospitals designated as Medicare-Dependent Hospitals (MDHs), Rural Referral Centers (RRCs) and Sole Community Hospitals (SCHs) under the Medicare program. MDHs, RRCs and SCHs provide rural populations with local access to a wide range of health care services. In doing so, MDHs, RRCs and SCHs 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.

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.

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.

Challenges Facing MDHs, RRCs, and SCHs

MDHs, RRCs, and SCHs are often the sole source of care within and around a community. Many patients that 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, RRC, or SCH closes, the consequences for the community may be more grave than otherwise.

Over 100 rural hospitals closed from January 2013–February 2020. When rural hospitals close, people living in areas that receive care from them must travel farther to get the same services—about 20 miles farther for common services like inpatient care. People have to travel even farther—about 40 miles—for less common services like alcohol or drug abuse treatment.[1] According to 2023 data from the Center for Healthcare Quality and 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.[2]

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.

In addition to negatively affecting patient care, the deteriorating rural health safety net also impacts the local economies that often depend on these hospitals as large employers in the communities they serve.[3]

These financial challenges were compounded over the past several years during the COVID–19 pandemic, which placed an additional strain on the resources and capacities of rural hospital that were already operating on thin—often negative—margins and serving particularly vulnerable patient populations.

Recommendations for Congressional Action

Congress and the Centers for Medicare and Medicaid Services (CMS) have reconfirmed their commitment to these hospitals repeatedly over the years by providing new protections to ensure their viability and to ensure patient access to hospital services in rural communities. ARHA and its members share this goal of ensuring that federal hospital payment policies recognize the unique role and important contributions these hospitals bring to the Medicare program and its beneficiaries. Consistent with this mission, the Alliance appreciates the opportunity to provide these comments to the Committee, as you continue to examine opportunities to improve access to health care in rural communities.

The Alliance requests that the Finance Committee consider and advance legislation to:

- Permanently extend the MDH program and low-volume hospital payment adjustment.
- Provide for updated 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 IME adjustments to encourage these hospitals to localize resident training in rural areas.

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[1] Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services. January 2021. *https://www.gao.gov/products/gao-21-93.*

[2] Rural Hospitals at Risk of Closing. *https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.*

[3] Rural hospitals: The beating heart of a local economy. June 2018. *https://www.ruralhealth.us/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ.*

- Reimburse rural hospitals equitably for uncompensated care by ensuring SCHs and MDHs paid on the basis of their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation.
- 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 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 by Enacting S. 1110

Finance Committee Members Robert Casey (D–PA) and Chuck Grassley (R–IA) reintroduced the Rural Hospital Support Act (S. 1110) in late-March. This bipartisan bill would permanently extend the MDH program and the low-volume adjustment—support mechanisms created by Congress decades ago that have traditionally been reauthorized together for limited periods.

The current authorization runs through September 30, 2024, requiring Congress to enact another extension before the final quarter 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 financially 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.

Enacting S. 1110 well in advance of the September 30, 2024, deadline would provide vulnerable hospitals with more predictable Medicare reimbursements and greater financial stability, and we urge the Finance Committee to take up the bill at its earliest convenience.

Provide for Updated Base Years for SCHs and MDHs by Enacting S. 1110

The Rural Hospital Support Act (S. 1110) contains two 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 help modernize this reimbursement methodology by adding 2016—a more recent and contemporary year—as an available base year from which SCHs and MDHs could derive a hospital-specific rate.

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 an SCH or MDH did not have a teaching program prior to the year that it uses to set its hospital-specific rate, the indirect costs of providing residency training are not reflected in that rate. If these hospitals establish a new teaching program, they will receive no extra money if the hospital-specific rate continues to exceed the federal rate. Even if a hospital had a teaching program in a base year, it faces similar disincentives to increase the number of residents trained in the program. Most rural hospitals lack the financial resources to establish a teaching program without some measure of additional financial support.

If a hospital paid on the basis of the *federal rate* initiates a teaching program, both Direct Medical Education (DME) and Indirect Medical Education (IME) payments

to that hospital increase for each resident the hospital trains. 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. The hospital-specific rate 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.

The Alliance encourages the Finance Committee to include such a provision in any 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 disproportionate share hospital (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. The Alliance urges the Finance Committee to consider this inequity when crafting legislation to protect and sustain access to care in rural America.

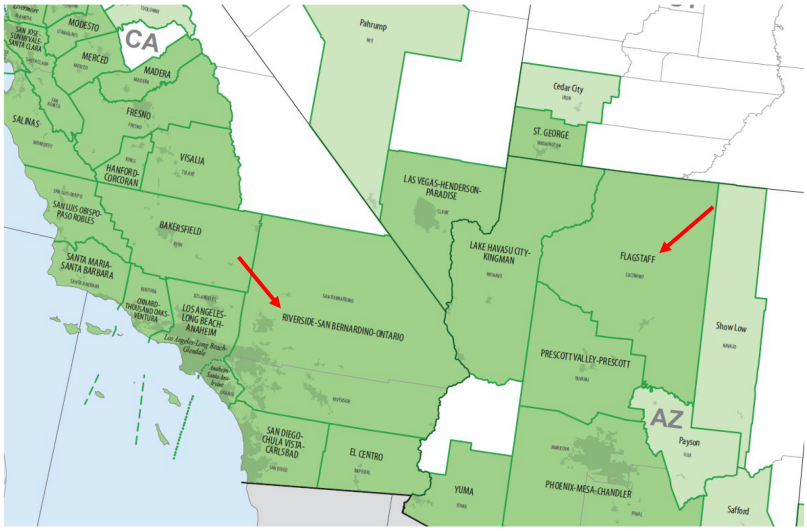
Direct CMS to Extend Rural SCH Site-Neutral Exemptions to Urban SCHs and MDHs

Under the Medicare outpatient prospective payment system (OPPS), CMS pays a "PFS-equivalent" rate of 40% 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, TX 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, US Government Accountability Office (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 commu-

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[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: August 29, 2018). *https://www.gao.gov/products/gao-18-634.*

nities. 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% of rural SCHs, 73% of urban SCHs, and 60% 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 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 Congress 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%. 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. In the 2023 OPPS rule, CMS proposed and finalized a provision to continue this payment adjustment for rural SCHs.

For the reasons set forth in the previous section, the Alliance 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 did not make 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.

We have repeatedly pressed CMS to extend this same adjustment to urban SCHs and MDHs, and CMS has repeatedly said Congress did not direct that. Congress should clarify its intent with respect to these adjustments.

Protect SCHs and MDHs from Site-Neutral Payment Reductions

As noted throughout, SCHs and MDHs are in dire financial straits. More cuts will force further closures. We concur that payment policies could be refined to better align payment incentives and protect beneficiaries, but we also encourage Congress

[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.*

[8] § 411(b), Pub. L. No. 108–173.

to balance beneficiary financial protection with beneficiary access to care. Payment policy changes that cause beneficiaries to lose access to hospital services will not serve beneficiary or taxpayer interests. Congress could exempt certain rural hospitals from cuts, create stop loss provisions, or at the very least delay or phase in changes for select rural providers.

Thank you for your consideration of these comments. The Alliance 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 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

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, Health Subcommittee hearing on "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." The Association and AIM thank the Subcommittee for its continued leadership on issues important to the millions of people living with Alzheimer's and other dementia and their caregivers.

We encourage the Committee to consider the below recommendations to improve care for the growing number of families affected by Alzheimer's, particularly those in rural areas given the unique challenges faced in these communities. This statement highlights the urgency of addressing a harmful decision made by the Centers for Medicare and Medicaid Services (CMS) that continues to block access to Food and Drug Administration (FDA)-approved Alzheimer's therapies, particularly for individuals living in rural areas. Specifically, the CMS National Coverage Determination (NCD) on "Monoclonal Antibodies Directed Against Amyloid (mAbs) for the Treatment of Alzheimer's Disease" is imposing severe restrictions on access to the first class of treatments to change the course of Alzheimer's disease. We also encourage the Subcommittee to expand rural access to a quality trained workforce through the expansion of Project ECHO models.

Alzheimer's Nationwide Impact

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research; to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

An estimated 6.7 million Americans age 65 and older are currently living with Alzheimer's dementia. In 2023, Alzheimer's and other dementia will cost the nation $345 billion—not including the value of unpaid caregiving. Medicare and Medicaid are expected to cover $222 billion—or 64 percent—of those costs while out-of-pocket spending is expected to be $87 billion. Total payments for health care, long-term care, and hospice care for people living with dementia are projected to increase to nearly $1 trillion in 2050. These mounting costs threaten to bankrupt families, businesses, and our health care system. Unfortunately, our work is only growing more urgent.

Access to Innovation and Breakthrough Treatments

Alzheimer's is one of the most significant health issues facing Medicare beneficiaries and their families, and now, for the first time, treatments have been approved by the FDA that change the course of the disease. Aducanumab (marketed as Aduhelm) received FDA accelerated approval on June 7, 2021, and lecanemab (marketed as Leqembi) received FDA accelerated approval on January 6, 2023. As with the first drugs in any class, additional therapies build upon initial breakthroughs to deliver more efficacious treatments. Lecanemab is proven to slow cognitive and functional decline over 18 months and significantly positively affects biological markers of Alz-

heimer's disease. In a study of 1,800 individuals in the early stages of Alzheimer's, lecanemab reduced the rate of cognitive decline by 27 percent. On well-established measures to assess the quality of life for dementia patients and caregivers, it slowed the decline by half. The peer-reviewed, published results show lecanemab will provide patients with more time to participate in daily life and live independently. This will mean patients have more months of recognizing their spouse, children, and grandchildren. This will also mean more time for people to drive safely, accurately, and promptly take care of family finances, and participate fully in hobbies and interests.

Adding to the strength of evidence around mAbs, on May 3, 2023, positive top-line results of the Phase 3 trial of donanemab were released and marked the strongest such results reported to date. The results showed donanemab met all of its primary and secondary endpoints, and slowed clinical decline by 35 percent compared to placebo on the primary outcome measure. According to the pharmaceutical company, we anticipate the FDA issuing a traditional approval decision on donanemab as soon as the end of the year. Additional clinical trials are underway and offer the hope of additional treatments.

This is just the beginning of meaningful treatment advances. History has shown that approvals of the first drugs in a new category invigorate the field, increase investments in new treatments, and encourage greater innovation. The progress we have seen in this class of treatments and in the diversification of treatment types and targets over the past few years provides hope to those impacted by this devastating disease.

While these breakthroughs are exciting and offer hope to those with Alzheimer's disease and their families, without Medicare coverage of this class of treatments, access for those who could benefit from these newly-approved treatments will only be available to those who can afford to pay out-of-pocket and find a health system willing to administer them. Without coverage, people, particularly those living in rural areas, simply are not able to access treatments.

Unfortunately, in 2022, CMS implemented an unprecedented and restrictive NCD that not only applies to the two currently approved FDA-approved Alzheimer's therapies but also applies to all future treatments in the same class. Using coverage with evidence development (CED) requirements, CMS will only cover mAbs treating Alzheimer's approved through the accelerated approval pathway for individuals enrolled in randomized clinical trials, and treatments approved through the traditional approval pathway when patients are enrolled in "prospective comparative studies." This decision creates an immediate barrier to care for older Americans, especially those living in rural and underserved areas as these unprecedented required studies will not exist in these areas. Unless CMS immediately reconsiders the NCD, access to these treatments for Alzheimer's will continue to be extremely limited, and for some in rural and underserved areas nonexistent, by the agency's CED requirements even after traditional approval by the FDA.

Americans living with Alzheimer's disease are entitled to FDA-approved therapies, just as are people with conditions like cancer, heart disease, and HIV/AIDS. And, they deserve the opportunity to assess if an FDA-approved treatment is right for them.

The Veterans Health Administration (VHA) now offers lecanemab for U.S. veterans. Medicare beneficiaries with early Alzheimer's deserve this same access, not delays. Treatments taken in the early stages of Alzheimer's would allow people more time to participate in daily life, remain independent and make health care decisions for their future.

CMS has stated that it is not covering FDA-approved anti-amyloid treatments for Alzheimer's because it has a different standard than FDA. The CMS standard is defined in statute as "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Using that statutory definition, CMS has decided these treatments are unreasonable and unnecessary for the Medicare population, even though the treatments have been definitively shown to slow the progression of the disease and improve the quality of life for patients and their caregivers. This is unprecedented. CMS has never before determined an FDA-approved drug to not be reasonable and necessary.

This decision sets a dangerous precedent that could stifle innovation for Americans who have no other options. If CMS continues to treat the accelerated approval pathway differently, it will not just be people living with MCI and early-stage Alzheimer's who are unable to access treatments that change the course of the disease,

it will ripple down to rare diseases, cancer, and others. If Medicare will not cover new treatments under accelerated approval, it discourages the research industry from pursuing crucial treatments for populations with unmet needs. This delay could mean fewer therapies on a slower timeline when days, weeks, and months matter. The dangerous precedent will widen the already existing care gaps in rural and underserved communities across all diseases.

These new FDA-approved treatments taken in the early stages of Alzheimer's could mean a better quality of life. They allow people more time to participate in daily life, remain independent and make future health care decisions. These benefits will only be realized if patients have access to the treatments. Any barrier—whether cost, coverage, logistics, or knowledge—to accessing FDA-approved treatments is unacceptable and is not patient-focused.

Expanding Capacity for Health Outcomes (Project ECHO)

Communities across America are facing severe health care workforce shortages. While the shortage of geriatricians and other specialists extends nationwide, it appears to be most acute in rural settings. It is crucial that legitimate steps are taken to equip providers in these areas with the tools and resources needed to provide quality care to individuals living with Alzheimer's.

We ask that you support an expansion of the use of technology-enabled collaborative learning and capacity-building models, often referred to as Project ECHO. These education models can improve the capacity of providers, especially those in rural and underserved areas, on how to best meet the needs of all patients, including people living with Alzheimer's. In 2018, the Alzheimer's Association launched an Alzheimer's and Dementia Care Project ECHO Network—a highly successful telementoring program that has trained more than 330 health care professionals from 116 primary care practices and more than 250 professional care providers from 91 long-term care communities in a free continuing education series of interactive, case-based video conferencing sessions across the United States.

Project ECHO dementia models are helping primary care physicians in real-time, throughout the country, understand how to use validated assessment tools appropriate for early and accurate diagnoses, educate families about the diagnosis and home management strategies, and help caregivers understand the behavioral changes associated with Alzheimer's. Participants express high levels of satisfaction with the program and the majority (95%) of primary care clinicians who join the Alzheimer's and Dementia Care ECHO program said the quality of care they provide improved as a result of their experience. Long-term and community-based care providers also benefit from Project ECHO dementia programs. Recent evaluations demonstrate statistically meaningful increases in confidence in working with people living with dementia and overall disease knowledge post-ECHO completion and 92 percent of long-term care participants felt that the information gained through participation was valuable in their work.

In 2020, the Alzheimer's Association launched the Alzheimer's and Dementia Care ECHO Global Collaborative. One partner in this collaborative is the Dementia ECHO Indian Country Program, designed to support clinicians at the Indian Health Service and caregivers that provide care to dementia tribal patients. These teleECHO programs are interactive online learning environments where clinicians and staff serving American Indian and Alaska Native patients connect with peers, engage in didactic presentations, collaborate on case consultations, and receive mentorship from clinical experts from across Indian Country. As a result, these ECHO programs enable primary care providers to better understand Alzheimer's and other forms of dementia and emphasize high-quality, person-centered care in community-based settings and aim to improve health outcomes while reducing geographic barriers and the cost of care through a team-based approach.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Subcommittee and its continued commitment to issues important to the millions of families affected by Alzheimer's and other dementia. As the Subcommittee looks to remove obstacles for people living in rural areas, we stress the urgency of CMS immediately opening an NCD reconsideration to remove the CED requirements for FDA-approved mAbs. We also look forward to working with the Subcommittee in a bipartisan way on opportunities to expand access to quality care for those living in rural areas through increased use of Project ECHO models.

AMERICAN ACADEMY OF FAMILY PHYSICIANS
1133 Connecticut Avenue, NW, Suite 1100
Washington, DC 20023–1011
202–232–9033
Fax: 202–232–9044
https://www.aafp.org/

Dear Chairman Cardin and Ranking Member Daines:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to applaud the Subcommittee for its focus on rural health care with its May 17th hearing titled "Improving Health Care Access in Rural Communities: Obstacles and Opportunities."

Individuals living in rural areas face significant barriers and challenges to accessing high-quality, comprehensive health care. Rural hospitals have closed at an alarming rate over the last ten 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.[1]

The AAFP has long advocated to improve access to high-quality care in rural communities *(https://www.aafp.org/about/policies/all/rural-practice-keeping-physicians.html)*. Seventeen percent of our members practice in rural areas, the highest percentage of any medical specialty. Family physicians are uniquely trained to provide a broad scope of health care services to patients across the life span. 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.

Physician Payment Reform

Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates and the continuing consolidation of insurers and large health systems threatens their long-term viability, especially in rural communities. Evidence indicates that consolidation increases health care prices and insurance premiums, as well as worsens equitable access to care for patients in rural and other medically underserved communities.[2, 3]

Medicare's current physician payment system is undermining physicians' ability to provide high quality, comprehensive care—particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. In October, the AAFP submitted robust recommendations to Congress on ways to reform the Medicare Access and CHIP Reauthorization Act (MACRA) to address challenges affecting our members and their patients *(https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-Congress-MACRA-RFI-102822.pdf)*. Since then, both Medicare Payment Advisory Commission and the Board of Trustees have raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending that Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[4]

Congress should heed these warnings. **The AAFP strongly urges Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to provide for an annual update to the Medicare Physician Fee based on**

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[1] Federal Communications Commission, "2019 Broadband Deployment Report," May 2019. Available at: *https://www.fcc.gov/reports-research/reports/broadbandprogress-reports.*

[2] Yerramilli, P., May, F.P., Kerry, V.B. Reducing Health Disparities Requires Financing People-Centered Primary Care. JAMA Health Forum. 2021;2(2):e201573. Available at: *https://jamanetwork.com/journals/jama-healthforum/articleabstract/2776056.*

[3] O'Hanlon, C.E., et al. Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation. December 2019. Health Affairs. Available at: *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00918.*

[4] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed April 6, 2023: *https://www.cms.gov/oact/tr/2023.*

the Medicare Economic Index (MEI). This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

In addition to already being insufficient, Medicare payments to physicians are generally less in rural areas than in suburban and urban areas, as reflected in the geographic adjustment factors associated with the Medicare Physician Fee Schedule (MPFS). This current structure of low payment can prevent physicians from being able to feasibly accept as many patients as urban and suburban physicians, further disadvantaging individuals living in rural areas and consequently reducing their access to primary care services. For this reason, **the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal** (*e.g.,* to encourage physicians to practice in underserved areas) *(https://www.aafp.org/about/policies/all/medicare-payment.html).*

Medicaid also plays an invaluable role in connecting many rural individuals to health care coverage. In 2018, nearly 25 percent of rural residents under 65 were on Medicaid and more were dually-enrolled in Medicare and Medicaid.[5] However, lack of parity between Medicaid and Medicare payment rates disproportionately impacts access for rural, low-income, disabled, and elderly Medicaid enrollees, as Medicaid payments fall below the actual cost of delivering care in those areas. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[6] This reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Strengthen and Target Graduate Medical Education Programs

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.[7] 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 eight percent of subspecialists practice in these areas.

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 Teaching Health Center GME (THCGME) program has trained more than 1,730 primary care physicians and dentists, 63 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 versus 23 percent) and remain in underserved (55 percent versus 26 percent) or rural (20 percent versus 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.

The THCGME program's authorization expires in FY 2024, and we strongly caution against a short-term extension since it does not provide the needed stability for current and future residents. In fact, flat funding of the program would mean a 40–50 percent reduction in per resident allocation for THC programs, putting them at risk of closure. **Congress should permanently authorize and expand the THCGME program by passing the Doctors of Community Act (H.R. 2569).**

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 *(https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/gme/*

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[5] Medicaid and CHIP Payment and Access Commission, "Medicaid and Rural Health Issue Brief." April 2021. Accessed online: *https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf.*

[6] Zuckerman, S., Skopec, L., and Aarons, J. (2021, February 1). Medicaid physician fees remained substantially below fees paid by Medicare in 2019. Retrieved February 9, 2023, from *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611.*

[7] Fagan, B.E., Finnegan, S.C., Bazemore. A.W., Gibbons, C.B., Petterson, S.M. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training—Graham Center Policy One-Pagers—American Family Physician.

LT-Congress-RuralWorkforceProductionAct-021423.pdf). 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 as the largest single payer—spends about $16 billion annually on GME—but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[8] 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.

Federal Programs to Support Physicians in Rural Areas

International Medical Graduates (IMGs) have a significant impact on addressing health care clinician shortages and improving access to care in rural communities. The Conrad 30 Waiver Program has brought more than 15,000 foreign physicians to underserved and rural communities. The program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients at a time when pervasive workforce shortages continue to restrict patients' access to necessary care. **We urge Congress to pass the Conrad State 30 and Physician Access Act (S. 665) to provide immigration certainty to the thousands of international medical graduates caring for patients in underserved communities** *(https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/gme/LT-Senate-IMGandConrad30-092822.pdf)*.

The National Health Service Corps (NHSC) also plays a vital role in addressing the challenge of regional health disparities arising from physician workforce shortages by offering financial assistance to meet the workforce needs of communities designated as health professional shortage areas. **We urge the reintroduction and passage of the Strengthening America's Health Care Readiness Act,** which increases investment in the National Health Service Corps and allocates 40 percent of the funding for racial and ethnic minorities and students from low-income urban and rural areas *(https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/debt/LT-Senate-SupportingStrengtheningAmericasHealthCareReadinessAct-012821.pdf)*.

Strengthen and Sustain the Health Care Safety Net

Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Family physicians are the most common type of clinician (46 percent) practicing in CHCs, and thus are well-positioned to ensuring accessible and affordable primary care and reducing racial, ethnic, and income-based health disparities.[9] CHCs also play an important role in training family physicians, and research shows that CHC-trained family physicians are more than twice as likely to work in underserved settings than their non-CHC-trained counterparts.[10] **The AAFP urges Congress to increase investment in CHCs,** including a long-term authorization for CHCs, to meet the health workforce needs of the underserved and to increase access to comprehensive primary care in rural communities.

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[8] 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.

[9] National Association of Community Health Centers, "Community Health Center Chartbook 2022." Accessed online: *https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf.*

[10] Morris, C.G., Johnson, B., Kim, S., Chen, F. Training family physicians in community health centers: A health workforce solution. Fam Med. 2008;40(4):271–276.

Telehealth

Permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs. As acknowledged earlier, the lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits.[11, 12, 13] One recent study of FQHCs found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[14]

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Congress should implement policies that strengthen patients' relationships with their primary care physician, and physicians should not be paid less for providing patient-centered care. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

The AAFP strongly urges Congress to pass the Protecting Rural Telehealth Access Act (S. 1636/H.R. 3440), which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services *(https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-Senate-ProtectingRuralTelehealthAccessAct-042522.pdf).* The available data clearly indicates that coverage of and fair payment for audio-only services is essential to facilitating equitable access to care after the PHE-related telehealth flexibilities expire.

This legislation would also permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home, which the AAFP has advocated to Congress in favor of previously. The COVID–19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

Finally, the Protecting Rural Telehealth Access Act would permanently allow RHCs and FQHCs to serve as distant site for telehealth services. As noted above, FQHCs and RHCs are essential sources of primary care for patients in underserved communities, including low-income individuals and those living in rural areas. During the pandemic, FQHCs and RHCs have made significant investments to integrate telehealth into their practices and ensure equitable access to telehealth services for their patient populations. Passing this bill would ensure these facilities can continue to provide telehealth services, improve equitable access to health care for historically underserved patients, and preserve care continuity with their primary care physicians.

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[11] Kelly A. Hirko, Jean M. Kerver, Sabrina Ford, Chelsea Szafranski, John Beckett, Chris Kitchen, Andrea L. Wendling. Telehealth in response to the COVID–19 pandemic: Implications for rural health disparities, Journal of the American Medical Informatics Association, Volume 27, Issue 11, November 2020, Pages 1816–1818, *https://doi.org/10.1093/jamia/ocaa156.*

[12] Congressional Research Service, "Broadband Loan and Grant Programs in the USDA's Rural Utilities Service." March 22, 2019. Accessed online: *https://sgp.fas.org/crs/misc/RL33816.pdf.*

[13] "Ensuring The Growth of Telehealth During COVID–19 Does Not Exacerbate Disparities in Care," Health Affairs Blog, May 8, 2020. DOI: 10.1377/hblog20200505.591306.

[14] Uscher-Pines, L., McCullough, C.M., Sousa, J.L., et al. Changes in In-Person, Audio-Only, and Video Visits in California's Federally Qualified Health Centers, 2019–2022. JAMA. 2023;329(14):1219–1221. doi:10.1001/jama.2023.1307.

Access to Mental and Behavioral Health

The AAFP has continuously advocated for and supported legislative proposals to permanently remove CMS' in-person requirement for tele-mental and behavioral health visits *(https://www.aafp.org/content/dam/AAFP/documents/advocacy/health_it/telehealth/LT-Congress-CONNECTforHealthAct-013023.pdf)*. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[15, 16] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients, which are even more pronounced in rural areas. Arbitrarily requiring an in-person visit prior to coverage of tele-mental health services will unnecessarily restrict access to behavioral health care. Removing the in-person requirement would improve equitable access to care for low-income patients and those in rural communities. We note that our position on in-person visit requirements is unique to tele-mental health services.

Additionally, to improve access to integrated tele-mental and behavioral health care in primary care settings, **the AAFP encourages Congress to establish a new program for adults that mirrors the Pediatric Mental Health Care Access Program (PMHCA) at the Health Resources and Services Administration (HRSA).** This program, which was most recently reauthorized in 2022, promotes behavioral health integration into pediatric primary care by using telehealth.

PMHCA has helped address increased mental and behavioral health needs in light of ongoing workforce shortages by meeting children and adolescents where they are. In Fiscal Year 2020, approximately 3,000 children and adolescents in 21 states were served by pediatric primary care providers who contacted the pediatric mental health team. Two out of every three of these patients lived in rural and underserved counties.[17]

Family physicians frequently share concerns and frustration that when they refer their patients for mental or behavioral health care, their patients are not always able to find a clinician in-network or one accepting new patients. As a result, family physicians see patients with exacerbated behavioral health symptoms and are sometimes forced to send them to the emergency department when there are no other acute care options. Given the well-documented shortage of mental and behavioral health clinicians and the growing demand for specialized care, a HRSA-funded program that provides primary care clinicians with virtual access to specialists could increase timely access to care for adult patients, particularly in rural areas.

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with you to advance policies that improve access to health care for our nation's rural communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., M.D., FAAFP
Board Chair

Founded in 1947, the AAFP represents 129,600 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, *www.familydoctor.org*.

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[15] Pew Trust (December 14, 2021). State Policy Changes Could Increase Access to Opioid Treatment via Telehealth. The Pew Charitable Trusts. *https://www.pewtrusts.org/en/research-andanalysis/issuebriefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth.*

[16] SY, L.-T., J, E., D, C., and PY, C. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. Psychiatric Services (Washington, DC), 69(6), 628–647. *https://doi.org/10.1176/APPI.PS.201700382.*

[17] Health Resources and Services Administration, "Pediatric Mental Health Care Access Program." Available at: *https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access.*

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE
7700 Old Georgetown Rd., Suite 250
Bethesda, MD 20814
(301) 968–4100
www.aacom.org

Statement of David Bergman, J.D., Vice President of Government Relations

Chairman Cardin, Ranking Member Daines, and esteemed Committee members, as you examine opportunities to improve access to healthcare in rural communities, the American Association of Colleges of Osteopathic Medicine (AACOM) believes that the physicians trained at our nation's colleges of osteopathic medicine (COMs) are an important part of the solution. We commend you for holding today's hearing and appreciate you permitting AACOM to offer this written testimony for the record. AACOM stands ready to work with you and your Senate colleagues to advance policies and programs that will help ensure our nation has the healthcare workforce we need for the patients of today and tomorrow.

About AACOM and Osteopathic Medicine

AACOM is the leading advocate for the full continuum of osteopathic medical education (OME) to improve public health. Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents 40 accredited COMs—educating more than 35,000 future physicians, 25% of all U.S. medical students—at 64 teaching locations in 35 states, as well as osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics and health systems.

Osteopathic medicine encompasses all aspects of modern medicine, including prescription drugs, surgery and the use of technology to diagnose and treat disease and injury. Osteopathic medicine also confers the added benefit of hands-on diagnosis and treatment of conditions through a system known as osteopathic manipulative medicine. Doctors of Osteopathic Medicine (DOs) are trained in medical school to take a holistic approach when treating patients, focusing on the integrated nature of the various organ systems and the body's incredible capacity for self-healing. DOs are licensed in all 50 states to practice medicine, perform surgery and prescribe medications. The osteopathic medical tradition holds that a strong foundation as a generalist makes one a better physician, regardless of one's ultimate practice specialty—which is the reason why more than half of DOs currently practice in primary care.[1] In excess of 7,300 DOs were added to the U.S. physician workforce in 2022, adding to the 141,000 DOs already in practice.[2]

Osteopathic Physicians Play a Significant Role in Addressing Workforce Shortages and Expanding Access to Care

According to the Bureau of Health Professions, osteopathic medicine is the fastest growing medical field in the United States. Over the past decade in the U.S., the total number of DOs and osteopathic medical students has grown more than 81%.[3] Moreover, greater than 25% of U.S. medical students are enrolled in colleges of osteopathic medicine (COMs)—a proportion that is expected to grow to 30% by 2030.[4]

Osteopathic physicians comprise one of the youngest segments of the healthcare workforce. More than 82,000 actively practicing DOs are under the age of 45, and 35% of DOs are under the age of 35.[5] The medical field continues to face devastating impacts left by the COVID–19 pandemic. The level of stress and burnout during the pandemic caused several physicians to retire early, take temporary leave, or permanently leave the practice of medicine. The field of osteopathic medicine is working to address the gaps in the physician workforce created by the pandemic. Osteopathic medicine is building a young, dynamic and resilient workforce that is helping to meet health system challenges.

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[1] National Resident Matching Program, 2021 Main Residency Match, available at *https://www.nrmp.org/wp-content/uploads/2021/08/Advance-Data-Tables-2021_Final.pdf.*

[2] American Osteopathic Association, 2022 report tracks increased growth in the osteopathic profession, available at *https://osteopathic.org/about/aoa-statistics/*.

[3] American Osteopathic Association, OMP Report, available at *https://osteopathic.org/about/aoa-statistics/*.

[4] American Association of Colleges of Osteopathic Medicine, *https://www.aacom.org/become-a-doctor/about-osteopathic-medicine/quick-facts#:~:text=Today%2C%20more%20than%2025%20percent,training%20to%20be%20osteopathic%20physicians.*

[5] American Osteopathic Association, OMP Report, available at *https://osteopathic.org/about/aoa-statistics/*.

While workforce shortages persist across the nation, some areas are impacted more heavily than others. This is especially true for rural and underserved communities. For individuals living in rural areas of the United States, staff shortages do not just lead to longer wait times for appointments, but can also lead to hospital and clinic closures, eliminating access to the only accessible healthcare providers. Rural residents often must wait hours for ambulances or travel hundreds of miles just to see a doctor. These long wait times can be the difference between life and death, where serious health conditions are exacerbated.

Rural areas often lack access to quality health care. Of the roughly 2,000 U.S. counties classified as rural, more than 170 lacked an in-county critical access hospital, federally qualified health center, or rural health clinic—facilities collectively referred to as safety-net providers.[6] Twenty percent (20%) of our country's population resides in rural areas, and they tend to have worse health outcomes than their urban or suburban counterparts.[7]

Additionally, rural communities are routinely situated in remote areas with little to no economic infrastructure, making it difficult to attract and retain medical talent.[8] These vulnerable communities have a dire need for healthcare providers, yet only 11% of physicians choose to practice in rural areas.[9] Often times, even where rural facilities exist, they are frequently understaffed and experience burden from workforce shortages. In fact, according to the Health Resources and Services Administration (HRSA), in March 2023 almost 70% of areas designated as primary medical health professional shortage areas were considered rural or partially rural.[10]

The physicians who do practice in rural areas tend to be older, work longer hours, see a greater number of patients and perform a greater variety of procedures than their counterparts who practice in urban settings.[11] This strain on rural physicians increases the likelihood they will experience provider burnout and abandon the practice of medicine. Of note, from 2000 to 2017, the number of physicians under age 50 living in rural areas decreased by 25%. By 2017, more than half of rural physicians were at least 50 years old, and more than a quarter were at least 60.[12] This highlights the need to recruit more younger physicians into the rural workforce.

Serving rural and underserved populations is a priority for AACOM and our member schools. While large academic medical centers represent only five percent of all hospitals in the U.S.[13] and only 20% of all hospital admissions, surgical operations and outpatient visits, community-based hospitals and facilities provide the overwhelming majority of healthcare.[14] That is why AACOM and its member institutions promote training in diverse healthcare settings, such as community hospitals and health centers located in rural parts of the country.

Sixty percent (60%) of osteopathic medical schools are located in a federally designated Health Professional Shortage Area (HPSA), and 64% require clinical rotations in rural and underserved communities. Moreover, 88% of COMs have a stated public commitment to rural health. Research shows that

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[6] Kaufman, B.G., et al., The Rising Rate of Rural Hospital Closures. *J Rural Health,* 2016. 32(1): p. 35–43.

[7] American Hospital Association, Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care, available at *https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.*

[8] National Rural Health Association Policy Brief, Health Care Workforce Distribution and Shortage Issues in Rural America, available at *https://www.ruralhealth.us/getattachment/Advocate/Policy-Documents/HealthCareWorkforceDistributionandShortageJanuary2012.pdf.aspx?lang=en-US.*

[9] The Association of American Medical Colleges, Attracting the next generation of physicians to rural medicine, available at *https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.*

[10] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services Second Quarter of Fiscal Year 2023 Designated HPSA Quarterly Summary, *https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.*

[11] National Rural Health Association Policy Brief, Health Care Workforce Distribution and Shortage Issues in Rural America, available at *https://www.ruralhealth.us/getattachment/Advocate/Policy-Documents/HealthCareWorkforceDistributionandShortageJanuary2012.pdf.aspx?lang=en-US.*

[12] Skinner, Lucy, et al. "Implications of an aging rural physician workforce." *N Engl J Med* 381.4 (2019): 299–301.

[13] Association of American Medical Colleges, Letter to Senators Patty Murray and Richard Burr, June 30, 2021, available at *https://www.aamc.org/media/55191/download?attachment.*

[14] Burke, L.G., Frakt, A.B., Khullar, D., Orav, E.J., Jha, A.K. Association Between Teaching Status and Mortality in U.S. Hospitals. *JAMA.* 2017;317(20):2105–2113. doi:10.1001/jama.2017.5702.

the location of medical education and residency training impacts practice location, so the osteopathic rural training model leads to more physicians in these underserved areas.

Training medical students in rural communities has been shown to mitigate chronic and acute shortages in these areas. **Nearly half of graduating 2020–2021 osteopathic medical students plan to practice in a medically underserved or health shortage area; of those, 49% plan to practice in a rural community.**[15] **Significantly, more than 73% of DOs practice in the state where they do their residency training, and that percentage increases to 86% when they attend both medical school and have their residency in the state.**

Moreover, most medical students graduating with a DO degree are opting to practice primary care. In 2023, 55.9% of senior DO medical students in the U.S. went into primary care, compared to only 36.2% of MD seniors.[16] Nationwide, 57% of DOs practice in primary care, including family medicine, internal medicine and pediatrics.[17] DOs have increased access to many underserved populations by providing primary care to rural populations.

AACOM Policy Recommendations

Osteopathic medicine has a blueprint for success in combatting the physician workforce shortages that plague our country's healthcare system. We respectfully offer several recommendations for the 118th Congress to ensure an adequate healthcare workforce for the nation:

- **Increase the funding for and number of graduate medical education (GME) positions, prioritizing development in rural and underserved areas.** GME is the pathway for DOs and MDs to gain experience and hone their clinical skills. Current federal funding levels for GME are insufficient in addressing the shortages faced by hospitals, doctors' offices and clinics throughout the nation, especially in rural communities. Congress needs to boost the number of residency positions and modify policies to allow GME funding to flow to rural and underserved areas. Doing so allows for these areas to have more access to the care they need.
- **Implement policies that leverage all available physicians by ensuring that DOs and MDs have equal access to federally-funded GME programs.** At least 32% of residency program directors never or seldom interview DO candidates, and of those that do, at least 56% require them to take the USMLE (the MD licensing exam), in addition to the osteopathic medical exam, COMLEX–USA.[18] The demands of medical school are arduous, and osteopathic medical students should not be subjected to the 33 hours and $2,235 (as well as prep costs and time) that are required to take the USMLE. Moreover, these burdensome and unnecessary practices thwart the development of osteopathic physicians, which in turn contribute to the nation's doctor shortage, especially in rural and underserved areas. **AACOM recommends that Congress pass the bipartisan Fair Access In Residency Act (H.R. 751) to ensure that all federally funded GME programs are open to DOs and equally accept the COMLEX–USA and USMLE, if an examination is required for acceptance.**
- **Provide permanent funding for the Teaching Health Center Graduate Medical Education (THCGME) Program.** This vital program trains students in outpatient settings, such as Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and tribal health centers. THCGME Program training sites prioritize care for high-need communities and vulnerable populations, with more than half located in medically underserved communities. The program is important to the osteopathic community: In 2021, there were 460 DO residents training in a THC—60% of all THCGME residents. Due to their reliance on variable annual discretionary funding, THCs face operational and planning struggles, which frustrate the growth and development of new and existing pro-

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[15] American Association of Colleges of Osteopathic Medicine, 2020–2021 Academic Year Graduating Seniors Survey Summary Report, available at *https://www.aacom.org/searches/reports/report/2020-2021-academic-year-graduating-seniors-survey-summary-report.*

[16] National Residency Matching Program. Advanced Data Tables 2023 Main Residency Match, available at *https://www.nrmp.org/wp-content/uploads/2023/04/Advance-Data-Tables-2023_FINAL-2.pdf.*

[17] American Osteopathic Association, OMP Report, available at *https://osteopathic.org/about/aoa-statistics/.*

[18] National Residency Matching Program, 2022 Program Director Survey, available at *https://www.nrmp.org/match-data-analytics/residency-data-reports/.*

grams. Permanent robust funding is needed to strengthen the THCGME Program and establish a healthy, stable infrastructure for physician training in outpatient settings. **AACOM recommends that Congress pass the Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act of 2023, which would increase THCGME Program funding by $50 million every 2 years and extend the program through fiscal year 2029.**

- **Expand funding and support for community-based training models, including clinical rotations in rural and underserved communities.** According to the Health Resources and Services Administration's (HRSA) Advisory Committee on Interdisciplinary, Community-Based Linkages, there is a growing trend toward providing care in smaller community-based clinics instead of academic hospitals. As the provision of care has shifted to community-based settings, so has the training of medical students. Clinical training in these settings expose medical students to the unique healthcare needs of rural and underserved populations and prepare them to serve those areas after graduation. Research suggests that medical education in a rural location increases the likelihood of rural practice. However, over three-quarters of all medical schools report concerns with the number of clinical training sites and the quality and supply of preceptors, especially in primary care. To support this trend toward less expensive and less centralized care, Congress must modify existing funding streams and establish new programs to support rural, community-based training. With rural communities suffering the most from physician shortages, Congress should fund a new program within HRSA that creates a consortium of osteopathic medical schools, rural health clinics and federally qualified health centers to increase medical school clinical rotations in rural community-based facilities.
- **Increase funding for Title VII programs.** Currently, Title VII is the only source of federal dollars that promotes the practice of primary care in rural and underserved communities. Its vital programs offer a lifeline to medical students facing financial barriers and underserved communities afflicted by physician shortages. The Title VIII Nursing Workforce Development Programs play an essential role in Boosting annual appropriations for Title VII programs will strengthen our healthcare workforce nationwide, and especially in underserved communities.

Conclusion

On behalf of the 64 osteopathic medical school campuses and the 35,000 medical students they serve, thank you for your consideration of our views and recommendations. Again, we are eager to be a resource as you examine and consider solutions to the nation's healthcare challenges. For questions or further information, please contact David Bergman, J.D., Vice President of Government Relations, at dbergman@aacom.org.

AMERICAN ASSOCIATION OF NURSE ANESTHESIOLOGY

Statement of Angela Mund, DNP, CRNA, President

Introduction

Chairman Cardin, Ranking Member Daines, and Members of the Subcommittee, 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, representing more than 59,000 members across the country. CRNAs provide 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.

We applaud the Senate Committee on Finance for its leadership in holding this hearing on improving healthcare access in rural communities. This hearing has added importance given the Public Health Emergency (PHE) ended on May 11, 2023, which marks an end to the flexibilities for providers at a time when our healthcare workforce is already strained. In addition, 170 rural hospitals closed in the last decade and 450 hospitals are vulnerable to closing, according to the National Rural Health Association, only adding to the strain on the workforce in this realm.

CRNAs play an essential role in ensuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures, including surgical and obstetrical care.

Furthermore, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[1] The importance of CRNA services in rural areas was highlighted in a recent study that examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type. The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists.

Addressing Barriers and Constraints in Rural Communities

Current data indicate that there is an anesthesia workforce shortage. To address the current rural workforce shortage, we need to ensure that all providers are practicing to the top of their education and training. CRNAs are a proven, high-quality anesthesia pain management provider, and exercise independent, professional judgment within their scope of practice. A 2021 study found that starting in 2017, there was an estimated 10.7% excess demand for anesthesia services, meaning there was an anesthesia workforce shortage of approximately 9,000 providers before the pandemic began and current workforce issues arose, and those shortfalls were projected to continue into the future.[2] Allowing CRNAs to work to the top of their scope has proven benefits to patients and facilities. Multiple scientific and clinical studies across a variety of practice settings have shown this to be true. A study in the *Journal of Medical Care* showed that increased CRNA scope led to no measurable differences in outcomes.[3] Similarly, a study published in Health Affairs found that states that had opted out of the Centers for Medicare & Medicaid Services (CMS) supervision requirement saw no change in outcomes.[4] These findings are further supported by a review of literature done by the Cochrane Library that found no identifiable differences in anesthesia delivery based on the anesthesia care model.[5] The proven ability of CRNAs to practice autonomously was also verified by data in the maternal care space,[6] in a study of complications during cesarean sections,[7] and in certain pain management techniques.[8] What remains unproven is the need and value of CRNA supervision requirements. Since March of 2020, Medicare has temporarily waived the physician supervision requirement of CRNA anesthesia services as a part of the Hospital and Critical Access Hospital Conditions of Participation (CoPs) and ambulatory surgical center Conditions for Coverage (CfC). During the three-year period of this waiver there has been no data to show that outcomes have deteriorated. In fact, there has been a significant decrease in liability premiums witnessed in recent decades and these declines continued after the time CMS issued the blanket waiver on supervision.

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[1] Liao, C.J., Quraishi, J.A., Jordan, L.M. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurse Econ. 2015;33(5):263–270. *https://www.semanticscholar.org/paper/Geographical-Imbalance-of-Anesthesia-Providers-and-Liao-Quraishi/77112f1f7ca09a86142b4f5e7c065ae9a073dec2.*

[2] Negrusa, Sebastian, Hogan, Paul, Cintina, Inna, Quraishi, Jihan, Hoyem, Ruby, et al. Anesthesia Services: A Workforce Model and Projections of Demand and Supply. Nursing Economics; Pitman Vol. 39, Iss. 6.

[3] Negrusa, et al. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. Medical Care 54(10): p913–920, October 2016.

[4] Dulisse, Brian, Cormwell, Jerry. No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians. Health Affairs. Vol. 29 #8. August 2010. *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff.*

[5] Lewis, S.R., Nicholson, A., Smith, A.F., Alderson, P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. Accessed 10 February 2023. *https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010357.pub2/full.*

[6] Needleman, J., Minnick, A.F. Anesthesia provider model, hospital resources, and maternal outcomes. Health Serv Res. 2009 Apr;44(2 Pt 1):464–82.

[7] Simonson, Daniel C., Ahern, Melissa M., Hendryx, Michael S. Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis. Nursing Research 56(1):p 9–17, January 2007.

[8] Beissel, D.E. Complication Rates for Fluoroscopic Guided Interlaminar Lumbar Epidural Steroid Injections Performed by Certified Registered Nurse Anesthetists in Diverse Practice Settings. J Healthc Qual. 2016 Nov/Dec.

Additionally, during this same period six additional states have opted out of CMS's supervision requirements (Arizona, Oklahoma, Utah, Michigan, Arkansas, and Wyoming) totalling 23 states that have recognized that federal supervision requirements are unproven and act as an unnecessary barrier to care. Forty-three states have no supervision requirements in their nursing/medicine laws or rules. Data shows that CRNA supervision by physician anesthesiologists is one of the least cost-effective models of anesthesia delivery and that CRNAs practicing autonomously are the most cost-effective for facilities and patients. As we look at how to best utilize our current healthcare workforce, especially in rural areas, we must ask at what cost to patients and facilities do we continue to force unnecessary supervision requirements on CRNAs? We strongly encourage Congress to pass legislation to end Medicare's supervision requirements and allow facilities to determine how best to maximize the anesthesia workforce.

To address the current rural workforce shortage, we need to ensure that all providers are practicing to the top of their education and training. Other unnecessary barriers to care in the Medicare and Medicaid programs reduce patient access to care, add to costs, and reduce competition. In their 2021 report, "The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity," the National Academy of Medicine specifically called for the elimination of barriers to advance practice registered nurses (APRNs) providing care.[9] This echoes data from a study published in Nursing Economic$ that shows that CRNA care is correlated more with vulnerable populations such as Medicaid-eligible patients, rural populations, and lower incomes.[10] In addition, 2022 the National Plan for Health Workforce Well-Being released by the National Academy of Medicine calls for preventing and reducing the unnecessary burdens that stem from laws, regulations, policies, and standards placed on health workers. Placing added barriers to CRNAs can adversely affect healthcare access for these at-risk populations. Currently, Medicare statute, regulations and policy include a number of barriers to patient care that do not serve patients, including not expressly stating that CRNAs abilities for ordering and referring medically necessary services, disincentives for physician anesthesiologists to teach students in a nurse anesthesia program, and not allowing APRN recognition in regard to the use of the Medicare locum tenens modifier.

In order to address the dual need of workforce shortages and ensuring patients in rural communities have access to the care they deserve, the Committee should review two pieces of legislation. We strongly urge the passage of H.R. 2713, the Improving Care and Access to Nurses (ICAN) Act. This legislation would remove barriers to care and increase access to services provided by CRNAs and other APRNs under the Medicare and Medicaid programs. In addition, we urge the Committee to pass H.R. 833, the Save America's Rural Hospitals Act. This legislation would provide needed relief to rural hospitals and to expand access to care for patients.

Conclusion

Everyone deserves access to the highest quality healthcare that CRNAs provide without undue burdens. CRNAs should also be able to perform anesthesia and pain management services to the full extent of their training without barriers to their practice. I thank the Subcommittee for its attention to this important issue and look forward to working with you as you seek to improve healthcare in our nation's rural communities. The AANA hopes to be a partner and work with you as you address the issues facing healthcare in our nation. Should you wish to discuss these issues further, please contact Matthew Thackston, Director of Federal Government Affairs at mthackston@aana.com or (202) 741–9081 or Kristina Weger, Director of Federal Government Affairs at kweger@aana.com or (202) 741–9084. We look forward to working with you.

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[9] National Academy of Medicine; National Academies of Sciences, Engineering, and Medicine; Committee on the Future of Nursing 2020–2030; Mary K. Wakefield, David R. Williams, Suzanne Le Menestrel, Jennifer Lalitha Flaubert, Editors. *https://nap.nationalacademies.org/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to.*

[10] Liao, C.J., Quraishi, J.A., Jordan, L.M. (2015). Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nursing Economic$, 33 5, 263–70. *https://www.semanticscholar.org/paper/Geographical-Imbalance-of-Anesthesia-Providers-and-Liao-Quraishi/77112f1f7ca09a86142b4f5e7c065ae9a073dec2.*

AMERICAN COLLEGE OF SURGEONS
20 F Street, NW, Suite 1000
Washington, DC 20001
T 202–337–2701
F 202–337–4271
https://www.facs.org/

The American College of Surgeons (ACS) appreciates the opportunity to share a statement for the record for the Senate Finance Health Care Subcommittee hearing entitled "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." The ACS appreciates the Committee's attention to the critical issue of health care access. Not every policy proposal included in this statement falls within the Finance Committee's jurisdiction, however the ACS welcomes the opportunity to share thoughts on the health care workforce shortage and the impact on access to care, and discuss legislative priorities aimed at addressing this issue.

Background

Increasing evidence indicates a maldistribution of surgeons in the United States, with significant shortages particularly in rural and underserved areas. A congressionally mandated 2020 report[1] conducted by the Health Resources and Services Administration (HRSA) examined surgical shortage areas and showed a maldistribution of the surgical workforce, with widespread and critical shortages of general surgeons particularly in rural areas. Likewise, a 2021 report[2] from the WWAMI Rural Health Research Center found that between 2001 and 2019, rural areas experienced a 29.1% decrease in the supply of general surgeons, and in 2019, 60.1% of non-metropolitan counties had no active general surgeon at all. This crisis extends beyond general surgeons as well. A 2021 report[3] released by the American Association of Medical Colleges projects shortages of 15,800–30,200 in all surgical specialties by 2034. This is a critical component of the ongoing health care workforce shortage because surgeons are the only physicians uniquely trained and qualified to provide certain necessary, lifesaving procedures.

Better data is needed to fully understand why these shortages exist and inform policy solutions. However, several factors are apparent today. The U.S. population continues to grow and age, increasing demand for physicians across the country. At the same time, the health care system has grown more and more complex, subjecting physicians to an arduous and ever-changing landscape of regulation and administrative burden. The COVID–19 pandemic exacerbated already high rates of physician burnout, leading many practicing physicians to leave the workforce. Repeated cuts to Medicare reimbursement have forced some physicians to see fewer patients or shut their doors altogether. Finally, limited rural Graduate Medical Education (GME) positions and the financial burden of medical education pose barriers to recruiting new physicians and encouraging them to practice in underserved areas.

Congress must act to address these critical issues. The ACS remains committed to working with policymakers to increase access to surgical care across the country and support the surgical workforce across the surgeon's career to ensure that all patients can receive the high-quality care they need.

Legislative Proposals

Ensuring an adequate and diverse surgical workforce that is representative of the population is a critical first step in guaranteeing access to high quality surgical care and reducing disparities in health outcomes for patients across the country. The ACS has long supported legislative efforts to increase the number of GME positions available in underserved areas in order to get more qualified medical students into the field of surgery. **However, we also assert that increasing the number of positions alone is not enough. We must ensure that the right type of physician is at the right place, at the right time, to optimally meet the needs of a particular population.** Recruiting diverse physicians who are representative of the population to the surgical workforce leads to improvements including better access to care for the underserved, better quality of care, increased patient trust in their health care providers, novel questions in research, and more inclusive and broad reaching solutions to policy challenges.

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[1] *https://www.facs.org/media/aqaj2m1r/hrsa-general-surgeon-projection-report-to-appropriations.pdf.*

[2] *https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2021/03/RHRC_PBMAR2021_LARSON.pdf.*

[3] *https://www.aamc.org/media/54681/download?attachment.*

The high cost of medical education is one barrier to individuals wishing to pursue a career in surgery. Physicians often accumulate immense student debt during their education, and then must undertake several years of residency training with low pay, during which time their student loans accrue significant interest. This financial burden may deter students from pursuing certain specialties, practicing in underserved areas, or even entering the health care profession at all. **The ACS supports legislative efforts to reduce the burden of student loan debt on physicians, including the Resident Education Deferred Interest Act (S. 704/H.R. 1202), which would allow borrowers in medical or dental internships or residency programs to defer student loan payments without interest until the completion of their programs, and the Specialty Physicians Advancing Rural Care Act (S. 705/H.R. 2761), which would establish a new loan repayment program for specialty physicians practicing in rural areas.**

Incentives like loan repayment programs can encourage surgeons to practice in underserved areas and help address the maldistribution that currently exists in the workforce. However, better data is critical to accurately identify shortage areas. **The ACS believes the periodic, repetitive collection and analysis of workforce data on both a regional and national basis, undertaken in consultation with relevant stakeholders, should be a top priority.** One step Congress can take to strengthen health care workforce data collection is to fully fund the National Health Care Workforce Commission. The Commission was established more than a decade ago as a multi-stakeholder body charged with developing a national health care workforce strategy, including reviewing current and projected health care workforce supply and demand and analyzing and recommending federal policies affecting the workforce. Unfortunately, this body was never funded and therefore has not been able to begin this important work. **The ACS supports funding the Commission at $3 million for fiscal year 2024.** Doing so will direct needed resources to address the nation's workforce challenges and provide a new opportunity for direct stakeholder engagement.

Unfortunately, current available data are not able to indicate if the supply of surgeons in a given geographic area is adequate to provide access to the services demanded by the population. This is largely because there is no agreed upon definition of what constitutes a shortage of surgeons for a given population, and unlike other key providers of the community-based health care system, HRSA does not maintain a geographic shortage area designation for surgery. **The ACS believes there is an urgent need to establish a surgical shortage designation. The Ensuring Access to General Surgery Act (S. 1140/H.R. 1781) would direct HRSA to study and define general surgery workforce shortage areas and collect data on the adequacy of access to surgical services, as well as specifically grant the agency authority to designate general surgery shortage areas.** Determining what constitutes a surgical shortage and designating areas where patients lack access to surgical services will provide HRSA with a valuable new tool for increasing access to the full spectrum of high-quality health care services.

In addition to a general surgery shortage area designation, the ACS supports reauthorizing the Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP) for a period of 5 years. The HSIP, which expired in 2015, provided a payment incentive to surgeons who performed major operations—defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule—in a geographic HPSA. A 5-year reauthorization of the HSIP will provide general surgeons, who are a key element of rural, frontline care, with the additional support they need to recover after the COVID–19 pandemic and continue serving rural communities. Renewing this program and targeting it to general surgery workforce shortage areas as described above would be a potent tool in reducing geographic workforce maldistribution.

Identifying where health care shortages exist and incentivizing surgeons to practice in those areas is critical. It is equally critical to support surgeons in their roles and prevent skilled practitioners from leaving the workforce due to burnout, administrative burden, safety concerns, or other factors. **The ACS is grateful for passage of the Dr. Lorna Breen Health Care Provider Protection Act, which aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among healthcare professionals, and looks forward to continuing to work with Congress on the issue of physician health and well-being.**

Likewise, the ACS supports legislative actions to eliminate unnecessary requirements that overburden surgeons and their practices and may hinder timely access

to surgical care. **One such bill is the Improving Seniors' Timely Access to Care Act (S. 3018/H.R. 8487 in the 117th Congress) which will help alleviate administrative burden for physicians by improving the transparency and efficiency of prior authorization under Medicare Advantage.** The ACS also maintains that surgeons should be free to practice where they choose. Unfortunately, many employed surgeons are subject to non-compete agreements, which prohibit individuals from joining a competing firm or starting a new venture in the same field after leaving their employer, at times preventing them from starting a private practice or moving to practice in an underserved area. **The Workforce Mobility Act (S. 220/H.R. 731) would free physicians from non-competes, providing them with an option to work for a competitor, rather than be forced to move hundreds of miles or forgo a professional opportunity.**

Finally, the ACS supports the directive that surgery should be performed by surgeons. Decades of efforts by non-physician health care providers to expand their scope of practice further into medicine continue to be considered in many state legislatures. The **ACS remains committed to working with our partners in the surgical community and with Congress to ensure that patients receive surgical care by surgeons.**

Concluding Remarks

The ACS is dedicated to working with Congress on addressing the maldistribution of surgeons across the country and supporting surgeons throughout their careers. Optimal quality, the centerpiece of the ACS' mission, is not achievable without optimal access. Identifying communities with workforce shortages and incentivizing surgeons to practice in those areas is critical to guarantee all patients have access to quality surgical care. **Designating general surgery shortage areas will help to identify underserved communities with surgical workforce challenges. Additionally, Congress should consider enhancing funding for graduate surgical education, providing loan repayment programs to surgeons who choose to practice in areas of need, funding the National Health Care Workforce Commission, and continuing its focus on physician health, well-being, and administrative burden reduction.**

This is only the beginning of the conversation. New issues that will shape the health care workforce continue to emerge, and Congress and stakeholders will have to work together to respond. For example, the newly implemented Rural Emergency Health Program has the potential to exacerbate surgical shortages. The ACS would welcome the opportunity to discuss how the program may be adjusted to maintain patient access to surgical care. Access to care is also impacted by shortages among other members of the care team, not just surgeons, and these shortages are growing. The end of the COVID–19 public health emergency brings changes to several federal and state policies and programs, the impact of which has yet to be seen. Finally, ongoing physician payment instability adds to the financial hardship surgeons already face due to record inflation and high practice costs, and further exacerbates disparities in access to care and health outcomes among rural and underserved populations.

The ACS thanks the Finance Committee for its thoughtful attention to the nation's health care access challenges and looks forward to continuing to work with lawmakers on these important issues. For questions or additional information, please contact Carrie Zlatos with the ACS Division of Advocacy and Health Policy at czlatos@facs.org.

AMERICAN DENTAL ASSOCIATION
1111 14th Street, NW, Suite 1200
Washington, DC 20005
T 202–898–2400
F 202–898–2437
https://www.ada.org/

On behalf of the American Dental Association's (ADA) more than 159,000 dentist members, thank you for the opportunity to submit testimony for the Senate Finance Health Care Subcommittee's hearing, "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." Addressing dental workforce shortages and maldistribution in rural areas so that everyone has optimal access to oral health care is one of the ADA's top priorities. America's dentists thank you for your leadership and focus on rural health care access.

We would like to highlight four pieces of legislation that reflect ADA's support for solutions targeted at student debt and public service, innovative programs, and Medicaid expansion.

Student Debt and Public Service

Student loan debt presents a major impediment to attracting new dentists to underserved and rural communities. Ensuring that loan forgiveness programs are well funded, easy to navigate and expanded to include shorter time commitments or fewer mandatory weekly hours worked could go far in attracting new dentists to these communities. Other incentives should also be considered, including tax incentives, small business grants and more attractive loan terms for purchasing or building a new dental practice in communities of need.

The Indian Health Service Health Professions Tax Fairness Act

The Indian Health Service Health Professions Tax Fairness Act would amend the tax code to allow dentists and other health care professionals participating in the Indian Health Service (IHS) Loan Repayment Program to exclude interest and principal payments from their federal income taxes, as well as certain benefits received by those in the Indian Health Professions Scholarships Program. This bill would allow qualifying IHS employees the same tax-free status enjoyed by those who receive National Health Service Corps (NHSC) and Army loan repayments. Congress made these loan repayment programs offered by the National Health Service Corps and the U.S. Army permanently tax exempt in 2012.

Under the IHS and NHSC programs, health care professionals provide needed care and services to underserved populations. However, the IHS uses a large portion of its resources to pay the taxes that are assessed on its loan recipients. In years past, IHS spent nearly 30 percent of its Health Professions account on taxes. Based on the 2021 average new award of $45,850, making the IHS loan repayments and scholarships tax-free would save the agency over $11.6 million a year and would fund an additional 253 loan repayment awards without increasing the Service's annual appropriation.

The loan repayment program has already proven to be among the IHS's best recruitment and retention tools. Exempting the scholarship and loan repayment funds from gross income would make this tool even more attractive to potential participants. Because IHS currently has a very high vacancy rate, enhancing popular recruitment and retention tools is crucial to providing adequate access to care for IHS beneficiaries, especially in rural areas.

S. 862, Restoring America's Health Care Workforce and Readiness Act

The Restoring America's Health Care Workforce and Readiness Act would double funding for the National Health Service Corps' (NHSC) scholarships and loan repayment programs for health care workers who serve in federally designated shortage areas. It would also provide $625 million in funding in FY 2024, increasing to $825 million in FY 2026. By reauthorizing the mandatory portion of the NHSC through 2026, this bipartisan bill prevents the NHSC's programs from expiring in September of this year.

The ADA strongly supports increasing NHSC scholarship and loan repayment opportunities for dentists, dental hygienists, and other health care professionals. Expansion of NHSC programs would address problems with health workforce distribution and local shortages, while also providing an opportunity for dentists and others to reduce student loan debt through service. The burden of paying off student loans for graduate dental education often contributes to geographical gaps in availability of dental services and access to oral health care because indebted graduates must seek out less risky and more lucrative opportunities. The Restoring America's Health Care Workforce and Readiness Act would encourage dentists and promising dental students to practice in underserved areas by providing loan repayment and scholarships in exchange for a service commitment.

The bill also would establish a NHSC Emergency Service demonstration project to improve the national health care surge capacity to respond to public health emergencies like the COVID–19 pandemic. The demonstration project would operate from 2024 to 2026, with up to $50,000,000 in funding, and participants would be eligible to receive loan repayments of up to 50 percent of the amount of the highest new award made through the NHSC loan repayment program.

S. 704, Resident Education Deferred Interest Act or the REDI Act

S. 704, the Resident Education Deferred Interest Act (REDI Act), is a bipartisan bill that would allow borrowers to qualify for interest-free deferment on their student

loans while serving in a medical or dental internship or residency program. The bill would address the difficulty, or inability, of those who must undertake several years of residency with very low pay to begin repaying student debt immediately. Although residents qualify to have their payments halted during residency through deferment or forbearance, their loans nevertheless continue to accrue interest that is added to the balance.

The REDI Act prevents physicians and dentists from being penalized during residency by preventing the government from charging interest on loans during a time when physicians and dentists are unable to afford payments on the principal. The REDI Act does not provide any loan forgiveness or reduce a borrower's original loan balance. By allowing medical and dental residents to save thousands of dollars in interest on their loans, the REDI Act makes opening practices in rural and underserved areas or pursuing an academic or research career in those areas more attractive and affordable to residents.

Innovative Programs

Reauthorize Action for Dental Health

ADA has long championed the Action for Dental Health (ADH) program, which provides federal funding for the dental health needs of underserved, often rural, populations. ADH funding is directed towards dental disease prevention through improved oral health education, reduction of geographic and language barriers, and improved access to care, among other initiatives. Programs supported by ADH advance the important goal of decreasing dental health disparities in communities where better access to care is most needed.

The ADA is asking Congress to reauthorize the Action for Dental Health Act of 2018 (Pub. L. 115–302) grants for innovative programs for a five-year period, from fiscal year 2024 through fiscal year 2028. To ensure program accountability and transparency, the ADA also asks that Congress require the Secretary of Health & Human Services (HHS) to submit a report to Congress on the extent to which the grants increased access to dental services in designated dental health professional shortage areas.

Medicaid Expansion

S. 570, Medicaid Dental Benefit Act

The Medicaid Dental Benefit Act would make comprehensive dental care a mandatory component of Medicaid coverage for adults in every state. By securing Medicaid dental coverage for adults, Congress can drive health and economic gains for families, states, and our nation. Covering dental benefits in Medicaid would also expand access significantly in rural areas, where nearly one in four non-elderly people are covered by Medicaid.[1]

Many adults who rely on Medicaid benefits find that there is little, if any, coverage for dental care. A long-standing lack of focus on adult oral health care from federal and state governments has created a patchwork of dental coverage by state Medicaid programs. American adults on Medicaid find options for dental care vary based on their state. Less than half of the states provide "extensive" dental coverage for adults in their Medicaid programs. The others offer limited benefits, emergency-only coverage, or nothing at all for adults. Without a federal requirement, and given the competing priorities for state budgets, the optional adult dental benefit is often not provided by states.

This lack of state coverage is particularly problematic because the millions of adults who rely on Medicaid are the least likely to access dental care (including basic preventive services), face the biggest cost barriers to dental care, and are more likely than their higher income counterparts to experience dental pain, report poor mouth health, and find their lives to be less satisfying due to their poor oral health.

Ensuring that states provide comprehensive dental services to adult Medicaid beneficiaries is a sound economic investment. Recently, new research from the ADA's Health Policy Institute estimated what it would cost to secure dental coverage for the millions of adults who rely on Medicaid for their health care. The study[2] shows

[1] The Role of Medicaid in Rural America, *https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/#:%7E:text=Medicaid%20plays%20a%20central%20role,other%20areas%20(61%25%20vs.*

[2] Making the Case for Dental Coverage for Adults in All State Medicaid Programs, *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/*

Continued

that across the 28 states that currently do not provide comprehensive dental coverage, the net cost of providing extensive adult dental benefits is $836 million per year. This includes an estimated $1.1 billion per year in dental care costs and $273 million per year in medical care savings.[3] As Medicaid oral health coverage opens the door to regular care in more appropriate and cost-effective settings, fewer people would turn to emergency departments to relieve dental pain. This change could save our health system $2.7 billion annually.[4] Also, poor oral health creates social and economic barriers that prevent many low-income adults from economic advancement.[5] Eliminating these barriers would generate additional savings and empower people to pursue better jobs and careers.

In conclusion, the ADA would like to reiterate its gratitude for your prioritization of rural access to care issues. Dental access issues should always be included in discussions of general health care access issues, remembering both the unique aspects of dental practice and that oral health is health. The ADA's priorities for addressing rural access to care are:

- Lessening the burden of student loan debt and making practicing in underserved areas more attractive through public service by passing S. 862, Restoring America's Health Care Workforce and Readiness Act and the Indian Health Service Health Professions Act;
- Supporting innovative programs directed towards communities in need by reauthorizing Action for Dental Health; and
- Expanding Medicaid by passing S. 570, the Medicaid Dental Benefit Act.

The ADA looks forward to working with the Finance Health Subcommittee on rural access to care issues in the future. ADA is continuing to work on legislative solutions that would provide tax and other financial incentives to health care professionals who live and practice in rural and underserved communities. If you have any questions, please contact Chris Tampio at tampioc@ada.org.

AMERICAN HOSPITAL ASSOCIATION
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001–4956

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) appreciates the opportunity to submit this statement for the record as the Committee on Finance Subcommittee on Health Care examines obstacles and opportunities to improve health care access in rural communities.

We appreciate the Subcommittee's interest in ensuring rural Americans have access to high-quality, affordable health care.

OBSTACLES AND CHALLENGES FACING RURAL COMMUNITIES

Rural hospitals and health systems are the lifeblood of their communities and are committed to ensuring local access to health care. At the same time, these hospitals are experiencing unprecedented challenges that jeopardize access and services. These include the aftereffects of a worldwide pandemic, crippling workforce short-

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whitepaper_0721.pdf?rev=cf603f948e6a4dd09fb62386e3ee2083&hash=4986B3ED8A5FD4F99A1D28F61D3C2DA1.

[3] Making the Case for Dental Coverage for Adults in All State Medicaid Programs, *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf?rev=a70876d749bf4e00965b122aed23ceb0&hash=38CB60D2D0BE01DA90BD606423142A2D.*

[4] Emergency Department Visits for Dental Conditions—A Snapshot, *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0420_1.pdf?rev=2912d9465aef4958882a485ae5f00665&hash=4B00090BAF2BC8FCBEC83FE9B191F13B.*

[5] Oral Health and Well-Being Among Medicaid Adults by Type of Medicaid Dental Benefit, *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0518_1.pdf?rev=17671fb131f845d6a3662779c5de2de1&hash=51EC39EA18B6F6981BDFB7795D8E337C.*

ages, soaring costs of providing care, broken supply chains, severe underpayment by Medicare and Medicaid, and an overwhelming regulatory burden.

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%). Compared to their non-rural counterparts, a significantly higher percentage of rural hospitals are owned by state and local governments—35% compared to just 13% of urban hospitals.

Trends Affecting Rural Hospital Financial Sustainability

There are a number of trends driving rural health care challenges and rural hospital closures, forcing hospitals to take a wide variety of approaches in addressing them. Despite myriad challenging circumstances, there are many pathways for rural hospitals' sustainability. We appreciate the Committee's focus on better understanding the obstacles to maintaining and improving access to care in rural communities because that is an essential step in developing policy responses to support rural hospitals and the patients and communities they serve.

Patient Volume and Health

Population densities are categorically lower in rural areas, and as a consequence, rural hospitals have much lower patient volumes. Lower patient volumes makes it challenging for rural hospitals to maintain fixed-operating costs.

Lower patient volumes also can impede rural hospitals participation in performance measurement and quality improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement.

Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. This can limit rural hospitals' participation in innovative payment models that can help improve patient outcomes and provide alternative streams of revenue.

In addition to lower patient volumes, rural hospitals often treat patient populations that are older, sicker and poorer compared to the national average. For example, a higher percentage of patients in rural areas are uninsured. A 2016 Department of Health and Human Services Assistant Secretary for Planning and Evaluation issue brief found that 26% of uninsured, rural patients delayed seeking care due to cost. These delays contribute to sicker, and subsequently more costly, patients seeking care. Indeed, this challenging patient mix and lower volumes strains rural health systems as the resources needed to provide care are more varied and intense than those in other regions. These delays in care are further worsened by the fact that people in rural areas face geographic isolation and limited access to transportation to receive care at medical facilities.

Overcoming Low Reimbursement

The bulk of rural hospital revenue comes from government payers, of which Medicare comprises nearly half. Yet, both Medicare and Medicaid reimburse less than the cost of providing these services. This resulted in rural hospitals incurring $5.8 billion in Medicare underpayments and $1.2 billion in Medicaid underpayments in 2020, on top of $4.6 billion in uncompensated care provided by rural hospitals. For Medicare reimbursements in particular, these underpayments grew by nearly 40% from 2016 to 2020. Medicare sequester cuts, which fully resumed July 1, 2022, have further strained rural hospital finances and that would be further compounded if Medicaid DSH cuts were allowed to go into effect Oct. 1, 2023. Additionally, any proposal for site-neutral policies would have a detrimental effect for rural communities.

Two programs designed to address rural financial issues, the Medicare-dependent Hospital (MDH) and enhanced Low-volume Adjustment (LVA) program—which provide vital support to rural hospitals to offset financial vulnerabilities associated with being rural, geographically isolated and low-volume—are scheduled to expire September 30, 2024. COVID–19 relief prevented many closures over the last several years but now that assistance has expired, the financial position of many rural hospitals, especially MDH and LVA hospitals, is more precarious. In 2020, one in five

rural closures were MDHs. Extending these programs or making them permanent will be critical to these rural hospitals moving forward.

In the commercial insurance market, rural hospitals are often forced to accept below average rates or are left out of plan networks entirely. Rural hospitals with low commercial patient volume and a lack of market power are often forced to "take it or leave it" when large insurers refuse to negotiate. In cases where rural hospitals are, in effect, excluded from certain plan networks due to unfair insurer negotiation tactics, patient access can be negatively affected.

Many patients residing in rural areas may already have to drive long distances to seek in-network care. Health plan practices that restrict access to network providers in rural areas further exacerbate these challenges by impeding timely patient access to care, compromising the stability of rural health care providers, and circumventing the intent of network adequacy requirements.

Additionally, affordable coverage remains a pressing challenge facing the health care system. Lack of health insurance coverage in rural areas results in high uncompensated care costs for hospitals. Medicaid expansion is one policy that has helped rural hospitals remain viable. The majority (74%) of rural closures happened in states where Medicaid expansion was not in place or had been in place for less than a year. Research has found that Medicaid expansion has been associated with improved hospital financial performance and lower likelihood of closure, especially in rural areas that had many uninsured adults prior to expansion.

Managing Staffing Shortages

Rural hospitals face significant staffing shortages that predated the pandemic but have been significantly exacerbated over the last three years. Only 10% of physicians in the United States practice in rural areas and over 65% of primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.

The shortage of primary care services has detrimental effects on the overall health of rural populations. For example, health outcomes in rural areas are significantly lower compared to more densely populated regions. Additionally, while clinical care shortages exist across the care continuum, the shortage of behavioral health and substance abuse professionals in rural populations is immense. Recent research finds that 65% of rural counties do not have a psychiatrist; 47% do not have a psychologist; and 81% do not have a psychiatric nurse practitioner. Clinician shortages are difficult to fill as rural hospitals find it challenging to recruit and retain qualified practitioners.

Recruitment and retention of health professionals has long been a persistent challenge for rural providers. Acute workforce shortages and increasing labor expenses resulting from the pandemic have placed additional pressure on rural hospitals. Many rural providers are seeking novel approaches to recruit and retain staff. Existing federal programs, such as the National Health Service Corps, work to incentivize clinicians to work in rural areas. Other programs, such as the Rural Public Health Workforce Training Network Program, help rural hospitals and community organizations expand public health capacity through health care job development, training and placement. Additional and continued support to help recruit and retain health care professionals in rural areas is needed from the federal governments.

Increased Cost of Caring—Rising Input Costs

Hospitals and health systems are facing significant financial challenges due to the increased cost of caring for patients. Expenses for labor, drugs, purchased services and personal protective equipment have all increased compared to pre-pandemic levels.

Hospitals have seen a 17.5% increase in overall expenses between 2019 and 2022, according to data from Syntellis Performance Solutions, a health care data and consulting firm. Further exacerbating the situation is the fact that the staggering expense increases have been met with woefully inadequate increases in government reimbursement. Specifically, hospital expense increases between 2019 and 2022 are more than double the increases in Medicare reimbursement for inpatient care during that same time. Because of this, margins have remained consistently negative, according to Kaufman Hall's Operating Margin Index throughout 2022.

In fact, over half of hospitals ended 2022 operating at a financial loss—an unsustainable situation for any organization in any sector, let alone hospitals. So far, that trend has continued into 2023 with negative median operating margins in January and February. According to a recent analysis, the first quarter of 2023 saw the high-

est number of bond defaults among hospitals in over a decade. This also is one of the primary reasons that some hospitals, especially rural hospitals, have been forced to close their doors. Between 2010 and 2022, 143 rural hospitals closed—19 of which occurred in 2020 alone. Finally, despite these cost increases, hospital prices have grown modestly. In fact, in 2022, growth in general inflation (8%) was more than double the growth in hospital prices (2.9%).

The explosive growth in contract labor expenses in large part fueled a 20.8% increase in overall hospital labor expenses between 2019 and 2022. Even after accounting for the fact that patient acuity (as measured by the case mix index) has increased during this period, labor expenses per patient increased 24.7%. These increases are particularly challenging, because labor on average accounts for about half of a hospital's budget.

Increased drug and medical supply costs have also contributed to ongoing financial challenges. For the first time in history, the median price of a new drug exceeded $200,000—a staggering figure that implies a double-digit year-over-year price growth. Department of Health and Human Services (HHS) found that drug companies increased drug prices for 1,216 drugs—many used to treat chronic conditions like cancer and rheumatoid arthritis—by more than the rate of inflation, which was 8.5% between 2021 and 2022. Increased expenses extend to medical supplies and equipment as well and hospitals have seen per patient costs increased by 18.5% between 2019 and 2022, outpacing increases in inflation by nearly 30%.

Overcoming Regulatory Barriers

Rural hospitals face a number of regulatory burdens that impact their ability to provide care. According to an AHA study, the nation's hospitals, health systems and post-acute care providers spend $39 billion each year on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for larger facilities. For example, while Medicare's Conditions of Participation (CoPs) and other compliance metrics are important to ensure the safe delivery of care, future CoPs should be developed with more flexibility and alignment with other laws and industry standards. Rural hospitals can protect their communities' access to health care by receiving relief from outdated and unnecessary regulations.

OPPORTUNITIES TO IMPROVE HEALTH CARE FOR RURAL COMMUNITIES

To mitigate rural hospital closures and improve health care in rural communities, hospitals continue to explore strategies that allow them to remain viable. Although rural hospitals have long faced circumstances that have challenged their survival, those dangers are more severe than ever. As a result, rural hospitals require increased attention from state and federal government to address barriers and invest in new resources in rural communities. The AHA continues to support policies that would help address these challenges, including:

Support Flexible Payment Options

As the health care field continues to change at a rapid pace, flexible approaches and multiple options for reimbursing and delivering care are more critical than ever to sustain access to services in rural areas.

- **Extend 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. AHA urges Congress to pass the Rural Hospital Support Act (S. 1110) to extend these important programs.
- **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 January 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 that small rural and critical access hospitals can convert to in order to provide emergency and outpatient services without needing to provide inpatient care. REHs are paid a monthly facility payment and the outpatient prospective payment system (OPPS) rate plus 5%. 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. They receive increased payments based on their cost per discharge in a base year. AHA supports adding an additional base year that SCHs may choose for calculating their payments as included in the Rural Hospital Support Act (S. 1110).

Ensure Fair and Adequate Reimbursement

Medicare and Medicaid each pay less than 90 cents for every dollar spent caring for patients, according to the latest AHA data. Given the challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of care.

- **Reverse Rural Health Clinic (RHC) Payment Cuts.** RHCs provide access to primary care and other important services in rural, underserved areas. AHA urges Congress to repeal payment caps on provider-based RHCs that limit access to care.
- **Extend Ambulance Add-on Payments.** 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.
- **Flexibility for Critical Access Hospitals (CAHs).** We urge Congress to pass legislation to extend the COVID–19 public health emergency waiver providing flexibly for the 96-hour average length of stay CoP. Many CAHs have had to increase their average length of stay because of challenges transferring patients to other sites of care, among other factors outside their control. We also support permanently removing the 96-hour physician certification requirement for CAHs. Removing the physician certification requirement would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours.
- **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 for hospitals below that threshold with new money.
- **Commercial Insurer Accountability.** Systematic and inappropriate delays of prior authorization decisions and payment denials for medically necessary care are putting patient access to care at risk. We support regulations that streamline and improve prior authorization processes, which would help providers spend more time on patients instead of paperwork. We also support a legislative solution to address these concerns. 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.
- **Maternal and Obstetric Care.** We urge Congress to continue to fund programs that improve maternal and obstetric care in rural areas, including supporting the maternal workforce, promoting best practices and educating health care professionals. We continue to support the state option to provide 12 months of postpartum Medicaid coverage.
- **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

PHE; and increase access to care in underserved communities by investing in supports for virtual care and specialized workforce.

Bolster the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for rural hospitals. Nearly 70% of the primary HPSAs are in rural or partially rural areas. 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 license.

- **Graduate Medical Education.** We urge Congress to pass the Resident Physician Shortage Reduction Act of 2023 (S. 1302), 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) to extend 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 three years to practice in federally-designated underserved areas.
- **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) 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 $1 billion to support nursing education and provide resources to boost student and faculty 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 federal protections for health care workers against violence and intimidation, and to provide hospital grant funding for violence prevention training programs and coordination with state and local law enforcement

Support Telehealth Coverage

The pandemic has demonstrated telehealth services are a crucial access point for many patients. We urge Congress to build on the practices that have proven successful in recent years, including:

- **Permanently eliminating originating and geographic site restrictions.**
- **Permanently eliminating in-person visit requirement for behavioral telehealth.**
- **Removing distant site restrictions on federally-qualified health centers and clinics.**
- **Ensuring reimbursement parity based on place of service where the visit would have been performed in-person.**
- **Continuing payment and coverage for audio-only telehealth services.**
- **Permanently expanding the eligible provider types.**
- **Removing unnecessary barriers to licensure.**
- **Establishing DEA Special Registration Process for Telemedicine for administration of controlled substances.**
- **Expanding cross-agency collaboration on digital infrastructure and literacy initiatives.**

CONCLUSION

Rural hospitals are the cornerstones of their towns and cities and are committed to continuing to serve their patients and communities. The AHA appreciates your efforts to examine ways to improve health care access in rural communities and looks forward to working with you on this important issue.

LETTER SUBMITTED BY EMILY BERGLUND, M.S.

Senator Daines,

I am a born and raised Montanan with family residing in the Bitterroot Valley. By the time I graduated from high school in Helena, I had lost numerous classmates to mental illness and had spoken to several more who had plans or were carrying out plans to die by suicide. As a college and then graduate student at Montana State University, I volunteered at a local helpline and heard the desperation of those struggling with depression in our community. As an educator at Carroll College, I witnessed and lent an ear to too many students who were struggling with their mental health, unsure of where to go or how to heal. I have lived the consistent and alarming mental health demands of my generation and the next, your current constituents and your next.

Inspired by these unwanted experiences, I began working for a company making tools to help the often overlooked and unreachable youth in rural America. Digital therapeutics have the power to quickly and accessibly deliver safe and effective healthcare to teens and young adults who so desperately need it. These evidence-based treatment apps are not an idea; they exist. And they have the power to change the lives of Montana's children. Their continued existence relies heavily on the support of pathways to reimbursement from influential legislators like yourself. From one Montanan to another, please create and support the legislation necessary to get digital therapeutics into the hands of our community, including the co-sponsorship of The Access to Prescription Digital Therapeutics Act of 2023 (S. 723/ H.R. 1458). We needed it then, and we need it now.

Earnestly,

Emily Berglund, M.S.

STATEMENT SUBMITTED BY ROBERT CHARLES BOWMAN, M.D.

Lifetime Rural Medical Educator at Academic Positions in Oklahoma, Texas, Tennessee, Nebraska.

Long Term Chair of the Society of Teachers of Family Medicine Group on Rural Health.

Long Term Editor of the *North American Section of Rural and Remote Health*.

One of the originators of the pipeline concept of rural training.

Rural Family Physician, Nowata, OK, 1983 to 1987, at the beginning of DRG and RBRVS decline by design.

My main message about Rural Medical Education is short. It cannot work to resolve deficits of rural workforce. Neither can nurse practitioner or physician assistant training. Workforce cannot just be produced. It has to be supported. The financial design is totally inadequate to support the required sufficient numbers of workforce. Even worse, most of the American population is behind and is growing fastest without a response in terms of workforce increases.

Innovations Are Not Going to Be Solutions

The populations most behind are not going to be served well by innovation, digitalization, virtual medicine, or regulation. They have lower levels of education, health literacy, Internet literacy, bandwidth, and access to communication issues. They most need one on one person to person care with a best delivery team member—yet their financial design shapes half enough professionals, less than half enough delivery team members, and other access barriers make their health care more challenging.

More than a Minority of the Population Is Impacted Negatively by Health Care Design

I am encouraging the Senate Finance Committee to understand that what has long been happening in Rural America, has been present across the nation urban and rural for many decades.

Rural is small. Rural is not pure for deficits as 25% are quite favored. Rural is growing slowest in the portions most behind.

Contrast this mix with urban and rural populations in 2,621 counties lowest in health care workforce are pure for deficits, complexity, and decline by design. US Counties were stacked by concentrations of physicians and divided into a top concentration 79 counties with 10% of the U.S. population in 2010, a higher 20% 152 counties, a middle concentration 286, and a lowest concentration 2,621 counties with about 130 million people in 2010. There were rural and urban components in these counties more pure for deficits of workforce and health care dollars.

Deficits of workforce and access are seen in a 37 million rural Americans or about 75% of the rural population. The deficits of lowest levels of workforce are also seen in about 90 million urban Americans or 32% of urbans. Comparison over time revealed the 2,621 counties as the fastest growing US population decade after decade. But a rural urban comparison indicated a stagnant 37 million rural people and a fastest growing urban component.

In 1970 about 40 million urban Americans were estimated to be found in the 2,621 counties lowest in health care workforce. They grew to 90 million by 2010. The rate of growth has continued and should shape them into about 150—160 million by 2070. There is no indication of growth of their workforce, access, or facilities.

It should be considered important that the fastest growing US population that is most behind and most complex, is not even on the radar scope while its remaining health care is being closed and compromised.

Rural Behind and Urban Behind Are Similar

The rural populations are known to have concentrations of conditions, diseases, environments, and worst outcomes. But so does the urban portion of the 2,621 counties lowest in health care workforce.

Diabetes, obesity, smoking, premature death, morbidity, mortality, mental health, and longevity issues are concentrated together at 45–50% of each found in this 40% of the population (County Health Rankings, Census Data).

Readmissions Year 2 Penalties illustrate the differences and the problem of performance based designs. In year 2 the top penalty was 1 to 2% of Medicare payments withheld. This was seen in 3% of urban hospitals, 5% overall, 9% of rural hospitals, and 14% of the hospitals in the 2621 counties most pure for behind in so many areas of health care dollars, outcomes, supports, access, and more.

Will our designs continue to worsen situations, or will we gain awareness of most Americans most behind, their situations, their outcomes, and how health care needs to help them and not harm them.

The Financial Challenge Is the Issue

The key to understanding the financial challenge is awareness. Designers must understand that these counties have concentrations of elderly, poor, fixed income, disabled, and worst employers. This shapes concentrations of the worst Medicare, Medicaid, Dual, high deductible, and other worst private health plans. These plans pay 15–30% less for the same services and cause other problems for providers including massive closures and compromises of their hospitals and practices.

Rural and urban populations in the 2,621 counties lowest in health care workforce suffer greatly. Historically only Hill Burton and the first decade of Medicare and Medicaid sent them the better financial design that built up workforce, facilities, and delivery team members. For the past 40 years, the financial design has steadily worsened for this 40% of the population (rural and urban) that will be about 50% or a majority by about 2060.

Half of the US population, the half growing fastest in numbers and demand for care and complexity, will suffer from another 40 years of closures and compromises without major changes in their health care financial designs.

The focus on rural geographic markers or racial or ethnic minorities has hidden much greater access problems in the nation, for a majority of Americans.

Training Interventions Cannot Resolve Deficits and Access Barriers

There is no training intervention that can work to resolve deficits of half enough primary care, mental health, women's health, and basic surgical workforce that have always been present over the last 60 years. The deficits and access barriers have been worsened by design since the 1980s with worse to come.

The Senate Finance Committee would do well to ignore claims that these workforce and access deficits can be fixed by new types of health professionals as new types have failed for 50 years including nurse practitioners, physician assistants, and family physicians. Rural medical education was my career for over 25 years and few have studied, taught, or researched it as much. It does not work and it is a best approach. More graduate medical education dollars cannot help. Teaching health centers cannot help. The power of CMS dollars is so great that anything that HRSA does to fund Community Health Centers or training grants, is already negated by CMS, state, and private payers.

Please ignore claims by schools, programs, associations or their representatives that they can fix these deficits since massive expansions of nurse practitioners, physician assistants, and osteopathic physicians averaging 7% more graduates a year for decades of class years have not worked (doubling annual graduates each 14 years).

These massive expansions come with consequences such as a less experienced workforce. This is due to so many more with no experience graduated each year, fewer active, and rapid departure from primary care and front line careers as shaped by the financial design.

Note that these expansion rates are multiple times faster than population growth or demand for care increases and are infinitely faster than the increases in dollars going to health professionals which are stagnant to shrinking. (Comment—in other hearings, Congress would do well to revisit what has happened with overexpansions of health professionals in the last 100 years with boom and bust cycles).

Of course what may prevent a massive glut, is the sad condition of practice environments that drive off so many nurses and other health professionals so rapidly. The financial design and profit focus help to create toxic practice environments.

Nurse practitioners have doubled twice in the 1990s and their primary care contribution per graduate has fallen as fast as they have expanded. Physician assistants and osteopathic graduates have also been increasing at 7% a class year since the 1960s. Interestingly they have done little for primary care since their primary care yield per graduate has been cut in half with each doubling.

Primary care entry and retention sets new low levels with each class year as you would expect for this poorly supported area. Internal medicine, family medicine, nurse practitioner, and physician assistant graduates were previously found at 60–90% in primary care for most of their careers. Since the 1980s this has changed. Family physicians have fallen to about 50% due to the opportunities for urgent, emergent, hospitalist, and other careers and the shambles of primary care design. NP and PA and IM have fallen below 20% in primary care. Multiple times more graduates of each type are required to be able to deliver the same primary care over a career as a single 1980 graduate.

The financial design simply does not have the added dollars in personnel budgets to accommodate more health professionals or more delivery team members or more regulation or more certification or more technology or more micromanagement.

Nurse Practitioner and Physician Assistant Contributions Can Increase, but Only With Departures of Physicians

It is true that nurse practitioners and physician assistants are increasing in numbers found in primary care, but this is small in increase compared to the non-primary care explosion from these sources. And there is only one reason for their increase in primary care.

Only departures of internal medicine and family medicine from primary care allow any increased in primary care from nurse practitioners and physician assistants.

One suggestion that I have for those that claim that their program or school or innovation can fix deficits of workforce is to ask them what the tracking databases show. For an example, I ran tens of thousands of regressions and did years of research on rural medical education. Nebraska had one of the best pipeline designs and you could show that University of Nebraska Medical School Graduates choosing family medicine (success in pipeline) were 10–12 times more likely to be located in one of 70 Nebraska counties of need (14 with no physician, 9 with plenty, 93 total). But tracking databases revealed little change in workforce levels over 20 years.

Rearranging the deck chairs is not solving deficits of workforce and access. Initials behind the names change, but not the workforce or access.

The validity of the research is good. Their devotion is great to rural health. But real success is about a major improvement in the levels of workforce for better access, economics, health equity, local health leadership, and more.

Fixed Finances Fix Deficits in Place

All training interventions are rearrangements of the deck chairs on the *Titanic* as basic health access goes under for most Americans.

More graduates of more types entering the workforce prefer better salaries, better benefits, better locations, better health insurance, and practice environments with more and better delivery team members and less patient complexity. This is least present for basic health access primary care and mental health and women's health where most Americans are most behind.

Even those who prefer to locate in these counties or in primary care face great difficulties. Primary care has only about 250 billion in spending, but the spending is maldistributed and supports only about 25% of the primary care workforce poorly with less than 20% of primary care spending in the 2621 counties lowest in health care workforce. This is about 50 billion in investment for about 50 primary care physicians per 100,000 or about half enough. More than 50 billion added would be required for the practices in these counties to reach adequate and more than that to move inadequacies in support teams to the more and better delivery team members required for higher functioning or person centered care.

Claims by experts that integration, coordination, and outreach can help are bogus since the various workforce levels and social supports are half enough or less with fewer and lesser delivery team members to do the arranging.

Worst Quality Health Insurance Continues to Get Worse

The reductions in spending force these practices into fewer delivery team members and lesser delivery team members because the various Medicare, Medicaid, and private plans pay 15–30% less where workforce is lowest and where the elderly, the poor, the disabled, and the worst employers and their worst quality worst paying health plans are concentrated.

This is not about insufficient quantity of health insurance. In 2010 these counties had 40% of the population and about 40–41% of the uninsured and unemployed. Their problem has always been worst quality health insurance and worst quality employers.

But it does get worse.

Reductions in funding are seen in Medicare cuts, Medicaid dollars, private insurance dollars and other sources. Inflation, new technology, regulation, and micromanagement have been forced on the practices and this steals dollars from the personnel side of the budget—and they can support fewer and lesser delivery team members. Lowest valued practices and populations suffer most from cost cutting designs and also from costly, burdensome micromanagement.

The basic design harming practice where needed most is stagnant revenue, increasing usual costs of delivery, more types of innovative costs of delivery, and higher costs in each innovative added type. Delivery team members are also squeezed by more to do with fewer and duties of higher complexity—that often are meaningless when compared to the one on one interactions with patients that are most compromised.

Does it make sense for innovation to rule from far away or should we focus on more and better delivery team members for more and better one on one innovation from within a personal relationship, a practice, and a community?

The Impossibility of Health Access Recovery

Under the current design with inadequate public plans and other worst quality health plans from the weaker employers there is no chance to improve local health care workforce, access, leadership, and other key areas.

Historically you can review the situations in these counties most behind. Appalachia is a great example that appears to apply across the 2,621 counties. Only counties that have become interstate hubs and those that are being absorbed by suburbs can escape. This is most likely because they have better jobs and employers and per-

sonal finances and have better quality better paying health insurance that can support more workforce, more team members, and better delivery team members.

The Compromise of Expansion of the Worst Quality Health Plans

Expansions of the worst quality health insurance that pays the least, excludes the most, and supports the least—cannot help most Americans most behind.

Rural economics are about weaker employers, health care, education, government jobs, and social supports as we have learned from Rural Health Matters, Doeksen, and others. The same is true for the 2,621 counties lowest in workforce.

Weaker Employers

Trade, mining, and agriculture policies are weakening employers and populations and plans. Outside ownership is not helpful for local people. Wall Street wars can take out employers critical to an area—as with corporate raiders after Phillips Petroleum with impacts on northeast Oklahoma. Declines in Phillips, oil, agriculture, and state programs took our county from 5 to 3 physicians, essentially closed the hospital, and stopped efforts such as Health Fairs, home visits, and new programs such as an Assisted Living program.

Health Care Compromise By Design

Health care design that minimizes basic services, generalists, and general specialists contributes the least to health equity, to basic health access, and to local economics. Hundreds of hospital closures and more carnage in practices have acted to devastate the health care economic contribution, a top 5 contributor where most needed.

Education Finance

Education finance is also compromised due to property tax based education and inadequate revenue impacting most children birth to high school graduation, or lack thereof. Formulas to compensate districts for inadequate revenue and more children in poverty may not always work out.

Government Jobs Federal and State

Government Jobs have been cut at all levels or these jobs have been centralized away. I saw this during my time as a rural family physician in the 1980s and it has been present since that time. Sometimes two communities fight over remaining government jobs or government supported jobs.

Social Supports Such as Food Stamps, Social Security, Disability

Social supports are essential for food, income, and other support for these counties and are a top 5 contributor due to concentrations of poor, elderly, disabled, fixed income, Veterans, Native Americans, rural African Americans, and Border Hispanic populations. And social supports are constantly under attack at federal and state levels. It appears that people that benefit most from the nutrition, jobs, economics, and support of these programs have to often been convinced that the programs are evil.

A final plea to reverse the financial designs from DRG, RBRVS, lower payments as workforce levels get lower.

Health access, jobs, and economics suffer by design, but there are other key areas to address.

Each hospital closed represents multiple administrators, nurses, social workers and others who were often locally focused health care leaders.

When my colleague Shane Avery was driven out of rural Indiana along with his nurse practitioner spouse, who will take over their practice, patients, community focus, fight against opioids, and more?

DRG, RBRVS and 15–30% lower payments is killing off locally focused health care leadership. It is not surprising that Congress and CMS have poor awareness of this, since those who could communicate and raise awareness have been closed, terminated, and compromised.

Health care and political leaders must understand practices and hospitals from the inside out—and stop meddling from above and outside.

Financial designs must not favor the bigs more and more across proposals, legislation, revision, and implementation. Those most distant must have a voice—and they are a majority left behind.

Designers Must Be Held Accountable as with Physicians and Human Subject Researchers

Cost cutting should protect vulnerable populations and their providers, not abuse them most.

Quality improvement is more and more questionable as we learn that outcomes are mostly about population and social drivers—and less about what practices and hospitals can do. Certainly fewer and lesser delivery team members by design even compromises this area. Congress should question an Innovation Center that is 5 for 52 in successful experiments. Perhaps cost cutting and quality improvement are innovations based on past assumptions.

Experimentation must take a back seat in health care delivery and front seat must go to delivery team members and their environments. This is also the way to address burnout, turnover, lack of experience, lower productivity, and more.

It took the last half of the 19th century to rein in physicians and the last half of the 20th century to rein in human subject researchers. We must rein in those who experiment upon tens of millions of Americans who are most vulnerable, most dependent, least valued, and most invisible. They need protection from the harms of cost cutting, from the harms of assuming overutilization to be the problem when populations with deficits suffer from underutilization and inappropriate utilization.

CENTER FOR FISCAL EQUITY
14448 Parkvale Road, Suite 6
Rockville, Maryland 20853
Fiscalequitycenter@yahoo.com

Statement of Michael G. Bindner

Chairman Cardin and Ranking Member Daines, thank you for the opportunity to submit our comments. These comments were provided to the House Ways and Means Oversight Subcommittee on April 26th. The access to healthcare theme for rural hospitals in the post-*Dobbs* world seems especially relevant.

The ultimate answer for rural healthcare is to send people from rural areas to medical school and nursing school (and to develop career ladders to both) and have the local hospital systems pay the tuition and living expenses in exchange for a period of service. This solves the human capital problem in healthcare, but not the general loss of rural population which is the story of the last 100 years.

Employee ownership of companies who provide healthcare services directly rather than through third party insurance will assure everyone has care, however this may or may not save rural areas if there is nothing to keep people there.

What we should not do (and stop doing) is to force vulnerable low-skilled workers into the healthcare field at low levels just because we have the power to do so. There is a term for that. Slavery.

In prior years, when religious organizations ran hospitals, they were trusted to provide for the poor. In some cases, it was in the name of the religious order, such as The Sisters of Charity or The Sisters of Mercy. . . .

. . . The recent *Dobbs* Case reminds us of the exemption granted under law to Catholic Hospitals regarding certain kinds of women's health care. When only Catholic hospitals are left in some states, due to consolidation, it makes this policy that more acute. In order for such hospitals to fully serve women, the drama of abortion politics must settle into compromise. There are proposals on both sides for a federal solution—either a federal law banning most abortions or permitting it in all cases. At some points, electoral stunts need to recede and real compromise must be sought.

In both scenarios, the need to take the issue away from the states is obvious. Justice Alito ignored the problems of both slavery and Jim Crow as reasons why there should not be abortion states and anti-abortion states. The respondents relied on the

question of rights rather than on the question of powers. Had they examined the competencies of federal and state government on the question of who makes the rules on personhood, the answer is obviously that this responsibility must be federal.

A ruling along those lines would have ended the issue at the status quo—with no regulation of abortion unless Congress recognized the rights of the unborn as reservoirs of positive rights. They are already recognized as having the right to life against government action. It is the same as the right to life for adults—the right to not be executed without due process. It is why we do not execute pregnant women, as well as the right to seek redress for outside injury.

What they cannot claim is a right against the welfare of its mother—especially if the child is doomed due to a fatal defect. In such cases, termination is the only ethical solution—even in Catholic hospitals. Especially if the Catholic hospital is the only hospital for miles around.

For the larger issue, the right to an abortion in the very early stages should be federally guaranteed. After the embryo becomes a fetus—a little person in Latin—then pregnancies should be ended in a live birth, but with no medical intervention required to save the child (other than baptism or other religious blessing). This form of termination should have no upper limit. No one has a right to NOT be born.

Regardless, the Catholic Health Association should have been asked to present testimony on this issue. Since they were not included, their comments should be specifically invited on the issue of charitable care. Ambushing them with an abortion discussion would be rude.

Finally, in a cooperative economy, where companies are owned by their employees and also provide cooperative (democratically chosen) consumption options—especially healthcare—the need for both outside insurance and charitable care will be eliminated. That day may be sooner than you realize, as capitalism's flaws are showing.

A few simple steps will quicken the process, such as allowing insured personal accounts for Social Security holding corporate preferred and voting stock (not shares in the Wall Street Casino) and giving holders of public stock the same capital gains exemption given to private company owners when selling to a qualified broad-based Employee Stock Ownership Plan. While the first option is unlikely to ever pass, the second should attract bipartisan support.

Please see our attachment on Asset Value-Added Taxes for more information.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment—Asset Value-Added Taxes—The President's Fiscal Year 2023 Budget, June 7, 2022

There are two debates in tax policy: how we tax salaries and how we tax assets (returns, gains and inheritances). Shoving too much into the Personal Income Tax mainly benefits the wealthy because it subsidizes losses by allowing investors to not pay tax on higher salaries with malice aforethought.

Asset Value-Added Tax (A–VAT) is a replacement for capital gains taxes and the estate tax. It will apply to asset sales, exercised options, inherited and gifted assets and the profits from short sales. Tax payments for option exercises, IPOs, inherited, gifted and donated assets will be marked to market, with prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed.

As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock Ownership Plan will be tax free. This change would be counted as a tax cut, giving investors in public stock who make such sales the same tax benefit as those who sell private stock.

This tax will end Tax Gap issues owed by high income individuals. The base 20% capital gains tax has been in place for decades. The current 23.8% rate includes the ACA–SM surtax), while the Biden proposal accepted by Senator Sinema is 28.8%. Our proposed Subtraction VAT would eliminate the 3.8% surtax. This would leave a 25% rate in place.

Settling on a bipartisan 22.5% rate (give or take 0.5%) should be bipartisan and carried over from the capital gains tax to the asset VAT. A single rate also stops gam-

ing forms of ownership. Lower rates are not as regressive as they seem. Only the wealthy have capital gains in any significant amount. The de facto rate for everyone else is zero.

With tax subsidies for families shifted to an employer-based subtraction VAT, and creation of an asset VAT, taxes on salaries could be filed by employers without most employees having to file an individual return. It is time to *tax transactions, not people*!

The tax rate on capital gains is seen as unfair because it is lower than the rate for labor. This is technically true, however it is only the richest taxpayers who face a marginal rate problem. For most households, the marginal rate for wages is less than that for capital gains. Higher income workers are, as the saying goes, crying all the way to the bank.

In late 2017, tax rates for corporations and pass-through income wee reduced, generally, to capital gains and capital income levels. This is only fair and may or may not be just. The field of battle has narrowed between the parties. The current marginal and capital rates are seeking a center point. It is almost as if the recent tax law was based on negotiations, even as arguments flared publicly. Of course, that would never happen in Washington. Never, ever.

Compromise on rates makes compromise on form possible. If the Affordable Care Act non-wage tax provisions are repealed, a rate of 26% is a good stopping point for pass-through, corporate, capital gains and capital income.

A single rate also makes conversion from self-reporting to automatic collection through an asset value added tax levied at point of sale or distribution possible. This would be both just and fair, although absolute fairness is absolute unfairness to tax lawyers because there would be little room to argue about what is due and when.

Ending the machinery of self-reporting also puts an end to the Quixotic campaign to enact a wealth tax. To replace revenue loss due to the ending of the personal income tax (for all but the wealthiest workers and celebrities), enact a Goods and Services Tax. A GST is inescapable. Those escapees who are of most concern are not waiters or those who receive refundable tax subsidies. It is those who use tax loopholes and borrowing against their paper wealth to avoid paying taxes.

For example, if an unnamed billionaire or billionaires borrow against their wealth to go into space, creating such assets would be taxable under a GST or an asset VAT. When the Masters of the Universe on Wall Street borrow against their assets to avoid taxation, having to pay a consumption tax on their spending ends the tax advantage of gaming the system.

This also applies to inheritors. No "Death Tax" is necessary beyond marking the sale of inherited assets to market value (with sales to qualified ESOPs tax free). Those who inherit large cash fortunes will pay the GST when they spend the money or Asset VAT when they invest it. No special estate tax is required and no life insurance policy or retirement account inheritance rules will be of any use in tax avoidance.

Tax avoidance is a myth sold by insurance and investment brokers. In reality, explicit and implicit value added taxes are already in force. Individuals and firms that collect retail sales taxes receive a rebate for taxes paid in their federal income taxes. This is an intergovernmental VAT. Tax withheld by employers for the income and payroll taxes of their labor force is an implicit VAT. A goods and services tax simply makes these taxes visible.

Should the tax reform proposed here pass, there is no need for an IRS to exist, save to do data matching integrity. States and the Customs Service would collect credit invoice taxes, states would collect subtraction VAT, the SEC would collect the asset VAT and the Bureau of the Public Debt would collect income taxes or sell tax-prepayment bonds.

DIGITAL THERAPEUTICS ALLIANCE
https://dtxalliance.org/

May 31, 2023

U.S. Senate
Committee on Finance
Subcommittee on Health Care
Chairman Benjamin L. Cardin
Ranking Member Steve Daines
430 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

The Digital Therapeutics Alliance commends the work of the Senate Subcommittee on Health Care for examining obstacles and opportunities to improve health care access in rural communities.

Rural communities often face significant challenges in accessing healthcare services, including limited resources, long distances to healthcare facilities, and a shortage of health-care professionals. However, the emergence of digital therapeutics offers a promising solution to address these issues and transform the landscape of healthcare delivery in rural areas. By leveraging the power of technology, digital therapeutics provide accessible, personalized, and evidence-based interventions, effectively bridging the gap between patients and care providers.

Increased Access

Digital therapeutics provide a convenient and accessible alternative to traditional healthcare services for individuals living in rural communities. Patients can access these interventions through mobile applications, web-based platforms, and telehealth services from the comfort of their homes, eliminating the need for long travel times and expenses associated with accessing healthcare services in urban areas. This increased access to care ensures that individuals in rural communities receive timely and effective interventions, reducing the burden of chronic conditions and preventing the progression of diseases.[1]

Personalized Care

Digital therapeutics offer tailored interventions based on individual needs, preferences, and progress. Machine learning algorithms and data-driven approaches help analyze user input and provide personalized treatment plans. These interventions can include cognitive-behavioral therapy (CBT), mindfulness exercises, psychoeducation, and medication adherence support. By personalizing care, digital therapeutics foster a sense of autonomy and empower individuals to actively participate in their own recovery journey. Moreover, engaging interfaces, gamification elements, and interactive features enhance user engagement, motivation, and adherence to treatment protocols.[2]

Remote Monitoring and Continuous Care

Digital therapeutics enable remote monitoring and continuous care, particularly critical for individuals living in rural communities with limited access to healthcare services. Wearables and sensors can track physiological and behavioral data, providing valuable insights into a patient's progress and facilitating early intervention. Healthcare professionals can use these data to adjust treatment plans, provide feedback, and offer support, ensuring that patients receive personalized and ongoing care. Moreover, remote monitoring enables healthcare providers to detect and manage chronic conditions, preventing the need for hospitalization and reducing healthcare costs.

Cost-Effectiveness

The cost of healthcare services is often a significant barrier for individuals living in rural communities, who may have limited financial resources. Digital therapeutics offer a cost-effective alternative to traditional treatment modalities, eliminating the need for physical infrastructure, reducing the demand for specialized personnel, and can be scaled up to reach a large number of individuals simultaneously. This affordability makes digital therapeutics an attractive solution for resource-

[1] *https://pharmanewsintel.com/features/challenges-to-improving-access-to-digital-therapeutics-in-healthcare.*
[2] *https://www.forbes.com/sites/glennllopis/2020/08/09/digital-therapeutics-are-accelerating--personalization-in-healthcare/?sh=717660162176.*

constrained healthcare systems and ensures that individuals with limited financial means can access quality care.[3]

Lastly, the challenges of accessing healthcare services in rural communities demand innovative solutions that can overcome barriers to access, deliver personalized interventions, and reduce stigma. Digital therapeutics provide a promising way forward, offering accessible, personalized, evidence-based, and cost-effective care. As technology continues to advance, the integration of digital therapeutics into mainstream healthcare systems has the potential to revolutionize the delivery of healthcare services in rural communities, improving outcomes and transforming lives on a global scale. By leveraging the power of technology, digital therapeutics offer a transformative solution that bridges the gap between patients and care providers, ensuring that every individual, regardless of their geographical location, receives timely, effective, and personalized care.

We look forward to further engaging with your committee on these critical issues. Please contact Sara Elalamy at sara@dtxalliance.org for any further information or insights.

Sincerely,

Sara Elalamy
Director of U.S. Government Affairs

FEDERATION OF AMERICAN HOSPITALS
750 9th Street, NW, Suite 600
Washington, DC 20001
202–624–1500
FAX 202–737–6462
https://www.fah.org/

May 17, 2023

The Hon. Benjamin L. Cardin
United States Senate
509 Hart Senate Office Building
Washington, DC 20510

The Hon. Steve Daines
United States Senate
320 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines,

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

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

The FAH and our member hospitals share the Subcommittee's goal of improving access to care in rural communities. More than 60 million Americans live in rural areas across the country[1] and rely on their local hospital as their main access point for receiving the care they need. These rural hospitals face major stresses and challenges including growing inflation, a unique patient mix, low patient volume, a growing workforce crisis, and funding shortfalls. These factors have contributed to the shuttering of 136 rural hospitals since 2010, including a record 19 closures in 2020 alone.[2]

Fortunately, there are several legislative solutions Congress can enact to support rural hospitals and their patients. To help further the Subcommittee's goal of improving health care access in rural communities, this Statement for the Record addresses: preventing Medicaid DSH cuts; making permanent Low Volume and

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[3] *https://www.nature.com/articles/s41440-022-00952-x.*
[1] FAH Blog: *https://www.fah.org/fah-celebrates-rural-hospital-week-2022/.*
[2] AHA Report: *https://www.aha.org/news/headline/2022-09-08-aha-report-rural-hospital-closures-threaten-patient-access-care.*

Medicare-dependent Hospital payment programs (LVH/MDH); a rural Medicare Disproportionate Share Hospital (DSH) equity legislative concept; health care workforce solutions; maintaining the current ban on self-referral to physician-owned hospitals; and opposition to site neutral policies.

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

Prevent Medicaid DSH Cuts

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

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

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

Make Permanent the MDH and LVH Adjustment Payment Programs

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

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

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

Advance Rural Health Equity by Enacting Rural DSH Parity

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

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

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

Investment in Health Care Workforce in Rural America

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

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

Hospitals are also investing heavily in both training and patient care management innovation to improve the bandwidth of registered nurses and reduce nurse

workload burden. Allowing nurses to reduce paperwork and non-clinical responsibilities through technology and process enhancements would have the added benefit of reducing burnout.

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

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

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

Enact Bipartisan Senate Rural Health Agenda

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

We urge the Senate to enact the following legislation:

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

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

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

[4] Center for Healthcare Quality and Payment Reform: *https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.*

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

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

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

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

The law helps ensure that full-service community hospitals, especially those in rural communities, can continue to meet their mission to provide quality care to patients. Data from the health care consulting firm Dobson | DaVanzo, released last month,[5] shows that POHs, when compared to other hospitals, treat less medically complex and more financially lucrative patients, provide fewer emergency services, and treat fewer COVID–19 cases. Specifically, the new study shows that POHs:

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

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

CMS itself recently proposed to reimpose "program integrity restrictions" on POH expansion criteria to guard against "a significant risk of program or patient abuse," and to "protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking."[6]

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

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

Oppose Cutting Medicare Through Site-Neutral Payment Cuts

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

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[5] Dobson | DaVanzo Study: *https://www.fah.org/wp-content/uploads/2023/03/2023-Fact-Sheet_20230323_wAppendixandCharts_POH-vs.-NonPOH-Only.pdf.*

[6] FAH Blog on POH. April 24, 2023: *https://www.fah.org/blog/physician-owned-hospitals-are-bad-for-patients-and-communities/.*

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

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

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

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

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

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

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

Telehealth

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

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

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

Sincerely,

Charles N. Kahn III
President and CEO

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[8] FAH Blog on Site Neutral: April 23, 2023: *https://www.fah.org/whats-in-a-name-because-there-is-nothing-neutral-about-site-neutral-policy/*.

[9] AHA Report: *https://www.aha.org/guidesreports/2023-03-27-comparison-medicare-beneficiary-characteristics-report.*

FREESPIRA, INC.
12020 113th Avenue NE
Building C, Suite #215
Kirkland, WA 98034
800–735–8995
FAX: 844–394–2533
https://freespira.com/

May 17, 2023

U.S. Senate
Subcommittee on Health Care
Committee on Finance
Chairman Benjamin L. Cardin
Ranking Member Steve Daines
430 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

Freespira, Inc. commends the work of the Senate Subcommittee on Health Care for examining obstacles and opportunities to improve health care access in rural communities.

Rural communities often face significant challenges in accessing healthcare services, including limited resources, long distances to healthcare facilities, and a shortage of healthcare professionals. However, the emergence of digital therapeutics offers a promising solution to address these issues and transform the landscape of healthcare delivery in rural areas. By leveraging the power of technology, digital therapeutics provide accessible, personalized, and evidence-based interventions, effectively bridging the gap between patients and care providers.

Increased Access

Digital therapeutics provide a convenient and accessible alternative to traditional healthcare services for individuals living in rural communities. Patients can access these interventions through mobile applications, web-based platforms, and telehealth services from the comfort of their homes, eliminating the need for long travel times and expenses associated with accessing healthcare services in urban areas. This increased access to care ensures that individuals in rural communities receive timely and effective interventions, reducing the burden of chronic conditions and preventing the progression of diseases.

Personalized Care

Digital therapeutics offer tailored interventions based on individual needs, preferences, and progress. Machine learning algorithms and data-driven approaches help analyze user input and provide personalized treatment plans. These interventions can include cognitive-behavioral therapy (CBT), mindfulness exercises, psychoeducation, and medication adherence support. By personalizing care, digital therapeutics foster a sense of autonomy and empower individuals to actively participate in their own recovery journey. Moreover, engaging interfaces, gamification elements, and interactive features enhance user engagement, motivation, and adherence to treatment protocols.

Remote Monitoring and Continuous Care

Digital therapeutics enable remote monitoring and continuous care, particularly critical for individuals living in rural communities with limited access to healthcare services. Wearables and sensors can track physiological and behavioral data, providing valuable insights into a patient's progress and facilitating early intervention. Healthcare professionals can use these data to adjust treatment plans, provide feedback, and offer support, ensuring that patients receive personalized and ongoing care. Moreover, remote monitoring enables healthcare providers to detect and manage chronic conditions, preventing the need for hospitalization and reducing healthcare costs.

Cost-Effectiveness

The cost of healthcare services is often a significant barrier for individuals living in rural communities, who may have limited financial resources. Digital therapeutics offer a cost-effective alternative to traditional treatment modalities, eliminating the need for physical infrastructure, reducing the demand for specialized personnel, and can be scaled up to reach a large number of individuals simultaneously. This affordability makes digital therapeutics an attractive solution for resource-

constrained healthcare systems and ensures that individuals with limited financial means can access quality care.

The challenges of accessing healthcare services in rural communities demand innovative solutions that can overcome barriers to access, deliver personalized interventions, and reduce stigma. Digital therapeutics provide a promising way forward, offering accessible, personalized, evidence-based, and cost-effective care. As technology continues to advance, the integration of digital therapeutics into mainstream healthcare systems has the potential to revolutionize the delivery of healthcare services in rural communities, improving outcomes and transforming lives on a global scale. By leveraging the power of technology, digital therapeutics offer a transformative solution that bridges the gap between patients and care providers, ensuring that every individual, regardless of their geographical location, receives timely, effective, and personalized care.

Our *Freespira digital therapeutic* is an evidenced-based, FDA cleared treatment for Panic Disorder, Panic Attacks, and PTSD. Patients are treated in their home with Freespira, and many of our patients are in rural settings. To date, many thousands of patients have been treated with Freespira, resulting in life-changing improvements in their symptoms and quality of life.

Unfortunately, only a handful of insurance companies are paying for the Freespira treatment for their members, so the number of patients covered is minuscule compared to the number of patients in the U.S. suffering from Panic and PTSD. We consistently receive requests from patients diagnosed with Panic and PTSD who want to be treated with the Freespira treatment, but neither their insurance company nor CMS will pay for their treatment, thus limiting access. The Freespira treatment has demonstrated cost reduction in both commercial and Medicaid populations, yet the lack of clarity around reimbursement for digital therapeutics creates a significant barrier to patient access, which does not allow these treatments to reach their full potential in improving patient outcomes and reducing healthcare costs.

We look forward to further engaging with your committee on these critical issues. Please contact Debra@freespira.com for any further information or insights.

Sincerely,

Debra Reisenthel
Founding CEO

MEDRHYTHMS, INC.
https://medrhythms.com/

May 23, 2023

U.S. Senate
Subcommittee on Health Care
Committee on Finance
Chairman Benjamin L. Cardin
Ranking Member Steve Daines
430 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

MedRhythms commends the work of the Senate Subcommittee on Health Care for examining obstacles and opportunities to improve health care access in rural communities.

Rural communities face significantly greater challenges in accessing healthcare services due to limited resources, long distances to healthcare facilities, and a shortage of licensed healthcare professionals. Healthcare access and quality, or lack thereof in rural communities, is a social determinant of health which can be overcome when Prescription Digital Therapeutics (PDTs) are available. With the emergence of PDTs, the landscape of healthcare delivery in rural areas can be transformed. PDTs are evidence-based therapeutic interventions that are driven by high quality software programs to treat, manage, or prevent a disease or disorder. They are used independently or in concert with medications, devices, or other therapies to optimize patient care and health outcomes.

Increased Access

The adoption of PDTs can level the healthcare playing field for individuals living in rural communities. PDTs can be provided to patients in a variety of ways considering their healthcare needs including software preloaded in a medical device that is delivered to the patient' home or a downloadable mobile application. These technologies are designed such that they require very little connectivity to WIFI or cellular networks to function addressing another challenge that exists in many rural areas. Furthermore, data has shown that utilizing these interventions in the comfort of the patient's home, eliminating the need for long travel times and expenses associated with accessing healthcare services in urban areas improves adherence to therapy and health outcomes. This increased access to care ensures that individuals in rural communities receive timely and effective interventions, reducing the burden of chronic conditions and preventing the progression of diseases.

Personalized Care

PDTs offer personalized interventions based on patient specific clinical goals based on machine learning algorithms and data-driven approaches. By personalizing care, PDTs foster a sense of autonomy and empower individuals to actively participate in their own recovery journey.

Remote Monitoring and Continuous Care

PDTs can enable remote monitoring, particularly critical for individuals living in rural communities with limited access to healthcare services. Wearables and sensors can track physiological and behavioral data, providing valuable insights into a patient's progress and facilitating early intervention. Healthcare professionals can use these data to adjust treatment plans ensuring that patients receive personalized and ongoing care in the most efficient manner. Moreover, remote monitoring enables healthcare providers to detect and manage chronic conditions, preventing the need for hospitalization and reducing healthcare costs.

Cost-Effectiveness

The challenges of accessing healthcare services in rural communities demand innovative solutions that can overcome barriers to access, deliver personalized interventions, and reduce cost. PDTs provide a promising way forward, offering accessible, personalized, evidence-based, and cost-effective care. As technology continues to advance, the further integration of PDTs into the healthcare systems has the potential to revolutionize the delivery of healthcare services in rural communities, improving outcomes and transforming lives on a global scale.

We look forward to further engaging with your committee on these critical issues. Please contact me at Owen@Medrhythms.com for any further information or insights.

Sincerely,

Owen McCarthy
President

NATIONAL ASSOCIATION OF ACOS

2001 L Street, NW, Suite 500
Washington, DC 20036
202–640–1985
advocacy@naacos.com
https://www.naacos.com/

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the health subcommittee's hearing on "Improving Health Care Access in Rural Communities: Obstacles and Opportunities." NAACOS represents more than 400 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 8 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs).

NAACOS appreciates the committee's leadership and commitment to improving access to health care in rural communities. Access to health care in rural communities presents many unique challenges with many communities facing shortages of pro-

viders. The USDA Economic Research Service published data last year showing that 40 percent of rural areas face primary care shortages and 80 percent have shortages of behavioral health services.[1]

For years doctors, hospitals, and other providers have been paid for each service provided—a system commonly referred to as fee-for-service. In recent years, innovative providers and policymakers have increasingly recognized the need to transition to alternative systems that reward accountability and create incentives for providing care in a coordinated manner focused around placing people at the center of their care, and keeping them healthy, rather than just treating them when they get sick.

The ACO model provides an opportunity for providers to work collaboratively along the continuum while remaining independent. With primary care as the backbone, ACOs can employ a team-based approach that allows clinicians to ensure patients receive high quality care in the right setting at the right time. Importantly, ACOs provides enhanced flexibilities that allow clinicians to develop interventions targeted to their populations.

Value-based care is the best care model for all patients, and we have seen significant adoption among rural providers. However, adoption of ACOs and value-based care has been stalled by several underlying issues. Specifically, a focus for rural providers is retaining access to care. Approaches that require savings to Medicare through discounts or shared savings may not be appropriate for providers who are paid at cost or are struggling to remain open.

As the committee continues to discuss long-term approaches to improving health care access in rural communities, we urge the committee to consider the following recommendations which would attract more rural providers to participate in value-based care models.

Extend Financial Incentives for Qualifying APMs. Appropriate financial incentives help attract physicians and other clinicians to participate in advanced APMs and reward those that continue to move forward on their value transitions. These incentive payments also provide financial support that helps rural practices join and remain in risk-based payment models. Many practices also reinvest these payments to help expand services for patients.

In 2022, Congress included a 12-month extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023. While this short-term extension ensures that the nearly 300,000 clinicians working to improve the quality and cost-effectiveness of care continue to have the financial resources to do so, it will expire at the end of 2023. Going forward the committee should consider:

- Providing a multi-year commitment to reforming care delivery by extending MACRA's 5 percent advanced APM incentive payments.
- Ensuring that qualifying thresholds remain attainable to promote program growth by giving the Centers for Medicare and Medicaid Services (CMS) authority to adjust qualifying thresholds through rulemaking and set varying thresholds for models that have difficulty qualifying because of design elements.

Ensure Participants Join and Remain in Existing APMs. Current and past APMs have allowed physicians and other clinicians to change care delivery and improve care coordination. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care. The MSSP is the largest and most successful value-based care program in Medicare and the committee should consider the following recommendations to continue driving innovation:

- Removing the high-low revenue designation in the MSSP that penalizes certain ACOs, especially safety net providers like Rural Health Clinics (RHCs), Critical Access Hospitals, and Federally Qualified Health Centers (FQHCs).
- Developing systems for Medicare to provide technical assistance for APMs that serve rural and underserved populations.
- Directing CMS to establish guardrails to ensure that the process to set financial benchmarks is transparent and appropriately accounts for regional variations in spending to prevent winners and losers.
- Engaging with CMS to encourage the agency to pilot test ACO quality reporting changes to address remaining implementation challenges that exist with the current policy. Otherwise, some ACOs may choose to leave the program because of increased costs and burdens.

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[1] *https://www.ers.usda.gov/amber-waves/2022/august/the-most-rural-counties-have-the-fewest-health-care-services-available/*.

Provide a Broader, More Predictable Pathway for More Types of Clinicians to Engage in APMs. Congress established the Center for Medicare and Medicaid Innovation (CMMI) in 2010 to develop and test innovative payment and service delivery models. While CMS's population health models have seen encouraging growth over the last 10 years, there has been insufficient model development for all types of physicians and other clinicians.

CMMI has tested over 50 models, expanding our understanding of how to shift payment and care processes to improve patient outcomes. However, few models have met the criteria for expansion and lessons learned are not always translated into new models. Unfortunately, little is known about the parameters that must be met for expansion and the model evaluations fail to consider key aspects of innovating care.

Congress should work with CMMI to ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. In February, NAACOS and other stakeholders sent a letter to committee leaders outlining the following recommendations for improving CMMI, including:[2]

- Broadening the criteria by which CMMI models qualify for Phase 2 expansion (*e.g.,* does the model account for retaining access to care in vulnerable regions).
- Directing CMMI to engage stakeholder perspectives during APM development, such as leveraging the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Evaluate Parity Between Medicare Value Programs. APMs and the Medicare Advantage (MA) program provide opportunity for providers to innovate care and move payments away from fragmented care options to coordinate care that is rewarded for value. As Congress looks for ways to improve access to care for rural communities it is important to understand how the differences between programs like APMs and MA impact care delivery. The committee should work with the Government Accountability Office (GAO) to design a study to evaluate parity between APMs and MA so policymakers can seek greater alignment between the programs to ensure that both models provide attractive, sustainable options for innovating care delivery, and to ensure that APMs do not face a competitive disadvantage.

We appreciate the opportunity to express our views and look forward to working with the committee to ensure that high-quality, coordinated, and person-centered care is accessible to all Medicare beneficiaries.

NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS
1009 Duke Street
Alexandria, VA 22314

On behalf of the over 5,300 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[1] and 11% of the entire country (approximately 37 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America. However, recent trends in healthcare such as the increased adoption of telehealth and the continued growth of Medicare Advantage present obstacles to the continued success of our nation's Rural Health Clinics.

While healthcare-wide trends such as increasingly complex prior authorization burdens and healthcare workforce shortages have major impacts on Rural Health Clinics, we would like to focus this statement on the following RHC-specific issues:

1—Medicare Advantage;
2—Telehealth Policy;
3—Outdated Conditions for Certification; and
4—Value-Based Care for RHCs.

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[2] *https://www.naacos.com/assets/docs/pdf/2023/118thCongressValue-BasedCareRecsCoalitionLetter.pdf.*

[1] *https://www.narhc.org/News/29910/Sixty-Percent-of-Rural-Americans-Served-by-Rural-Health-Clinics.*

Medicare Advantage

The RHC program incentivizes providers to practice in rural areas through two major benefits: enhanced Medicaid reimbursement, and enhanced Medicare reimbursement. Operating as a rural health clinic provides no benefit relative to Medicare Advantage (MA) reimbursement.

This fact stands in contrast to Federally Qualified Health Centers (FQHCs), who receive supplemental payments[2] from Medicare which make up the difference between what traditional Medicare would pay and what the Medicare Advantage plans are offering. This policy ensures that FQHCs are not disadvantaged if their patients are increasingly enrolled in Medicare Advantage plans.

As Medicare Advantage enrollment now exceeds[3] 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. We conducted a survey of RHCs and found that approximately half of our RHCs reported that Medicare Advantage plans do not pay the same as traditional Medicare.

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. Our fear is that Medicare Advantage plans will enroll a substantial portion of the local Medicare population and refuse to offer RHCs reimbursement rates that are tenable in rural settings.

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.

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[4] 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[5] 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

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[2] *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-X/subject-group-ECFRb16e804c561ceb4/section-405.2469.*

[3] *https://www.barrons.com/articles/medicare-advantage-surpasses-traditional-medicare-2e5ba7b9.*

[4] *https://www.narhc.org/News/28244/NARHC-Sends-Letter-to-Trump-Administration-on-Telehealth-Services-During-Covid-19-Pandemic*

[5] *https://www.narhc.org/News/28271/CARES-Act-Signed-Into-Law.*

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.

Should Congress agree to reimbursing RHCs and FQHCs through their normal payment mechanisms, NARHC believes that some guardrails may need to be created to ensure that only safety-net providers serving safety-net patients may receive the enhanced reimbursement rates. We do not want to create a loophole that allows patients and clinicians in well-served suburban or urban areas to route their telehealth billing through the RHC and take advantage of the RHC reimbursement methodology.

We are pleased that the CONNECT for Health Act would eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs and we urge Congress to rectify this issue, at the latest, as part of any telehealth extension legislation.

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[6] 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[7] 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.

Value-Based Care for Rural Health Clinics

NARHC supports the establishment of a quality payment program designed specifically for Rural Health Clinics. As discussed above, the RHC program offers a unique reimbursement structure for both Medicare and Medicaid patients and this payment model is the key distinguishing feature of the entire program. The enhanced payment methodology allows for clinics and clinicians to operate in rural and underserved areas, significantly bolstering access to outpatient care in these communities.

The unique mechanisms of RHC reimbursement have made it difficult and/or impossible for RHCs to properly participate in Medicare quality programs. The current slate of quality initiatives available to providers are designed for traditional fee-for-service (FFS) settings and do not translate well into the RHC space. As an example,

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[6] *https://www.narhc.org/News/29766/RHC-Burden-Reduction-Act-Introduced-by-Senators-Barrasso-Smith-Blackburn-and-Bennet.*

[7] *https://ojin.nursingworld.org/table-of-contents/volume-26-2021/number-2-may-2021/post-covid-19-reimbursement-parity-for-nurse-practitioners/.*

RHCs use a different form to submit claims to Medicare than their peers, the UB–04, as opposed to the CMS–1500 that fee-for-service providers use. As a result of this fundamental fact, RHC Medicare reimbursement is not compatible with many of the Medicare quality and value-based programs.

We believe that clinicians that bill exclusively through the RHC payment methodology should have an opportunity to participate in some type of quality payment program. As HHS sets ambitious goals to have every Medicare beneficiary in a value-based care relationship by 2030, it is imperative for us to consider how the safety-net programs, specifically RHCs and FQHCs, will be able to participate in this broader vision.

RHC participation in quality programs could be greatly increased and improved if a quality payment program specifically for RHCs was created. Because the RHC payment structure is essential to the RHC program but also quite different than FFS payment, NARHC asserts that the best way to bring value into the RHC model is to design a program solely for RHCs using the All-Inclusive Rate methodology as the foundation. We believe that such a quality reporting program could be implemented in a cost neutral way that would improve efficiency and encourage improved value-based care across the entire RHC program.

Conclusion

The National Association of Rural Health Clinics thanks the Senate Finance Subcommittee on Health for organizing this hearing. We hope that the above statement helps illuminate some of the policy obstacles and opportunities facing the 5,300 Rural Health Clinics across the country. Should the Committee have any questions, the NARHC is happy to serve as a resource, you may reach us by phone at (202) 543–0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.

RENALIS
425 Literary Road
Cleveland, OH 44113

May 17, 2023

U.S. Senate
Committee on Finance
Subcommittee on Health Care
Chairman Benjamin L. Cardin
Ranking Member Steve Daines
430 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

Renalis commends the work of the Senate Subcommittee on Health Care for examining obstacles and opportunities to improve health care access in rural communities.

Introduction to Renalis

Renalis is a Cleveland-based company committed to developing pelvic health platforms to improve effectiveness and efficiency of Patient and Urology Provider interactions, optimize patient outcomes, and decrease healthcare costs.

Renalis' first commercial platform will be an FDA-approved prescription digital therapeutic for Overactive Bladder (OAB) in women. Of the 33 million adult Americans suffering from some form of urinary incontinence, 75% to 80% of those are women. And about 23% of these women are over 60.

Urinary Care in the Rural Communities

Rural communities face significant challenges in accessing healthcare services, including limited resources, long distances to healthcare facilities, and a shortage of healthcare professionals. When a woman seeks care like OAB, unfortunately, if she happens to live in one of the over 60% of the counties that have ZERO Urology Providers, she will not be able to access the high-quality in-person care that she needs. (Please see last page for the US Map).

OAB affects performance of daily activities and social function such as work, traveling, physical exercise, sleep and sexual function. If this condition is left untreated, it leads to impaired quality of life accompanied by emotional distress and depression.

Innovative Solution to Increase Access

The emergence of digital therapeutics offers a promising solution to address these issues and transform the landscape of healthcare delivery in rural areas. By leveraging the power of technology, digital therapeutics provide accessible, personalized, and evidence-based interventions, effectively bridging the gap between patients and care providers.

Digital therapeutics provide a convenient and accessible alternative to traditional healthcare services for individuals living in rural communities. Patients can access these interventions through mobile applications, web-based platforms, and telehealth services from the comfort of their homes, eliminating the need for long travel times and expenses associated with accessing healthcare services in urban areas. This increased access to care ensures that individuals in rural communities receive timely and effective interventions, reducing the burden of chronic conditions and preventing the progression of diseases.

Personalized Care

Digital therapeutics offer tailored interventions based on individual needs, preferences, and progress. Machine learning algorithms and data-driven approaches help analyze user input and provide personalized treatment plans. These interventions can include cognitive-behavioral therapy (CBT), mindfulness exercises, psychoeducation, and medication adherence support. By personalizing care, digital therapeutics foster a sense of autonomy and empower individuals to actively participate in their own recovery journey. Moreover, engaging interfaces, gamification elements, and interactive features enhance user engagement, motivation, and adherence to treatment protocols.

Remote Monitoring and Continuous Care

Digital therapeutics enable remote monitoring and continuous care, particularly critical for individuals living in rural communities with limited access to healthcare services. The digital dashboard can track a patient's progress. Healthcare professionals can use this data to adjust treatment plans, provide feedback, and offer support, ensuring that patients receive personalized and ongoing care. Moreover, remote monitoring enables healthcare providers to detect and manage chronic conditions, preventing the need for hospitalization and reducing healthcare costs.

Cost-Effectiveness

The cost of healthcare services is often a significant barrier for individuals living in rural communities, who may have limited financial resources. Digital therapeutics offer a cost-effective alternative to traditional treatment modalities, eliminating the need for physical infrastructure, reducing the demand for specialized personnel, and can be scaled up to reach many individuals simultaneously. This affordability makes digital therapeutics an attractive solution for resource-constrained healthcare systems and ensures that individuals with limited financial means can access quality care.

The challenges of accessing healthcare services in rural communities demand innovative solutions that can overcome barriers to access, deliver personalized interventions, and reduce stigma. Digital therapeutics provide a promising way forward, offering accessible, personalized, evidence-based, and cost-effective care. As technology continues to advance, the integration of digital therapeutics into mainstream healthcare systems has the potential to revolutionize the delivery of healthcare services in rural communities, improving outcomes and transforming lives on a global scale. By leveraging the power of technology, digital therapeutics offer a transformative solution that bridges the gap between patients and care providers, ensuring that every individual, regardless of their geographical location, receives timely, effective, and personalized care.

Renalis welcomes the opportunity to discuss in further detail. If you have any questions regarding these comments, please do not hesitate to contact me at: (312) 287–1951 or at: missy@renalis.health.

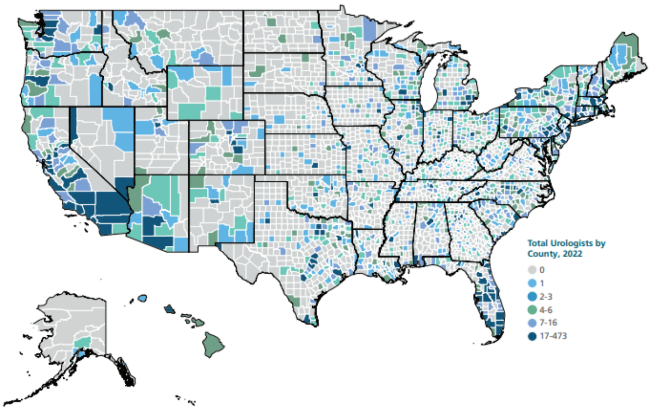
Respectfully submitted,

Missy Lavender
CEO and Founder

Attachment: Over 60% of counties have ZERO Urologists.

FIGURE 1-5

Number of Practicing Urologists (by County)



Data sources: National Provider Identifier 09/2022 file and ABU certification records from the ABMS Directory of Board-Certified Medical Specialists.

*Some AUA Sections have non-U.S. urologists who were not included in this report due to a lack of urologist population files in those countries.

TABLE 1–5
Rurality Level of Primary Practice Location

Rurality Level*	Number of Practicing Urologists	Percent (%)
Metropolitan areas	12,576	90.0
Nonmetropolitan areas	1,397	10.0
Micropolitan	1,111	7.9
Small town	224	1.7
Rural	62	0.5
Total	**13,976**	**100.0**

Data sources: National Provider Identifier 09/2022 file, Rural-Urban Commuting Area Codes Data from RUCA3.10.

*An area was classified as a Metropolitan Area with a population size ≥ 50,000 or a Nonmetropolitan Area otherwise. The Nonmetropolitan Area was further classified as Micropolitan Area (population 10,000–49,999), Small Town (population 2,500–9,999) and Rural Area (population < 2,500).

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