Kansas Hospital
ASSOCIATION

The Honorable Jason Smith
Chairman
Committee on Ways and Means
United States House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith and Members of the Committee,

The Kansas Hospital Association (KHA) is pleased to offer comments on your request for information on rural health care. KHA is a non-profit membership organization. Our membership includes 82 Critical Access Hospitals, 24 Rural Sole Community and Medicare Dependent Hospitals, and 17 Urban and Specialty Hospitals.

Our state and rural hospitals face significant challenges, including the following:

- The overall health of Kansans has declined more than any other state over the past 30 years. Residents in rural areas suffer from higher rates of chronic health conditions.

- The population in rural Kansas has been shrinking and will continue to do so. The economic impact of a declining population is particularly significant for rural hospitals.

- The population in rural Kansas continues to get older. The largest age group in over half of Kansas counties is 70 or older. These adults often have more complex health conditions and require access to health care frequently.

- Most of Kansas is classified as frontier (37 out of 105 counties) or rural (89 out of 105 counties). Older residents in these counties often face transportation challenges, making accessing health care services outside their community difficult.

- The number of uninsured patients in rural Kansas continues to grow.

- How hospitals deliver care in our state has changed. Many common procedures no longer require an overnight hospital stay. Current data shows that 37 Kansas hospitals have fewer than two patients staying overnight on any given day. Technology and specialists needed for complex procedures are available at a regional level rather than locally.

- Kansas hospitals are financially struggling. Recent studies report that 79% of Kansas hospitals operate with a negative margin, and 60 Kansas hospitals are at risk for closure.

Kansas hospitals are committed to working on efforts that provide flexibility for rural communities while sustaining access to care. There is no one-size-fits-all all fix to the challenges facing rural health care. A variety of solutions will be needed. The policy solutions in our response would significantly impact access, affordability, and provider stability.

Sustainable Provider and Facility Financing

Rural Hospital Designations

As the Committee notes, there is a patchwork of Medicare payment designations aimed at supporting rural hospitals. Each designation is designed to alleviate a particular challenge for a subset of rural hospitals. For example, CAHs are paid at 101% of reasonable costs to reduce financial vulnerability, while low-volume hospitals (LVH) receive a payment adjustment to account for extremely low patient volumes. While it is necessary to truly fix rural healthcare financing challenges, overhauling the current framework of different payment designations is likely not a feasible path forward. KHA supports NRHA's suggestion that Congress direct the Government Accountability Office (GAO) to assess the effectiveness of current rural hospital and provider designations. The outcome of this study should then be used to inform changes to rural hospital payment mechanisms. Congress should also give HHS the authority to act upon the evidence-based findings in the assessment to fix rural provider payment.

In a year set to surpass the highest number of rural hospital closures, incremental changes can help keep providers open in the meantime. H.R. 833, Save America's Rural Hospitals Act, includes several critical fixes for rural hospitals that would improve financial stability and ease administrative burdens, including exempting rural hospitals from Medicare sequestration, reinstating hold harmless provisions for Sole-Community Hospitals (SCH) and reversing cuts to bad debt for critical access hospitals (CAHs). For CAHs, in particular, their reimbursement at 101% of reasonable costs is actually at 99% given sequestration, meaning they are currently providing services to Medicare beneficiaries at a loss.

KHA also suggests reopening necessary provider status for CAHs, which ended in 2006. The Rural Hospital Closure Relief Act, S. 1571, should be introduced in the House to waive the 35-mile rule and bring back necessary provider status with certain parameters. Additionally, Medicare Dependent Hospital (MDH) and LVH designations and payment adjustments should be made permanent rather than continually facing the uncertainty of their designation. The House should support H.R. 833 and/or pursue a companion bill to S. 1110, the Rural Hospital Support Act, to do so.

Medicare cost report methods date back to 1965 and have remained largely unchanged since. Congress should direct CMS to establish a working group to address critical issues such as waiver or modification of CAH cost allocation regulations to allow greater integrated community services and review of cost exclusions that further reduce hospital reimbursement for essential services.

Support for rural provider capital and technical assistance (TA) is essential. In many cases, Medicare reimbursement is insufficient to cover the cost of care, and rural hospitals accept a loss when providing Medicare services, as discussed above. This leaves little room for rural hospitals to pay for overhead costs and keep up with infrastructure and technology improvements. The House should reintroduce the Hospital Revitalization Act in the 118th Congress to provide for a grant program that assists hospitals with the costs of upgrading physical infrastructure and expanding facility capacity. Other than physical upgrades, rural hospitals require support to purchase or upgrade EHR technology to meet interoperability standards. H.R. 4713, the Rural Hospital Technical Assistance Program Act, was introduced recently and authorized a program that has supported almost 20 rural hospitals through TA to date. The program assists in improving their financial position, increasing operational efficiencies, implementing quality improvements, addressing workforce recruitment and retention, and more. Further, H.R. 833 reauthorizes the critical Medicare Rural Hospital Flexibility program, which provides TA to CAHs, Rural Emergency Hospitals (REHs), and rural PPS hospitals.

Rural Emergency Hospital Fixes

Our members were pleased when Congress authorized the Rural Emergency Hospital Program. It shares many similarities to the Primary Health Center Model that Kansas hospitals spent years developing. We believe the services allowed would be a good fit for many communities struggling to sustain their hospitals. As a state that took early action to prepare for this opportunity, we currently have two hospitals in the process of conversion.

The REH program could use several legislative changes to make it more accessible for hospitals that otherwise cannot currently transition. Communities that have lost their hospitals to closure in the recent past have expressed interest in the REH Model. However, the enabling legislation limits the opportunity to hospitals currently in operation. KHA urges Congress to consider options for allowing those recently closed entities to be eligible for the REH model. Some hospitals that would benefit from converting are barred due to statutory date restrictions: hospitals that closed before December 27, 2020; providers that essentially furnish REH services (Frontier Extended Stay Clinics and hospitals that converted to outpatient provider-based entities); rural hospitals that reduced their bed count below 50 after December 27, 2020; and hospitals designated as rural by their state but did not have active reclassification with CMS under 42 C.F.R. § 412.103.
Restrictions on participation in certain hospital programs create a barrier to conversion. KHA urges Congress to add REHs as covered entities in the 340B statute. Some hospitals exploring conversion have put it off because they would lose their 340B savings. KHA members have also expressed concerns over losing swing bed capacity and inpatient psychiatric distinct part units.

Further, KHA believes that the 5% add-on payment for all OPPS services should be extended to non-OPPS services paid under other fee schedules. In addition, a one-time upfront payment to support infrastructure improvements would be valuable for aging hospitals considering conversion.

The success of the REH Program is critical to preserving access to essential health care services in rural communities. Thus, Congress should do all it can to eliminate uncertainty from the REH conversion process. One way to do so is by making clear that a critical access hospital that is

designated as a necessary provider that converts to an REH can, if it chooses to do so, revert to CAH status without reapplying through the federal government. Current CMS interpretation of the REH legislation would prohibit a necessary provider CAH who becomes an REH from reverting to CAH status without reapplying. Because necessary provider status is no longer available to CAHs, hospitals are reticent to consider the REH model, even if it benefits them.

We saw this concern when the critical access hospital program was implemented as well. Hospitals and the communities they serve will not take a chance of losing their health care. We believe the CMS interpretation of the legislation directly contradicts its purpose–to protect healthcare access in rural areas. Making clear the intent was to allow even necessary providers to revert to their prior status without reapplying for that status is critical to the success of the REH program.

Medicare Advantage

Medicare Advantage plans have become a larger part of the market in rural areas. Our members are frustrated with the MA plans as they work with patients who don't have the coverage they believe they were sold with their MA plan. We will watch closely as CMS implements additional oversight and limitations on MA plans during the upcoming open enrollment to determine if more significant action is necessary to protect patients.

Emergency Medical Services

EMS agencies operate in a patchwork across the country, with financing and organization varying from state to state and even by locality. Due to workforce shortages and growing financial crisis, it is increasingly difficult for ambulance services to respond to emergencies in rural America. About a third of rural EMS agencies in the U.S. are in immediate operational jeopardy because they cannot cover their costs, largely from insufficient Medicaid and Medicare reimbursements, which pay, on average, a third of actual EMS costs. Private insurance pays considerably more than Medicaid, but because of low call volumes, EMS agencies cannot make up the difference in reimbursement. Thus, the federal government must help support EMS funding through sustainable reimbursement mechanisms. As a short-term measure, KHA supports H.R. 1666/S. 1672 to permanently increase Medicare payments for ground ambulance services in rural areas.

Aligning Sites of Service

There has been significant discussion in congress about implementing site neutral payments as a cost saving measure for Medicare and private insurance, ostensibly to be shared with patients. While on its face, this seems logical that a service should cost the same regardless of where it is provided, site-neutral policies ignore the very different requirements in place for different types of providers.

For example, a physician office or clinic is open for a limited number of hours a day, while a hospital is open 24/7. Physician offices and clinics can limit the number of non-paying or Medicare/Medicaid patients they care for to help maintain financial stability. Hospitals do not have that option. EMTALA

requires the evaluation and stabilization of every patient who presents in the hospital ER regardless of ability to pay. Hospitals are required to incur costs for services that may not result in payment. This requires the hospital to absorb those costs into all areas of service to maintain financial stability.

Site-neutral payment policies at any level ignore the difference in services and regulatory requirements between providers. Lowering reimbursement levels to that of providers with fewer requirements endangers the availability of services only hospitals provide to their communities and threatens access to care.

Healthcare Workforce

There are a number of actions which would assist in addressing current workforce issues at the federal level. The first is increasing funding for nursing educators to market rate. Congress must act to help support health care programs to ensure that our schools have the faculty available to prepare the next generation of health care workers for years to come. The first step is additional salary funding to support nursing and other allied health education programs in areas with the most significant shortages.

The second is creating an allied health equivalent of the Nurse Corps Scholarship Program. While there are many incentive programs for physicians and nurses, an incentive program for allied health careers, including Laboratory careers, is essentially nonexistent. Many of our hospitals have stressed to KHA that they are having increasing difficulty finding Lab employees. This high-demand need does not have appropriate incentives in the status quo. Loan Repayment/Service Programs are needed for additional health care occupations, in particular allied health roles like Pharmacy Technicians, Clinical Laboratory Technologists and Technicians, Radiologic Technologists and Technicians, Medical Dosimetrists, Medical Records Specialists, Health Technologists & Technicians, Respiratory Therapists, Occupational Therapy Assistants, Surgical Technologists, and Diagnostic Medical Sonographers.

The third is adding a Bachelor of Science in Nursing to the STEM degrees the Department of Homeland Security recognizes. Congress can act now to help address the nationwide nursing shortage by passing a bill that lists the Bachelor of Science in Nursing among the STEM degrees recognized by the Department of Homeland Security to allow students who attain them to stay in the United States for 17 months beyond the expiration of their student visas for "optional practical training."

In 2008, the Department of Homeland Security announced that foreign nationals who hold F-1 student visas could extend their stay in the United States by 17 months beyond the expiration of their visas to complete what is considered "optional practical training" (OPT)—an internship or job-related to their recently completed field of study—for students who receive degrees in a STEM field. This program has been upheld in court numerous times. Moreover, it is firmly entrenched in the fabric of the American labor market. As a result, it is often used as a bridge to permanent residency and

eventually citizenship for students who receive an American education in technically challenging fields with labor shortages.

A Bachelor of Science in Nursing degree does not qualify for DHS's STEM OPT 17-month visa extension program despite its relationship with science and technology. Additionally, DHS' profound backlog in processing H-class work visas means that many students who receive a high-quality American education leading to BSN degrees and have jobs lined up after graduation are forced to return to their home counties for visa processing. Congress should remedy this situation by passing a bill that lists BSN degrees in DHS' STEM OPT visa extension program, thus allowing these students to fill much-needed nursing job vacancies here in the United States.

Innovative Models and Technology

Public Health Emergency Flexibilities

One silver lining of the Public Health Emergency was that rural providers were freed from administrative burdens and outdated regulations. Rural providers often wear many different hats and spend precious time on administrative tasks that could be spent on patient care. Some PHE flexibilities require legislative action. NRHA calls on the Committee to implement these flexibilities permanently to make rural health care administration and delivery more efficient.

NRHA asks that Congress permanently end the 96-hour average length of stay rule for CAHs. Relatedly, KHA urges Congress to remove the condition of payment that requires physicians to certify upon admission that a patient can reasonably expect to be discharged within 96 hours. Annual average lengths of stay and certification requirements are too prohibitive. Rural hospitals need flexibility to treat patients as clinically appropriate in a local setting while adjusting to larger system fluctuations like infectious disease surges and delays in post-acute placement. We ask that the Committee advance H.R. 1565, the Critical Access Hospital Relief Act, out of Committee. For the average length of stay, the Committee should introduce legislation immediately to remove this outdated rule.

Further, KHA views the requirement for beneficiaries to have a 72-hour qualifying hospital stay before admission to a Skilled Nursing Facility or CAH Swing Bed as an outdated barrier to placing beneficiaries in the appropriate care setting that should be removed. Due to advances in treatment for many conditions, like joint replacements, hospital stays and recovery are short-term. In the past, a procedure would have a longer length of stay in acute care before transfer, but often, that is not the case now, and hospitals should be able to move beneficiaries to rehabilitative care appropriately. Congress should also allow direct admission to hospital swing beds for patients who do not require acute care and otherwise meet SNF admission criteria for many of the same reasons. This would help rural beneficiaries receive care when showing signs of declining health without waiting to deteriorate further or get sicker. Preventively allowing patients in swing beds would ultimately achieve cost savings for providers, the government, and beneficiaries while supporting patient safety and access.

Telehealth

During the PHE, several Medicare telehealth flexibilities were in place and were subsequently extended through the end of 2024 by Congress. Retaining these flexibilities is essential to patient access in rural communities. NRHA urges Congress to continue these flexibilities permanently. In particular, it is critical that RHCs remain eligible distant site providers and receive payment parity to in-person services.

For RHCs, providing reimbursement for telehealth services at a lower rate than in-person makes telehealth unsustainable in the long-term, given their cost structure and volumes of services. RHCs maintain a brick-and-mortar location in addition to furnishing care via telehealth, meaning that they must continue to pay the overhead of operating a physical location plus staff regardless of the mode of care delivery, as well as pay for a telehealth platform. In order to increase access, there must be payment parity between telehealth and in-person.

Another telehealth priority is retaining audio-only telehealth. Older adults typically have less technology literacy and access to technology supporting audio-video telehealth. Keeping audio-only leaves the option for practitioners to decide that it is clinically appropriate to use this technology for beneficiaries who otherwise would not be able to access care.

Innovative Models

Fee-for-service reimbursement does not align with the reality of operating rural hospitals and providers, mainly due to low patient volumes. Value-based care, or population-based payment models, can potentially solve rural low-volume challenges that come with FFS payment. However, in some circumstances, CMS' Innovation Center has struggled to properly include rural providers in its models due to statutory barriers. In particular, Congress charged CMMI with developing and testing new payment and service delivery models that must achieve cost savings. The decades of underinvestment in rural healthcare delivery makes achieving cost savings virtually impossible. Alternative payment methodologies for rural providers and higher acuity patient mix can create additional barriers to model integration. In some cases, CMMI has explicitly excluded some rural providers from participating in their models. Most recently, RHCs were removed from the new Making Care Primary model. Another barrier is the requirement on the number of attributed beneficiaries for providers, which cuts out rural providers because of sparse patient populations and lower volumes.

Congress should direct investments to building out and supporting rural providers in value-based care. The Committee should grant greater authority to the HHS Secretary, through CMMI, to develop and implement voluntary alternative rural payment models. Such models should include a global budget or enhanced cost-based reimbursement. In addition, NRHA believes that exempting rural providers from CMMI's cost-savings mandate would alleviate some barriers to entry in innovative demonstration projects. Congress must equip CMMI with the authority to waive the cost savings requirement to develop rural-centric models or allow rural providers to engage in CMMI models broadly without achieving cost savings at the outset.

Thank you for the opportunity to weigh in on this critical issue. Please contact Jennifer Findley (jfindley@kha-net.org) with any questions or for more details on any of the information above.

KHA thanks the Committee for the opportunity to submit these comments and its continued work to support access to affordable, high-quality health care services in rural communities. As a state with a significant number of rural hospitals, KHA stands ready to provide any assistance to the Committee as it evaluates future ideas. If Committee Members would find it helpful to visit a small, rural hospital, I would happily coordinate that opportunity.

Sincerely,

Chad Austin
President and Chief Executive Officer
Kansas Hospital Association