American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

May 8, 2024

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 provide comments on legislative proposals that are to be considered before the Committee on Ways and Means on May 8. The AHA is providing feedback on sections of H.R. ___, the Preserving Telehealth, Hospital, and Ambulance Access Act (H.R. 7931), the PEAKS Act (H.R. 8245), the Rural Hospital Stabilization Act (H.R. 8235), the Rural Physician Workforce Preservation Act, and the Second Chances for Rural Hospitals Act (H.R. 8246).

H.R. ___, PRESERVING TELEHEALTH, HOSPITAL AND AMBULANCE ACCESS ACT

Telehealth Access

The AHA supports Section 101 to grant two-year extensions for key telehealth flexibilities before they expire on Dec. 31, 2024, to maintain patients' access to quality virtual care. We appreciate the committee's commitment in ensuring that essential telehealth flexibilities are extended so that patients continue to receive access to high-quality care. The expansion of telehealth services has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients, especially those with transportation or mobility limitations. Given current health

care challenges, including major clinician shortages nationwide, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. These provisions, including the removal of geographic and originating site requirements, the expansion of practitioners able to perform telehealth services, the delay of in-person visit requirements for mental health services furnished through telehealth, the extension of telehealth services for Federally Qualified Health Centers and Rural Health Clinics, and the continuation of audio-only telehealth services, are essential in accomplishing these goals.

The AHA also supports Section 102, which would require dissemination of best practices to support individuals with limited English proficiency in accessing telehealth services. By requiring the Department of Health and Human Services to issue best practices for how to integrate interpreters in telehealth encounters with behavioral health patients, teach patients with limited English proficiency how to use technology, and provide patient materials in multiple languages, this section will help bridge the digital divide for these patients.

Hospital-at-home Program

The AHA supports Section 104, to extend the hospital-at-home waiver for five years, through the end of 2029. The hospital-at-home (H@H) model — where patients receive acute-level care in their homes, rather than in a hospital — has emerged as a promising approach to provide high quality care to patients in the comfort of their homes.

The AHA commends the committee for including an extension of the H@H program. Over the past few years, hospitals and health systems have expressed the need for long-term stability within the H@H program. Standing up a H@H program requires logistical and technical work, with an investment of time, staff and money. In addition to being approved for the federal waiver, some providers must navigate additional regulatory requirements at the state level. For some, this whole process could take a year or more to complete before the first patient can be seen at home. A extension of the H@H program would provide much needed stability for existing programs to continue providing care and encouragement for additional hospitals and health systems to participate.

Medicare-dependent Hospital (MDH) and Low-volume Adjustment (LVA)

The network of hospitals, health systems and providers that serve rural Americans is financially fragile and more dependent on Medicare revenue due to the high percentage of Medicare beneficiaries who live in rural areas. Rural residents also on average tend to be older, have lower incomes and higher rates of chronic illness than urban counterparts. Medicare pays most acute-care hospitals under the inpatient prospective payment system (IPPS). Some of these hospitals receive additional support from Medicare to help address potential financial challenges associated with being rural, geographically isolated and low volume. MDHs are small, rural hospitals where at least

60% of admissions or patient days are from Medicare patients. MDHs receive the IPPS rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. The LVA provides increased payments to isolated, rural hospitals with a low number of discharges. **AHA supports Sections 201 and 202 to extend the MDH designation and the LVA as critical measures to protect the financial viability of rural hospitals to ensure they can continue providing access to care.**

H.R. 7931, PRESERVING EMERGENCY ACCESS IN KEY SITES ACT (PEAKS ACT)

Rural hospital-based ambulance service providers ensure timely access to emergency medical care but face higher costs than other areas due to lower patient volume. Medicare pays critical access hospital (CAH) owned and operated ambulance services 101% of reasonable costs if there are no other ambulance providers within a 35-mile drive of the CAH.

Patients seeking care at CAHs in mountainous terrain face unique transportation challenges. Congress has recognized those barriers to access by creating different CAH eligibility requirements for facilities that are more than a 15-mile drive from another hospital in an area with mountainous terrain or only secondary roads. Despite the shorter mileage criteria for the CAH designation in mountainous terrain, current law still only allows cost-based reimbursement for CAH-based ambulance services if there is no ambulance provider within 35-miles. **AHA supports the PEAKS Act provision providing cost-based reimbursement for CAH-based ambulance servicers where there are no other ambulance service providers within a 15-mile drive of a CAH in mountains terrain or in areas with only secondary roads.** This legislation aligns the CAH-designation mileage requirements and the mileage criteria for cost-based reimbursement for CAH-provided ambulance services to ensure improved access to emergency services for patients in isolated rural communities.

AHA supports reopening the necessary provider designation for CAHs to further support local access to care in rural areas. We also support the more narrowly targeted proposal in the PEAKS Act to protect the CAH designation of any facility in mountainous terrain whose CAH eligibility may be adversely impacted by a new hospital opening more than 10 miles from the hospital.

H.R. 8245, RURAL HOSPITAL STABILIZATION ACT

AHA supports H.R. 8245 which provides important financial assistance to CAHs that are financially challenged. In rural communities across America, hospitals and health systems are cornerstones for the health and well-being of the patients and communities they serve. Rural hospitals and health systems provide much needed access to affordable, quality health care for patients close to home and operate as economic anchors in their local communities, supporting good paying jobs and infusing the local economy with spending on goods and services.

H.R. 8235, RURAL PHYSICIAN WORKFORCE PRESERVATION ACT

To address nationwide physician shortages in a timely manner, the AHA supports the distribution of additional Medicare-funded residency positions as required by the Consolidated Appropriations Act of 2021 (CAA). The CAA requires CMS to distribute at least 10% of the 1,000 slots to rural hospitals, a category that includes geographically urban hospitals that have reclassified as rural.

AHA supports the goal of the CAA of 2021, with 10% of slots going to rural hospitals and appreciates the interest from the committee in ensuring rural hospitals fully participate in the program. However, the AHA has concerns that the language in H.R. 8235 would result in unused GME slots and hopes to work to clarify the language According to the Centers for Medicare & Medicaid Services, in the first round of graduate medical education (GME) slot allocations, only eight geographically rural hospitals applied, and five were granted slots. We are concerned that the small number of rural hospitals that applied for slots, due in part to limited resources with which to operate training programs, has led to fewer slots being awarded.
In addition, the AHA is committed to working with the committee and Congress to ensure all slots are used by helping rural hospitals with any financial, regulatory or administrative burdens that prevent them from applying for or receiving GME slots.

H.R. 8246, SECOND CHANCES FOR RURAL HOSPITALS ACT

We appreciate the committee's intent to consider ways to build on the rural emergency hospital (REH) designation. We look forward to working with you to strengthen the REH designation to ensure access to care in rural communities. However, we urge Congress to establish common sense guardrails to prevent expansion of physician-owned REHs. Data have shown that physician-owned hospitals increase costs for patients, other providers and the federal government. **Like the legislation enacted to close the whole hospital exception loophole, we ask Congress to close potential loopholes to the rural provider exception of Stark by adding language to the bill to prevent new physician-owned REHs from being established.**

CONCLUSION

Thank you for your consideration of the AHA's comments on these legislative proposals. We look forward to continuing to work with you to address these important topics on behalf of patients and communities.