Statement for the Record

Submitted by Premier Inc.

"Rural Health Care: Supporting Lives and Improving Communities"

Senate Finance Committee

May 16, 2024

Premier Inc. appreciates the opportunity to submit a statement for the record on the Senate Finance Committee hearing titled "*Rural Health Care: Supporting Lives and Improving Communities*" on May 16, 2024. Premier applauds the Committee's leadership in this area and strongly supports efforts to develop innovative policy approaches to expand access to this critical and vulnerable population. As discussed in more detail below, Premier highlights opportunities to strengthen the quality and sustainability of care for patients and providers in rural and underserved areas, including by:

- Expanding patient access to home infusion care by revising Medicare reimbursement policy for these services;
- Extending key Medicare telehealth flexibilities and the Medicare hospital at home program;
- Promoting financial stability for rural providers; and
- Supporting policies that help strengthen the rural healthcare workforce.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company, uniting an alliance of more than 4,350 U.S. hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 2.7 billion hospital outpatient and clinic encounters and 177 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. IMPROVE PATIENT ACCESS TO HOME INFUSION

Patients served under the Medicare Part B home infusion therapy services benefit are among the country's most vulnerable and often suffer from advanced chronic diseases, such as congestive heart failure, cancer and primary immune deficiency. For decades, home infusion has offered these patients the ability to receive safe and effective care in their homes, which improves their quality of life, minimizes exposure to infectious diseases and provides a more cost-effective option for patients to receive critical medications.

These services are particularly valuable to patients in rural areas who otherwise could be forced to travel significant distance to access care. Unfortunately, the Centers for Medicare & Medicaid Services' (CMS') interpretation of the Medicare home infusion benefit has led to access gaps, which are most prevalent in many rural and underserved areas, as revealed in CMS' own reporting on the program, which shows no home infusion services provided to beneficiaries in Arkansas, Montana, North Dakota, South Carolina, Vermont and Wyoming.

Premier urges Congress to pass The Preserving Patient Access to Home Infusion Act (S.1976/H.R.4104) to promote patient access to home infusion care by aligning Medicare reimbursement policy with the successful model employed by commercial plans.

III. EXTEND ACCESS TO TELEHEALTH

Telehealth was a critical tool during the COVID-19 public health emergency, allowing providers to continue to furnish much-needed services to patients from the safety of their homes. The flexibilities that CMS granted around Medicare telehealth served to highlight that many services can be effectively and efficiently furnished remotely. Congress recognized the value in easing barriers to virtual care and extended several key telehealth flexibilities in the Consolidated Appropriations Act (CAA) of 2023 through the end of calendar year (CY) 2024, as advocated by Premier.

Today, telehealth continues to serve as a means for providers to expand care to many patients who previously had access barriers, particularly in rural and underserved communities. Congressional action, however, is needed to preserve this important care tool, which is especially critical for those using telehealth to reach specialists at longer distances, for access to mental and behavioral health practitioners and those receiving ongoing remote care for chronic conditions. ***Premier urges Congress to further extend the telehealth flexibilities as policymakers continue to evaluate the impact of these policies on patient care.***

As Congress considers extending telehealth flexibilities it is critical that it also extends use of audio-only technology. Nearly a quarter of beneficiaries that received a telemedicine service during the COVID-19 pandemic did so by using audio-only telephone technology in both 2020 and 2021. Accessing video technology can be particularly challenging and creates barriers for beneficiaries who are low-income, elderly or who live in rural areas where the broadband infrastructure cannot support streaming video. The COVID-19 public health emergency (PHE) has highlighted that many services can be effectively delivered as audio-only and do not require a video-connection. ***Premier urges Congress to allow for use of audio-only technology for services where it would be clinically appropriate.*** For example, many patients have benefited from receiving virtual behavioral health services through interactive audio-only technology. CMS could continue to differentiate which services are eligible to be furnished via audio-only as compared to those that require both audio and video technology. CMS should provide stakeholders with the opportunity to weigh in on these lists as part of annual rulemaking.

IV. EXTEND HOSPITAL AT HOME PROGRAM

In November 2020 in response to the COVID-19 pandemic, CMS promulgated the Acute Hospital Care at Home (AHCAH) waiver, which allowed patients to receive certain acute care services from the comfort and safety of their homes. With these flexibilities as the springboard, more than 300 hospitals across 37 states have embraced the "hospital at home" concept and have tailored their programs to meet specific patient and organizational objectives. We appreciate The AHCAH program enables providers to effectively monitor

and care for patients as they recover in the comfort of their own homes. This can include remote monitoring capabilities, in-home provider visits, telehealth, medication management and many other care strategies. This new avenue of care has freed up hospital capacity, offered a safe and effective method to care for COVID-19 patients, and reduced avoidable emergency department visits.

We appreciate efforts by Congress to extend these COVID-19 flexibilities through CY 2024 while CMS continues to evaluate the program. Preliminary studies from both CMS and external researchers have found that Medicare patients treated under the CMS hospital at home initiative had low rates of mortality and few hospital readmissions. ***Premier urges lawmakers to further extend the Medicare hospital at home program beyond 2024 as it continues to evaluate how these flexibilities can best support patient access to high quality care in their homes.*** As part of this, Congress should examine alternatives and refinements to the current hospital at home waiver to permit further adoption in rural and underserved areas.

V. ENSURE ADEQUATE PAYMENT TO RURAL PROVIDERS

Health systems and hospitals continue to operate under enormous financial challenges stemming from a combination of increased labor costs, record inflation and lagging reimbursement rates that do not account for these unprecedented financial challenges. The impact of this problem falls disproportionately on facilities in rural and underserved communities, as providers are increasingly sparse in these areas and therefore require a premium to recruit. Premier has expressed significant concerns to CMS that the methodology used to determine annual hospital payment updates does not adequately capture the true costs hospitals have faced over the last few years, especially as it relates to labor. A PINC AI™ analysis found that labor costs have increased by more than 15 percent since the start of FY 2020 through the first half of FY 2023 and do not show signs of returning to a lower level.

Premier urges Congress to develop legislation that requires CMS to reevaluate the data sources it uses for calculating labor costs and adopt new or supplemental data sources that more accurately reflect the cost of labor, taking into account geographic disparities in rural and underserved areas, such as more real time data from the provider community inclusive of contract labor. This would provide a more accurate, blended and aggregated payment adjustment to all hospitals across the nation based upon their true labor costs. Doing this would also allow payments to ebb and flow as needed to account for any readjustments that occur to labor costs in the future.

Additionally, ***Premier recommends Congress develop long-term solutions to stabilize Medicare payments, including eliminating the Medicare sequestration cuts, which have a significant impact on providers in rural and underserved areas***. Congress should also consider how any provider cuts currently being contemplated may inequitably impact rural providers. By establishing policies that create stable, predictable payments for Medicare providers, Congress will help ensure stability for providers in rural and underserved areas and address unjustified geographic payment disparities.

Finally, ***Premier urges Congress to take additional actions to promote provider stability and strengthen access to care for patients in rural areas*** by:

- ***Reforming Rural Emergency Hospitals (REH) policies.*** Congress established the REH provider designation as an option for rural communities to maintain access to emergency and certain outpatient services in light of potential hospital closures. To date, only 21 hospitals have converted to REH status. While many more hospitals may benefit from this policy, there are statutory restrictions that make the provider type untenable for many rural hospitals. ***Premier encourages Congress to work with stakeholders to address statutory barriers that have limited uptake***

of the REH provider type to ensure this new provider type is a viable option for rural hospitals and their communities.

- ***Extending Medicare-dependent hospital (MDH) program and low-volume hospital (LVH) payment adjustment.*** Congress established the MDH program in the late 1980s to support small rural hospitals where Medicare patients made up a significant portion of their inpatient population. The LVH program, which was established in 2005, provides higher Medicare payments to qualifying rural hospitals to help offset the higher costs associated as a result of low inpatient volume. Congress has modified the LVH payment methodology several times in order to allow more hospitals to qualify. Both programs have been critical to ensuring the sustainability of rural hospitals and access to care in rural communities. However, both the MDH program and adjustments to the LVH program expire at the end of CY 2024. ***Premier urges Congress to stabilize rural hospital funding by extending both the MDH program and LVH payment adjustment for multiple years.***

- ***Extend support for Community Health Centers (CHC).*** CHCs increase access to crucial primary care by reducing barriers related to cost, lack of insurance, distance and language for more than 30 million patients nationwide, many in rural and underserved communities. Through the timely delivery of preventative care, CHCs improve the well-being of countless Americans and reduce government spending on healthcare. In addition, CHCs serve on the front lines in our battle against addiction and mental health and are a lifeline for many patients and their communities. The CHC Fund (CHCF) accounts for nearly 70 percent of health center funding and authorization for the program is set to expire at the end of CY 2024. CHC funding is vital to communities nationwide, over half of which are rural. Further, this funding supports CHC data modernization efforts and preparation for future public health emergencies. Funding for CHCs has historically always received bipartisan support in Congress. ***Premier urges Congress to work together to provide stable and strong multi-year funding for CHCs*** which support critical care in underserved areas and play a vital role in America's rural communities***.***

- ***Delay cuts to Medicaid Disproportionate Share Hospital (DSH) Program.*** The Medicaid DSH program was created to help offset uncompensated care costs for hospitals that provide care to large numbers of Medicaid and uninsured patients. These hospitals provide critical services and are economic and healthcare anchors in their communities. More than 2,500 hospitals nationwide receive DSH payments which help keep many hospitals financially viable and able to provide care to vulnerable individuals. The Affordable Care Act (ACA) required reductions to the Medicaid DSH program over time, beginning in FY 2014, under the assumption that the law would increase health insurance coverage and therefore hospitals would be providing less uncompensated care. Unfortunately, the coverage levels anticipated under the ACA have not been fully realized and therefore the levels of uncompensated care provided by DSH hospitals to uninsured and underinsured remains at pre-ACA levels.

  Premier appreciates recent efforts by Congress to delay the onset of these cuts until January 1, 2025. ***Premier urges Congress to act before the end of the year to prevent the pending Medicaid DSH cuts once again for at least two years and protect access to care for our nation's most vulnerable patients.***

- ***Reauthorize the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act:*** The SUPPORT Act, which passed in 2018 with robust bipartisan support, has been instrumental in helping our nation address the opioid epidemic through programs and policies that impact treatment, prevention and recovery.

Unfortunately, the SUPPORT Act authorization lapsed as of Sept. 30, 2023. The ongoing opioid epidemic continues to overwhelm hospitals with an estimated 66 million emergency department visits and 760,000 inpatient admissions each year. ***Premier urges Congress to reauthorize the SUPPORT Act to reduce barriers to receiving and delivering care for substance use disorders*** by improving payment policies (including those that promote telehealth services), reducing unnecessary regulatory and administrative burden for providers and strengthening the behavioral healthcare workforce.

VI. STRENGHTEN RURAL HEALTHCARE WORKFORCE

The healthcare workforce is currently experiencing severe shortages because of unprecedented pressures exacerbated by the pandemic, pushing our healthcare system to its limits. Projections by the Association of American Medical Colleges (AAMC) show that physician demand will grow faster than supply leading to a projected total physician shortage of up to 124,000 physicians by 2034. These shortages will have real impact on patients, particularly those living in rural and underserved communities. In addition to the physician workforce, we must also take steps to bolster the ranks of non-physician clinical roles, including nursing, but also other vital roles such as pharmacists, occupational therapists, respiratory therapists and more. ***Premier believes addressing workforce shortages requires a multi-pronged approach and urges Congress to take the following actions***:

- ***Extending workforce training programs.*** The Teaching Health Centers Graduate Medical Education (THCGME) program, the Children's Hospital Graduate Medical Education Program (CHGME) and the National Health Service Corps (NHSC) program are not only fundamental for tackling the healthcare labor shortage, but they provide essential and comprehensive services for rural and tribal communities as well as children nationwide. These programs expand our ability to deliver primary care across the country and are fundamental to tackling the healthcare labor shortage. Premier appreciates recent legislation to extend many of these programs through CY 2024. ***Premier urges Congress to continue its record of bipartisan support for workforce training programs and provide stable multi-year funding for these programs***. Congress should also consider support for "earn while you learn" programs that support the growth and development of healthcare workers while employed in a healthcare facility.

  Additionally, under the Conrad 30 program, each state is allocated 30 waivers that exempt J-1 physicians from the requirement to return to their country of origin in exchange for three years of service in an underserved community. Premier supports The Conrad State 30 and Physician Access Reauthorization Act (S. 665/H.R. 4942). While a temporary extension of the program's authorization until Sept. 30, 2024 was recently enacted, Premier urges Congress to further extend this program which has helped Americans in rural and underserved areas receive medical care.

- ***Investing in residency training.*** To help grow a sustainable physician workforce to meet patient needs, increased Medicare support for graduate medical education (GME, or residency training) is needed. ***Premier urges Congress to take additional action to increase Medicare-supported GME slots by passing the bipartisan Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389).*** This legislation which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied needs, including hospitals in rural areas and hospitals serving patients from federally-designated health professional shortage areas.

- ***Boosting non-physician pipeline.*** An issue Premier frequently hears with respect to nursing shortages is that the pool of willing candidates exceeds the number of available training slots in schools of nursing, at least partly due to limited number of available training faculty. ***Premier encourages Congress to consider ways to increase training facility capacity,*** including examining whether all educators in such programs should require an advanced degree or if there are opportunities for flexible standards that might create additional training capacity if some educators are permitted to have a bachelor's degree only for example. ***Premier also recommends that Congress seek opportunities to provide support to grant programs that expand vocational programs to help train advanced practice providers, such as nurse practitioners, and other clinical roles that do not require four-year degrees, such as home health aides; nursing assistants; or technicians for pharmacy, radiology and laboratory***. Premier additionally encourages Congress to support approaches and programs that connect high school students to health careers by enhancing recruitment, education, training and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in healthcare, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from those communities.

- ***Reforming loan forgiveness programs.*** Loan forgiveness programs should be considered to incent new talent to join the field. However, in many cases healthcare workers opt to not accept loan forgiveness funds because they are accounted for as income and can have a detrimental impact on an individual's finances if pushed into a higher tax bracket. Similarly, healthcare workers are often hesitant to accept employer assistance funds as they can also be counted as income and force the worker into a "benefit cliff." Therefore, ***Premier urges Congress to ensure that the tax implications of loan forgiveness programs do not act as inadvertent disincentives to individuals participating.***

VII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments in response to the Finance Committee's hearing. Please consider Premier and our significant cohort of rural providers a resource as you continue this important work. If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy at melissa_medeiros@premierinc.com.