United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

H.R. 8261, Preserving Telehealth, Hospital, and Ambulance Access Act

Rep. Schweikert (R-AZ), Rep. Thompson (D-CA)

Americans benefit from access to care at home.

- During the COVID-19 public health emergency (PHE), access to telehealth services was expanded for Medicare patients. Congress has passed legislation to extend patient access to these key services, but only for a short term and those policies expire in December 2024.
- Advancements in telehealth and remote patient monitoring (RPM) technologies allow patients to receive care and transmit health information to their doctors from home.
    - **25%** of adults report having utilized telehealth in the past month.
    - **91%** of patients utilizing telehealth report having a favorable experience and **78%** are likely to complete a medical appointment via telehealth again.
- Medicare's Hospital at Home (HaH) Initiative allows hospitals to provide acute care to seniors in their homes rather than in a hospital but also expires in December 2024.
    - **300** hospitals in **37** states now participate in HaH.
    - **99%** of patients were "satisfied" or "very satisfied" with HaH.
- Remote care options especially help rural patients who otherwise have to travel twice as far, on average, than urban patients to reach their nearest hospital.

Rural hospital and ambulance bonus payments help maintain access to critical services.

- Nearly **4.5 million** Americans live in counties without an acute care hospital.
- Rural hospitals have low patient volumes and rely more on federal health programs, contributing to unique care delivery and financial challenges.
    - Medicare's Low Volume Adjustment (LVA) and Medicare-Dependent Hospital Program (MDH) provide needed bonus payments but expire in December 2024.
- **84%** of rural counties and **77%** of urban counties have "ambulance deserts" where access to an ambulance station is more than **25 minutes away**.
    - Rural patients may wait up to **30 mins** for emergency services after dialing 911.
    - Medicare bonus payments for rural ambulance services expire December 2024.

Solution: The Preserving Telehealth, Hospital, and Ambulance Access Act (H.R. 8261).

- Preserves Medicare patients' access to vital telehealth through 2026, and HaH services through 2029.
- Improves telehealth experiences, makes important program reforms and instills new integrity measures.
- Extends essential Medicare programs that sustain rural and low-volume hospitals through September 30, 2025.
- Extends essential Medicare add-on payments for urban, rural, and super-rural areas to preserve access to crucial emergency ambulance services.

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H.R. 7931, The Preserving Emergency Access in Key Sites (PEAKS) Act

Rep. Miller (R-WV), Rep. Caraveo (D-CO)

Medicare's treatment of Critical Access Hospitals Ambulance Services in mountainous areas is misaligned.

- Critical Access Hospitals (CAHs) are important rural hospitals that, due to their unique location and patient population, are reimbursed by Medicare at the cost of providing medical services, which is higher than most other hospitals.
- Under current law, to be eligible for the CAH designation, a hospital must be a **35-mile** drive from another hospital or a **15-mile** drive if the hospital is accessible only by secondary roads or located in mountainous areas.
- Medicare pays the CAH rate for ambulance services provided by a CAH-owned ambulance provider, but only if it is the sole provider within **35 miles**.
    - There is no **15-mile** permission, unlike the general eligibility requirements.
    - Without a **15-mile** permission, access is harmed for seniors in mountainous areas.

Solution: The Preserving Emergency Access in Key Sites (PEAKS) Act (H.R. 7931).

- Permanently aligns Medicare's ambulance reimbursement policy with existing CAH general eligibility requirements.
    - Clarifies that Medicare will pay the CAH rate for CAH-owned ambulances located a **15-mile** drive away in mountainous areas or areas accessible only by secondary roads.
- Ensures existing CAHs in mountainous areas can maintain their CAH status should other hospitals encroach on their 15-mile radius.

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H.R. 8245, The Rural Hospital Stabilization Act

Rep. Feenstra (R-IA)

Rural hospitals face financial instability due to low patient volumes.

- Critical Access Hospitals (CAHs), small rural hospitals, and Rural Emergency Hospitals are important rural facilities that, due to their location and patient population, have unique Medicare reimbursement structures.
- Medicare reimburses CAHs at **101 percent** of reasonable cost, provides REHs a monthly lump-sum payment and adds **five percent** on outpatient reimbursements, and provides small rural hospitals various adjustments and other programs intended to improve financial stability.
    - While rural hospitals have special payment mechanisms, low patient volume and reliance on government health programs contribute to significant financial challenges.
    - A majority of CAHs have an average of **less than five** inpatient patients each day.
    - In **21 states**, the median CAH has at least **20 percent** less cash on hand than the national median of hospitals.
    - From 2005 to 2022, **186** rural hospitals closed nationwide.
- Medicare's Low Volume Adjustment bonus payment provides extra funds to hospitals with low patient volumes, but CAHs are ineligible to receive them due to their cost-based payment system.
- Many small rural facilities would benefit from assistance in identifying and applying best practices with respect to maintaining and enhancing services.

Solution: The Rural Hospital Stabilization Act (H.R. 8245).

- Authorizes stabilization grants administered by the Federal Office of Rural Health Policy.
    - Struggling rural hospitals, CAHs, and REHs, as well as providers of technical assistance will be able to apply for grants.
    - For hospitals, grants may be used for minor renovations, care delivery training, hiring new staff or supplementing compensation of existing staff, and equipment acquisition.
    - For providers of technical assistance, grants may be used to help hospitals seek grants or use grant funding.
- Requires reporting on the facilities and technical assistance providers receiving grants.

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H.R. 8235, Rural Physician Workforce Preservation Act

Rep. Murphy (R-NC)

Rural areas are facing physician shortages and need a reliable physician pipeline.

- **91 percent** of rural communities face health care workforce shortages and **65 percent** of rural areas have a shortage of primary care physicians.
- The number of medical school entrants from rural areas declined by **28 percent** from 2002-2017.
- Family medicine residents who train in a rural area are **six times** more likely to practice medicine in rural areas, yet less than **10 percent** of residents experience any rural training.
- Students from rural backgrounds are **10 times** more likely to prefer to work in rural areas, but the number of physician residents from rural areas has declined to fewer than **5 percent**.

Few hospital residency programs train physicians in rural areas.

- Medicare is the largest federal funder of medical residency training through the **Graduate Medical Education (GME) program**, but training in rural areas is lacking.
    - **Two percent** or less of residency training occurs in rural areas, and only **21 percent** of medical schools have any type of formal rural health program.
- Congress created a total of **1,200** new Medicare-funded residency slots in 2020 and 2022 with a formula intending to allocate **10 percent** of the slots to **rural hospitals**, but a loophole allows non-rural hospitals to receive these slots.
    - This loophole allows urban hospitals to reclassify their facility to be "treated as rural" if they meet certain criteria.
    - So far, **93** slots are attributed as "rural," but in reality, only **12** of those slots went to hospitals that are truly rural, while **81** slots went to hospitals that *reclassified* as rural.

Solution: Rural Physician Workforce Preservation Act (H.R. 8235).

- Ensures that **10 percent** of the recently approved **1,200** Medicare GME slots dedicated to rural hospitals go to truly rural hospitals by striking the "treated as rural" loophole.

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H.R. 8244, The Ensuring Seniors' Access to Quality Care Act

Rep. Ron Estes (R-KS), Rep. Gerry Connolly (D-VA)

Nursing home workforce is in crisis and getting worse.

- **99 percent** of nursing homes currently have job openings.
- **46 percent** of nursing homes have had to limit new patient admissions due to lack of staff.
- Nearly **20 percent** of nursing homes have closed part of their facility due to lack of staff.
- The Biden Administration's recently finalized **nursing home staffing mandate** will worsen workforce shortages across the country.
    - Requires nursing homes nationwide who are already struggling to find staff to hire more than **100,000** additional nurses and nurse aides.
    - Exacerbating existing nationwide labor shortages in nursing homes and could also lead to follow-on shortages as nurses are hired away from hospitals, home health agencies, hospices, and other settings of care.
    - One estimate suggests nearly **300,000** residents will lose access to care – more than **one-fourth of all residents** – as nursing homes slow admissions to comply with the mandate.

Medicare unnecessarily restricts Certified Nurse Aide training.

- Under current law, Medicare prevents nursing homes from operating a Certified Nurse Aide (CNA) training program for two years if the facility is fined a certain amount.
    - In making the decision to prohibit the training program, Medicare does not account for the seriousness of the underlying deficiency or activity the fine was related to.
    - For example, a nursing home could be fined for a deficiency unrelated to direct resident care, like having expired crackers in a food pantry, yet would still be prohibited from operating a CNA training program for two years.
- While current law contains a waiver, it is seldom used and has proven inadequate.

Solution: Ensuring Seniors' Access to Quality Care Act (H.R. 8244).

- Allows nursing homes to continue operating their CNA training program if they incur fines above a certain amount, so long as the fines are issued for reasons unrelated to direct resident care.

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H.R. 8246, The Second Chances for Rural Hospitals Act

Rep. Arrington (R-TX)

The Rural Emergency Hospital (REH) designation is promising but needs commonsense updates.

- In 2020, Congress created the **REH designation** to allow low-volume rural hospitals at risk of closure to eliminate underused inpatient beds but keep needed emergency and outpatient services, thus converting to become a REH, preserving care access for communities who would otherwise lose services.
    - Currently, only Critical Access Hospitals (CAH) and rural hospitals that were open as of December 2020 and had **50** or fewer inpatient beds are eligible to **convert to REH status**.
    - Medicare pays REHs approximately **$276,000** monthly to offset the cost of maintaining a 24/7 emergency department, plus a **five percent** add-on payment to the normal Medicare rate for outpatient services.
- Only **19** of the nearly **400** eligible hospitals have converted to REH status, in part because:
    - Each state must create licensure rules for the new model, and some have not.
    - A hospital must "fail first" before converting to REH status. Currently, **new REHs may not be built or hospitals that closed prior to December 2020 can't reopen as an REH**.
    - Hospitals must weigh tradeoffs when forfeiting inpatient and post-acute care beds.

Solution: The Second Chances for Rural Hospitals Act (H.R. 8246).

- Moves back the eligibility date for a closed hospital to **convert to an REH** from **December 27, 2020** to **January 1, 2014**, allowing previously closed rural hospitals to convert to an REH and bring back services to rural and underserved communities.
- Includes a tiered funding structure for hospitals reopening as an REH so not to financially harm existing points of care.