Statement by

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Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify today on behalf of the Health Resources and Services Administration (HRSA) and the Federal Office of Rural Health Policy (FORHP). I am pleased to discuss with you our investments in rural health and initiatives to support infrastructure in rural communities, our response on the opioid epidemic, and our plans to grow the rural workforce.

To begin, I want to thank members of this Subcommittee and your colleagues in the House of Representatives and the Senate for the bipartisan, bicameral efforts in passing the Consolidated Appropriations Act, 2018 and the Bipartisan Budget Act. The funding and initiatives included as part of those Acts will provide rural communities valuable resources and support in their efforts to improve access to health care for rural individuals.

HRSA is the primary Federal agency charged with improving access to health care services for people who are medically underserved because of their economic circumstances, geographic isolation, or serious chronic disease. FORHP serves as a focal point for rural health activities within the Department of Health and Human Services (HHS). Section 711 of the Social Security Act charges the Director of the Office of Rural Health Policy with advising the Secretary of HHS on the effects of current policies and regulations on rural communities. FORHP ensures that there is a continual focus on improving access to care, ranging from the recruitment and retention of health care professionals to maintaining the economic viability of hospitals and rural health clinics to supporting telehealth and other innovative practices in rural communities.

Support for Rural Hospitals and Rural Health Infrastructure

Rural hospitals play a critical role in the rural health infrastructure, serving as a locus for health care in small communities. They can play a key role in helping to attract and retain health care providers and ensure access to emergency and inpatient medical services. The rural health care delivery system also includes community health centers and Rural Health Clinics, who play a key role in ensuring access to primary care. Over 40 percent of the community health centers nationally are either located in or serve rural populations, and may be the only source of care for behavioral health, substance abuse treatment and oral health.

Telehealth plays an increasingly important role in ensuring access to care for more specialized services that may not be available locally. HRSA plays a lead role in supporting telehealth through a number of its grant programs. The Telehealth Network Grant programs supports the use of telehealth that links specialists with patients in rural and underserved areas. HRSA also administers a national network of Telehealth Resource Centers to help communities that want to start new telehealth projects or expand existing efforts to other clinical areas. HRSA also funds two Telehealth Centers for Excellence to test out new approaches for how to best leverage this technology to not only expand access but enhance health care outcomes. The agency also is working to address policy barriers such as cross-state licensure for telehealth clinicians who often practice across state lines. HRSA's licensure and portability program is working with physician and psychology boards to look at ways to reduce the burden for telehealth clinicians who have to apply for licensure in multiple states.

While rural hospitals are an essential part of the rural health infrastructure, they continue to face ongoing challenges. There are efforts across HHS to enhance rural hospitals' financial viability and rural residents' access to hospital services. Section 711 of the Social Security Act also charges the Director of the Office of Rural Health Policy with advising the Secretary on the effects of proposed changes in the programs related to the financial viability of small rural hospitals, and the ability of rural communities to attract and retain physicians and other health professionals.

HRSA meets this charge by monitoring the environment for rural hospitals through the Rural Health Research Center grant program, which focuses a significant part of its efforts on assessing hospital finance, quality and access to care. This research has shown that there are a number of financial driving factors affecting rural hospital viability. These facilities tend to have low patient volume, paired with high fixed costs. Rural hospitals, like all hospitals, are also seeing declining inpatient admissions, compounded by declining rural populations in many rural communities that can make it challenging for a rural hospital to remain financially viable. These facilities also have a payer mix that is heavily dependent on public payers like Medicare and Medicaid with a smaller share of privately insured patients relative to urban hospitals. Our research shows that rural hospitals often have lower operating margins, less cash on hand and limited ability to invest in capital infrastructure. There is also ongoing market consolidation with rural hospitals becoming part of larger regional systems, some of which may seek to centralize some services. All of these factors have created a challenging environment for rural hospitals and the communities they serve.

In addition to the financial factors facing rural hospitals, it is important to consider the populations that these facilities are serving. Many rural communities have higher rates of chronic disease, higher rates of poverty, higher rates of patients who are dually eligible for Medicare and Medicaid, lower life expectancy, higher mortality rates, and higher rates of avoidable excess death.[1,2,3,4]

While the challenges facing rural hospitals are complicated, there are a number of efforts aimed at supporting rural hospitals. Over the past 25 years, Congress has created a number of special payment classifications and adjustments to assist rural hospitals. This includes payment designations such as Critical Access Hospital (CAH; N: 1,343), Sole Community Hospital (N: 337 with 299 located in rural), Medicare Dependent Hospital (N: 154) and Rural Referral Center (N: 187), which all can play a key role in ensuring financial viability. Congress has also created the Medicare Disproportionate Share Hospital and low-volume hospital adjustments that are also critically important to many rural hospitals. A significant number of CAHs and other rural hospitals also benefit from participating in the 340B Drug Pricing Program.

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[1] Meit, M., Knudson, A., Gilbert, T., Tzy-Chyi Yu, A., Tanenbaum, E., Ormson, E., Ten Broeck, S., Bayne, A., Popat, S. National Opinion Research Center. "The 2014 Update of the Rural Urban Chartbook." October, 2014. https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf

[2] Freeman et al. "The 21st Century Rural Hospital: A Chart Book." North Carolina Rural Health Research Center. March 2015. http://www.shepscenter.unc.edu/wp-content/uploads/2015/02/21stCenturyRuralHospitalsChartBook.pdf

[3] "Health Care Spending and the Medicare Program: A Data Book." Medicare Payment Advisory Commission. June 2017. http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf

[4] CDC Data Visualization Website (https://www.cdc.gov/nchs/data-visualization/potentially-excess-deaths/)

While these protections are critically important to ensure access to care for essential services in rural communities, challenges remain. More than 80 rural hospitals have either closed or ceased offering inpatient services since 2010, though the pace of these closures has slowed in the past year. Our research shows that many more rural hospitals are at varying degrees of financial distress.

Across HRSA and HHS, we are seeking ways to use existing programs and authorities to address the needs of rural hospitals. We are collaborating with the Centers for Medicare and Medicaid Services' Innovation Center (CMMI) in its administration of several rural demonstrations projects. This includes the Rural Community Hospital Demonstration, the Frontier Community Health Integration Project and the Pennsylvania Rural Health Model. CMMI has also seen strong rural participation in broader demonstrations such as the Accountable Care Organization Investment Model and the State Innovation Models. Lessons learned from all of these demonstrations can inform future policy developments for enhancing access to care in rural communities.

HRSA supports rural and Critical Access Hospitals (CAHs) through a number of grant programs. In FY 2017, under the Medicare Rural Hospital Flexibility Grant (Flex) Program, HRSA invested $24 million in state Flex programs to work with CAHs to improve quality, financial performance, and integration of emergency medical services. HRSA's Medicare Beneficiary Quality Improvement Program encourages voluntary reporting and support for CAH quality improvement activities. From 2009 to 2016, the percentage of CAHs reporting Hospital Consumer Assessment of Healthcare Providers and Systems surveys increased from 35.4 percent

to 81.2 percent.[5] This is significant because unlike other hospitals, CAHs are not required to submit quality measure data to Medicare. We are also seeing improved quality scores and enhanced financial performance for CAHs that take part in Flex program activities.[6,7]

The Small Hospital program provides $15 million a year to assist rural hospitals with fewer than 50 beds to prepare for value-based purchasing, participation in Accountable Care Organizations or other shared savings programs. These funds can also assist small rural hospitals on billing issues such as compliance with ICD-10 standards.

We also know that rural communities and their hospitals in some areas such as the Mississippi Delta region face unique challenges that call for a more targeted approach. We are using funding provided by Congress in FY 2017 and FY 2018 to provide hospitals and communities in the Delta region with more targeted technical assistance to improve health care delivery.

In FY 2016 and FY 2017, HRSA awarded a total of 11 Rural Health Network Development Planning grants to communities that were addressing hospital closures or mitigating the loss of services due to hospitals facing financial distress. Rural communities frequently lack the resources and infrastructure to evaluate community needs and develop local and regional plans for access to care after a hospital closure. This funding can help these communities strategically

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[5] Lahr et al. "Patients' Experiences in CAHs: HCAHPS Results, 2016." Flex Monitoring Team. December 2017. http://www.flexmonitoring.org/wp-content/uploads/2017/12/DSR24.pdf
[6] Swenson, T., Casey M. "MBQIP Quality Measure Trends, 2011-2016." Flex Monitoring Team. November 2016. http://www.flexmonitoring.org/wp-content/uploads/2016/12/DSR20.pdf
[7] Whitaker et al. "Impact of Financial and Operational Interventions Funded by the Flex Program." Flex Monitoring Team. November 2015. http://www.flexmonitoring.org/wp-content/uploads/2015/11/PB41.pdf

plan for the continued provision of care.

The Rural Opioids Communities Initiative

Rural communities continue to face significant challenges in responding to the opioid epidemic. According to the Centers for Disease Control and Prevention (CDC), while the rate of drug use is lower in rural areas than in urban areas, the fatal overdose rate in rural areas continues to rise. From 2006 to 2015, the most recent year included in the review, the rural overdose death rate has been higher than the urban rate.[8] In FY 2016, five out of the top 10 states with the highest overdose mortality rates were majority rural states (WV, NH, OH, ME and KY). Rural communities also face challenges in recruiting and retaining providers with the necessary training and education to treat individuals with opioid use disorder. More than half of rural counties nationally (60.1 percent) still lack a physician with a Drug Enforcement Agency waiver to prescribe buprenorphine.[9]

The FY 2018 appropriation includes $100 million for a new Rural Communities Opioid Response program, directing HRSA to support treatment for and prevention of substance use disorders, with a focus on the 220 vulnerable counties identified by the CDC, which ranked each county's vulnerability to an outbreak of HIV and Hepatitis-C. That analysis took a number of

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[8] Preventing Opioid Overdoses among Rural Americans. Centers for Disease Control. March 2018. https://www.cdc.gov/ruralhealth/drug-overdose/pdf/Policy-Brief_Opioiod-Overdoses-H.pdf
[9] Holly et al. "Barriers Rural Physicians Face Prescribing Buprenorphine for Opioid Use Disorder." WWAMI Rural Health Research Center. August 2017. http://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC5505456&blobtype=pdf

factors into consideration, including drug overdose deaths, opioid sales, unemployment, and per capita income.[10] We will leverage all of our HRSA partners in this effort.

The program will focus on the areas of prevention, treatment, and recovery of substance-use disorders, including the opportunity to improve access to and increase the recruitment of new substance-use disorder providers. HRSA also hopes to build sustainable treatment resources, increase use of telehealth, and build strong community partnerships. Communities will also be strongly encouraged to learn about and to leverage and coordinate with other local, state and federal opioid resources such as the funds provided through the 21st Century Cures Act (P.L. 114-146).

Rural Workforce and Rural Physician Residency Programs

Maintaining the healthcare workforce is fundamental to providing healthcare quality and access in rural areas. Rural areas have historically faced challenges attracting and retaining physicians and other providers. Data from HRSA's Area Health Resource File shows that while urban areas have 7.9 physicians per 10,000 residents, that ratio drops to 5.4 in rural areas. [11] HRSA data also shows that 59 percent of the Primary Care Health Professional Shortage Areas are in rural

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[10] Van Handel, M., Rose, C., Hallisey, E., Kolling, J. Zibbell, J., Lewis, B., Bohm, M., Jones, C., Flanagan, B., Siddiqi, A., Iqbal, K., Dent, A., Mermin, J., McCray, E., Ward, J., Brooks, J. The Journal of Acquired Immune Deficiency Syndrome. "County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. Nov. 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5479631/

[11] US Department of Health and Human Services, Health Resources and Services Administration. Area Health Resource File. HRSA Data Ware House. 2018. The AHRF data includes county, state, and national-level files in eight broad areas: Health Care Professions, Health Facilities, Population Characteristics, Economics, Health Professions Training, Hospital Utilization, Hospital Expenditures, and Environment. https://datawarehouse.hrsa.gov/topics/ahrf.aspx

areas.[12] Additionally, while physician residency training has been heavily urban, there are new models such as Rural Training Tracks (RTTs) and the Teaching Health Centers, of which 21 percent are rural areas, that have emerged that focus on community-based residency training in rural areas.

In FY 2016, HRSA completed a small pilot program to provide technical assistance to communities interested in creating RTTs. This model allows a medical resident to spend one-year in an urban location and then two years in a rural community. A University of Washington study funded by HRSA shows that residents in these programs are twice as likely to practice in rural communities.[13] Through the RTT pilot program, the number of rural training tracks increased from 23 to 41 over the course of program. Through that work, we also learned about the challenges of creating rural residencies. For example, working through the accreditation process requires a high degree of time and effort that can be a challenge for small rural hospitals and organizations.

The Consolidated Appropriations Act, 2018 provides a way to build on our past efforts at supporting rural residency training by providing $15 million for a new Rural Residency Program

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[12] US Department of Health and Human Services, Health Resources Services Administration, *Designated Health Professional Shortage Areas Statistics*, HRSA Data Ware House. 2018. Available at *https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false*

[13] Patterson DG, Schmitz D, Longenecker R, Andrilla CHA. "Family medicine Rural Training Track residencies: 2008-2015 graduate outcomes." Seattle, WA: WWAMI Rural Health Research Center, University of Washington. Feb 2016. http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/02/RTT_Grad_Outcomes_PB_2016.pdf

to expand the number of rural residency training programs. The program will focus on developing programs that are sustainable beyond the Federal grant funding.

Conclusion

Thank you again for the opportunity to discuss these rural health issues with you today and for your support of HRSA's work through the Federal Office of Rural Health Policy to improve access in rural communities across the country. I would be pleased to answer any questions you may have.