ALASKA HOSPITAL & HEALTHCARE ASSOCIATION 70 YEARS

October 5, 2023

Chairman Smith
U.S. House Committee on Ways and Means
1139 Longworth House Office Building
Washington, D.C. 20515
WMAccessRFI@mail.house.gov

Re: Alaska Comments on Improving Access to Healthcare in Rural Areas

Dear Chairman Smith,

For 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and other healthcare partners across the continuum of care. AHHA members play an invaluable role, both as community providers and essential employers, in cities, towns, and villages across Alaska. Our mission is to advance the shared interests of Alaska healthcare to build an innovative, sustainable system of care for all Alaskans.

We commend you for recognizing the uniquely difficult access challenges for patients and families living in rural and underserved areas in America, and the need for innovative care models and technology to improve access and care. Given Alaska's unique geography, we are accustomed to finding innovative ways for care delivery, but often run into the very issues highlighted in your letter such as workforce shortages, misaligned payment incentives for both Medicare and Medicaid, and onerous administrative barriers.

Today, we focus our comments on healthcare workforce and innovative models from the perspective of delivering care in rural Alaska. Our state's geography is vast, and heavily rural. Alaska is 663,268 square miles, which is one-fifth the size of the U.S. mainland, and Alaska is "underbedded" for hospital and nursing home services. We have approximately 2.0 acute care hospital beds per 1,000 Alaskans (national avg is 2.5), and Alaska has the fewest nursing home beds per 1,000 persons 65 and older in the U.S.

A significant portion of healthcare delivery comes from our robust Alaska Tribal Health System (ATHS). ATHS covers 586,000 square miles of land, most of which is rural without road access. In fact, over half of Alaska's acute care hospitals (tribal and non-tribal) are critical access hospitals, and 70% of our nursing homes are co-located with a critical access hospital or sole community hospital. The fact that 20% of our acute care hospital beds are only accessible by boat or plan shows that "rural" means something very different to us than the lower 48.

Inadequacy of graduate medical education (GME) Slots

Alaska faces a dire need for family doctors, particularly in rural and remote communities. We were the last state to get GME and our single residency program, the Alaska Family Medicine Residency, was created to prepare family medicine doctors to practice in these under-resourced settings. The program has one of the highest rates of placing graduates in rural and underserved practices of any training program in the United States. Family medicine residents spend time throughout residency in rural Alaska and nearly 80% will choose to stay and practice in state.

Despite being an example of how to expand access to rural communities, the Alaska Family Medicine Residency is unable to expand and is at risk of needing to downsize as the result of CMS barriers. We are currently "above the cap," meaning we receive CMS funding for only 21 of the existing 36 training spots. The way that the per resident amount is calculated places an additional strain on Alaska as we have a lower than typical per resident amount. This means that Alaska not only has a low number of training spots, but also lower reimbursement per resident. This is a clear demonstration of the inadequacy of GME slots because our sponsor hospital, Providence Alaska Medical Center, is essentially being asked to subsidize a majority of the costs for the "above the cap" residents and the remaining per resident reimbursement gap during a time of historic financial challenges for hospitals and healthcare in our country.

Brief Commentary on Harmful Policies

Policies like nursing home staffing mandates create unachievable requirements that fail to advance access or quality. In fact, they do the opposite. Like the rest of the country, Alaska is being crushed by worker shortages, and artificial staffing requirements do nothing to create more workers. Instead, they limit operations—if a facility cannot find workers to meet the standards, the facility must reduce capacity, and reduced capacity means there are less long-term care beds available to receive discharges from hospitals and other environments of care.

This essentially backs up the rest of the healthcare system because patients in hospitals who are medically clear have nowhere to discharge to, so they are stuck in the highest cost of care environment occupying a precious resource that is needed for sicker people, and the hospital receives virtually zero reimbursement from payers, including Medicare and Medicaid.

Another example of a harmful federal policy that negatively impacts rural healthcare is a nursing home survey requirement in 42 U.S.C. 1395i–3. This statute requires the Centers for Medicare and Medicaid Services (CMS) to conduct five federal surveys in every state annually. While this may not sound like much, it creates inequities for heavily rural states. For example, Alaska only has 20 nursing homes in our state, which means our facilities can

expect to be surveyed every 3-4 years under this rule (in addition to their annual state surveys). In contrast, 40 other states have more than 100 skilled nursing facilities, so their facilities can anticipate a federal survey every 15 years. If Alaska was treated the same as those 40 states (i.e. a federal survey every 15 years), there would still be at least one federal survey annually in Alaska.

Innovative Care Delivery Models

The pandemic identified major gaps in care, patient-directed infrastructure, and technology that is critical to improving access and overall health, especially in rural areas. Based on successful strategies in rural Alaska, we recommend CMS and other private payers consider a different model of care in rural communities where there is only a critical access hospital and limited to no in-home skilled services available, which is often the case.

More specifically, we should embrace flexibility and innovation to allow critical access hospitals to operate an "outreach department" consisting of an interdisciplinary team that can continue to provide services to discharged patients to avoid unnecessary and costly readmissions. For this to be effective and sustainable, this type of service must be recognized and reimbursed by Medicare, Medicaid, and other payers. This type of innovation will save money and prioritize the community because we are going outside the hospital to provide services that are otherwise unavailable, thus reducing hospital admissions, poor outcomes, and expensive transfers.

This type of model was deployed during the pandemic to help preserve the acute environment. Here are real life examples and why it makes sense to allow critical access hospitals to extend beyond normal boundaries to provide care:

- *"We were able to triage our outpatients, as many of them were coming up to three times a week to get wound care. Many of these patients were also debilitated and had challenges being mobile and traveling to the hospital. With these patients, and the threat of COVID infections at that time, we had our Wound Care Nurse equipped with appropriate PPE to visit the patients in their homes and to provide the care there. Vital signs and any usual assessments were done as they would in an outpatient visit, but instead of the patient coming to us, we went to the patient in their home. This proved to be a great relief to the patient and to our staff."*

- *"Today, we regularly have patients who want to return home for their final days to die. We do not have hospice care available to them in our rural setting. There is no one who can oversee medication administration and other skilled care needs. If they do not have family who can be trained to oversee or coordinate the management of their care, it is a constant barrier to be able to die with dignity in the home. We can fill this need if we have flexibility to go outside the hospital and in the community where our patients live."*

- *"We have patients who continue to need outpatient infusions of antibiotics or just maintenance fluids. Some patients need home O2 monitoring. There are patients who are newly diagnosed with chronic conditions (eg. Diabetics) who need oversight or assistance with insulin administration, and others who need subcutaneous administration. These patients do not need to be admitted to our critical access hospital, but there is nowhere else to go in our community. If we want good outcomes at a lower cost, we should be able to go to them, but as a critical access hospital, it is not a covered service."*

Conclusion

On behalf of Alaska's hospitals, nursing homes, and community partners throughout our state, we want to thank you for your efforts to improve access to healthcare in rural Alaska and beyond. We also want to thank Alaska's Congressional Delegation for their constant support and desire to improve healthcare and access for Alaskans. We are available to answer any questions and provide follow up information as needed.

Sincerely,

Jared C. Kosin, JD, MBA
President & CEO

CC U.S. Senator Lisa Murkowski
U.S. Senator Dan Sullivan
U.S. Representative Mary Peltola
Alaska Department of Health Commissioner Heidi Hedberg