October 5, 2023

The Honorable Jason Smith
Chairman
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Submitted electronically via email to WMAccessRFI@mail.house.gov

Re: House Ways and Means Committee Request for Information - Policy Solutions to Improve Access to Care for Individuals Living in Rural and Underserved Communities

Dear Chairman Smith:

Premier Inc. appreciates the opportunity to submit comments on the House Committee on Ways and Means request for information (RFI) on improving access to healthcare in rural and underserved areas. Premier applauds your leadership in this area and strongly supports efforts to develop innovative policy approaches to expand access to this critical and vulnerable population. Below, Premier highlights opportunities to strengthen the quality and sustainability of care for patients, providers and payors in rural and underserved areas, including:

- Develop legislation that requires the Centers for Medicare & Medicaid Services (CMS) to adopt new or supplemental data sources for calculating labor costs in the annual provider payment update processes to more accurately reflect the true cost of labor inclusive of contract labor costs;
- Develop long-term solutions to promote financial stability for rural providers, including eliminating the Medicare sequestration cuts, preventing impending cuts to the Medicaid Disproportionate Share Hospital (DSH) program for at least two years, and removing statutory restrictions on the Rural Emergency Hospital (REH) designation;
- Pass the bipartisan Preserving Patient Access to Home Infusion Act (S.1976 / H.R.4104) to unlock access barriers for vulnerable beneficiaries;
- Support policies that help strengthen the healthcare workforce, as well as provide maximum telehealth flexibilities to providers in alternative payment models (APMs);
- Engage with rural providers to develop and recruit participants for innovative Medicare payment models that emphasize improving quality, access and sustainability in rural communities;
- Pass the bipartisan Medical and Health Stockpile Accountability Act (H.R. 3577) to help ensure rural providers have access to critical medications and supplies during an emergency response;
- Support the adoption of technology in healthcare settings to optimize workflows, reduce administrative burden and stress on workers and permit healthcare workers to focus their time and energy on direct patient care, including addressing electronic prior authorization issues;
- Incentivize the wider adoption of interoperable health information technologies across the spectrum of care, particularly in long-term care and post-acute care (LTPAC) settings; and
- Ensure adequate payment for patients receiving long-term care (LTC) pharmacy services that choose to reside in their home.

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, 812 million hospital outpatient and clinic encounters and 131 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. GEOGRAPHIC PAYMENT DIFFERENCES

Addressing Labor Costs

Hospitals, health systems, and providers continue to operate under enormous financial challenges, due in significant part to skyrocketing labor costs. As talent shortages become more severe, providers are paying more to attract and retain scarce staff, a reality that is not expected to significantly subside. A PINC AI™ analysis found that labor costs increased by more than 16 percent since the start of FY 2021 and increased by more than 10 percent in FY 2022 alone, whereas CMS calculates labor costs to rise at approximately 3 percent annually. A major reason for this difference in estimated labor costs is that CMS leverages labor cost estimates from the Bureau of Labor and Statistics for its analysis and excludes contract labor costs whereas PINC AI leverages actual data from hospitals regarding their true labor costs inclusive of contract labor costs.

The impact of this problem falls disproportionately on individuals in rural and underserved communities, as providers are increasingly sparse in these areas and therefore require a premium to recruit. To address these geographic payment differences, ***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.

III. SUSTAINABLE PROVIDER AND FACILITY FINANCING

Ensuring Adequate Payment for Rural Care

More broadly, Medicare provider payments continue to be unstable and have proven to be slow in response to the dual shock of the COVID-19 Public Health Emergency (PHE) and sharp increases in the cost of providing care stemming from historic inflation and rising wages. ***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***. Additionally, Congress should 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.

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

- *Rural Emergency Hospitals (REH).* ***Congress should remove statutory restrictions on the Rural Emergency Hospital designation*** to ensure this new provider type is a viable option for rural hospitals and their communities and does not impact rural providers' access to skilled nursing facility (SNF) swing beds.
- *Community Health Centers (CHC).* ***Premier urges lawmakers to quickly act to ensure there is strong continued funding for CHCs*** which support critical care in underserved areas and play a vital role in America's rural communities. The CHC Fund (CHCF) accounts for nearly 70 percent of health center funding and is currently funded through Nov. 17 under the current continuing resolution (CR). We urge Congress to work together to provide stable and strong multi-year funding for CHCs.
- *Medicaid Disproportionate Share Hospital (DSH) Program.* The onset of Medicaid DSH cuts totaling $4 billion in FY 2024 alone that were set to begin Oct. 1 has been similarly delayed until November 17 as part of the CR. DSH payments are critical to sustaining safety-net hospitals that have high Medicaid patient volume, including many rural facilities. ***Premier urges Congress to protect access to care and take action to prevent these Medicaid DSH cuts for at least two years.***
- *340B Program*. ***Congress should address the unprecedented threats to the 340B Program*** that are arising on an almost daily basis, as advocated by Premier.

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, 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.***

IV. ALIGNING SITES OF SERVICE

Improving Access to Telehealth

Expanding telehealth flexibilities provides a clear, viable pathway for Congress to help align sites of service to support care for individuals residing in rural and underserved areas. Telehealth benefits are more widely utilized in Medicare Advantage (MA) than in Traditional Medicare – a recent HHS OIG report found that 49 percent of MA beneficiaries used telehealth during the first year of the COVID-19 pandemic, compared to 38 percent of those enrolled in Medicare fee-for-service. By CMS' analysis, nearly one-third of beneficiaries that received a telemedicine service did so by using audio-only telephone technology. However, MA plans are prohibited from counting diagnoses captured through audio-only telehealth visits towards beneficiary scores for risk adjustment. This reduces the available resources for plans and providers in risk-sharing arrangements that utilize audio-only telehealth to manage care. It also creates access issues for

beneficiaries who are physically unable to attend an in-person office visit and lack adequate resources, including access to broadband in rural communities, to use audio-video technology. Consistent flexibility across all Medicare programs is critical. Accordingly, ***Premier urges Congress to allow audio-only telehealth diagnoses to be included in risk adjustment methodologies across Medicare payment models, including ACOs.***

While Medicare Shared Savings Program (MSSP) and other Center for Medicare and Medicaid Innovation (CMMI) waivers contain telehealth waivers, APM participants have used them in a very limited capacity due to strenuous reporting requirements. ***Premier urges Congress to provide maximum telehealth flexibilities to providers in APMs and increase those flexibilities with adoption of risk.*** Specific areas include:

- *Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) ability to furnish services.* While RHCs and FQHCs can serve as a site where patients can receive telehealth services ("originating site"), statute has restricted them from serving as the site where practitioners can furnish telehealth services ("distant site"). During the PHE, Congress enacted legislation which allows RHCs and FQHCs to serve as distant sites. RHCs and FQHCs are a critical source of care for many patients in underserved communities. Expanding this flexibility would improve access and continuity of care for patients who rely on RHC or FQHC services. ***Premier urges Congress to work with CMS to ensure regulatory action is taken to allow for RHCs and FQHCs that are participating in APMs to serve as distant sites for telehealth services.***
- *Expanded set of services.* CMS established a process to temporarily add numerous services to the telehealth list during the PHE while CMS builds the evidence base for permanent inclusion. The telehealth waivers limit APMs to services available on the existing telehealth lists. ***Congress should work with CMS to test expansion of telehealth services by creating a list of covered telehealth services specifically for APMs, with special consideration for individuals in rural and underserved communities.***
- *Frequency limits.* As part of the PHE, CMS waived frequency limits on certain services furnished via telehealth, including subsequent nursing facility care. Under a fee-for-service construct, these limits may help ensure patients receive proper in-person care and that bad actors do not abuse billing for these services. However, APMs are already incented to provide care in the most appropriate setting to ensure the best outcomes. ***Premier urges Congress to work with CMS to permanently exempt services provided under APMs from these frequency limits***.
- *Established patient requirements.* Under Medicare, several telehealth services require patients to also see their provider in person regularly to continue to be eligible for remote care. This requirement could limit beneficiary access to receiving telehealth to a single provider within the broader APM team of providers. For example, there may be instances where a provider, such as a specialist, could furnish appropriate care to a patient who may be new to the specialist but has already received in-person care from another provider within the APM. ***Premier recommends that Congress work with CMS to create permanent exemptions from established patient requirements for APMs, building on lessons learned from PHE-era waivers.***

V. HEALTHCARE WORKFORCE

Safety from Violence for Healthcare Employees

Addressing workplace safety and violence is essential to recruiting and retaining a robust healthcare pipeline. In a 2018 study, nearly 89 percent of nurses reported incidents of workplace violence - ranging from verbal abuse at the low end of the spectrum, to physical assaults and even deaths at the other - and there are indications that workplace violence against nurses increased during the pandemic. This trend, coupled with the aging of the clinical workforce and pandemic burnout, explains why nearly five million nurses are expected to leave the profession by 2030.

Premier encourages Congress to enact the bipartisan Safety from Violence for Healthcare Employees (SAVE) Act (H.R.2584/S.2768) that would provide federal protections for healthcare workers who experience violence and intimidation in their workplace settings similar to those in the federal statute for aircraft and airport workers. Premier believes that these legal protections would help provide healthcare workers with a safer environment in which to deliver patient care. The SAVE Act additionally would provide grants to hospitals for programs to help reduce the incidence of violence in our care settings. These grants could be used for training hospital personnel, coordinating with state and local law enforcement and purchasing of equipment or technology that will assist in creating a safer environment.

Growing the Physician Workforce

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[1]. These shortages will have real impact on patients, particularly those living in rural and underserved communities. To help grow a sustainable physician workforce to meet patient needs, increased Medicare support for graduate medical education (GME, or residency training) is needed.

Congress in recent years has made investments in physician training by adding 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act of 2021 and an additional 200 slots dedicated to behavioral health in 2022. ***Premier urges Congress to take additional action to increase Medicare-supported GME slots.*** Premier supports the bipartisan Resident Physician Shortage Reduction Act of 2023 (H.R. 2389), 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 (HPSAs). Premier also urges Congress to continue to support the Teaching Health Center (THC) GME program, which supports the training of medical and dental residents in alternate sites such as FQHCs and increases access to primary care physicians in underserved areas.

Strengthening the Pediatric Physician Workforce

Premier believes it is also vitally important to provide strong support for the Children's Hospitals Graduate Medical Education (CHGME) program. CHGME is the most important federal investment supporting the pediatric physician workforce. Since its creation in 1999, the CHGME program has enabled children's hospitals to dramatically increase pediatric physician training and significantly increase the number of pediatricians and pediatric specialists. This has helped alleviate critical pediatric workforce shortages which can be especially acute in rural areas. Continued support for CHGME is vital to maintaining access to care for children and strengthening the pediatric physician pipeline. ***Premier urges Congress to reauthorize the CHGME program in 2023, without delay.***

Boosting the Non-Physician Pipeline

Beyond physician workforce needs, we must 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. 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 capacity, including examining whether all educators in such programs should require an advance 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.***

In addition, 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

[1] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)

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.***

***Premier also recommends that Congress seek opportunities to provide support to grant programs that expand vocational programs to help train for clinical roles that do not require four-year degrees, such as home health aides; nursing assistants; or technicians for pharmacy, radiology, and laboratory**.* For example, most states permit training opportunities for emergency medical technicians (EMTs) to begin in high school and similar programs should be considered for other non-four-year degree programs in the healthcare space. 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.

Finally, Premier recommends that ***Congress provide continued strong funding for existing health workforce training programs under the Health Resources and Services Administration (HRSA) intended to target allied health professionals***. Congress should continue to support the National Health Service Corps (NHSC), which provides scholarships and loan repayment funds for medical providers who agree to practice in medically underserved areas. 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.

Leveraging Qualified International Resources

During the pandemic, a backlog of 10,000 international nursing visas built up because of an inability by the U.S. State Department to process visa applications, delaying the deployment of critical resources to reduce labor pressure across the nation. In recent months, progress has been made in working through this backlog, providing some short-term relief. However, more can be done to leverage qualified international healthcare workers domestically in ways that will ensure appropriate standards of care are met and labor shortages are addressed. Specifically, international nurses play a critical role in filling shortages of lower acuity nursing positions. In addition, there are almost 280,000 unused nursing visas from FYs 1992-2020 that can be recaptured and utilized to help address the current workforce challenges, as highlighted in the Healthcare Workforce Resilience Act (S.1024) from last Congress. Therefore, ***Premier urges Congress to work with the State Department to address the backlog of nursing visas and identify opportunities to recapture the unused visas from the past three decades.*** Critical to this will be ensuring that the State Department continues to prioritize visa applications and interviews for nurses and other healthcare workers, as well as ensuring proper staffing at U.S. embassies to carry out this work.

Premier also recognizes that several U.S. health systems have an international footprint and believes this may serve as an opportunity for these international outposts to recruit and train healthcare workers to U.S. standards. By working collaboratively with the State Department and HRSA, international training programs could help match workers with shortage areas in U.S. communities. Therefore, ***Premier urges Congress to consider a grant program or pilot program to test leveraging U.S. healthcare facilities overseas to recruit and train healthcare workers for placement in shortage areas in the U.S.***

Premier also encourages Congress to pass the bipartisan Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942/S.665) which would allow international doctors to remain in the U.S. upon completing their residency under the condition that they practice in areas experiencing doctor shortages.

Nursing Home Minimum Staffing Proposal
Premier is deeply concerned about the proposed CMS nursing home minimum staffing mandate and believes the agency's proposal reflects a lack of understanding of the true state of the workforce environment. The implementation of any unfunded staffing ratios in any healthcare setting is preposterous given the current labor challenges that are occurring across the board but are particularly acute for long-term care facilities (LTCFs). Premier intends to submit detailed comments to CMS regarding the proposal and asks Congress to monitor this issue closely as it may have negative consequences on access to SNF care in rural and underserved areas.

VI. INNOVATIVE MODELS AND TECHNOLOGY

Preserving Access to Care in Rural Areas
There is significant variation in MA penetration across different geographies, with rural areas generally having a lower proportion of MA beneficiaries and a higher proportion of beneficiaries in Traditional Medicare compared to urban areas. Premier appreciates that Congress and CMS have recognized the specific needs of rural hospitals and health systems in Traditional Medicare through offering cost-based payment for Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs). Cost-based payment preserves access to care for rural beneficiaries by adequately funding costly rural hospital operations. As MA penetration increases nationwide, rural providers face the challenge of negotiating in-network payment rates, which may not sufficiently cover the cost of care, with private health plans. When CMS implemented prospective Medicare fee-for-service payments for hospitals and moved away from cost-based payment in the 1980s, rural hospital finances were disproportionately affected. From 1985-1988, 140 rural hospitals closed, most of which had fewer than 50 beds. One-third of the smallest rural hospitals that closed faced the highest negative margins on Medicare patients.

Congress must urgently act to ensure that rural Medicare beneficiaries maintain access to care as MA penetration increases. ***Premier recommends that Congress work with CMS to engage with rural providers to develop and recruit participants for innovative Medicare payment models that emphasize improving quality, access and sustainability in rural communities.*** Incenting rural providers to join APMs is crucial to not only equipping them to succeed under MA, but to CMS achieving the agency's goal of moving all Medicare and a majority of Medicaid beneficiaries into an accountable care relationship by 2030. Specifically, Premier recommends the following actions:

- *Adopt more sustainable financial methodologies for rural providers.* This includes lowering the minimum savings rate or reducing discounts applied under the models for rural ACOs, adjusting benchmarks to account for historical underutilization of services and modifying benchmarks to hold rural ACOs harmless for cost increases that are driven by the underlying cost-based payment system.
- *Provide new opportunities for upfront funding.* CMS recently proposed a new upfront funding opportunity for low-revenue ACOs new to the MSSP and inexperienced with other ACO initiatives. Many rural providers use single tax identification numbers (TINs) for their CAH and provider groups and will be unable to qualify as low-revenue by CMS' existing standards.
- *Create a glide path to risk.* A value-based purchasing program should be developed for CAHs that are not currently participating in APMs to put them on a path to value-based care. Additionally, rural ACOs should be allowed at least two years to progress to the next risk level, with the option to progress faster.
- *Modify risk adjustment approaches.* Rural providers often have lower patient risk scores, but higher rates of comorbid conditions and chronic disease among their patient populations. To address this challenge, these providers should be incentivized to more accurate coding capture practices by counting diagnoses captured via telehealth for risk adjustment, incorporating social determinants of health (SDOH) into the risk adjustment methodology, and removing or setting a higher score cap for beneficiaries aligned through rural providers.

Access to Medical Supplies

One of the most vexing problems that presented during the COVID-19 PHE was the lack of visibility into the quantity and location of critical medical supplies and pharmaceuticals on U.S. soil. As highlighted by the GAO, the opaqueness of the healthcare supply chain failed to provide us with early warnings of supply shortages and the information necessary to overcome them. The Medical and Health Stockpile Accountability Act (H.R. 3577) is designed to ensure the nation's healthcare providers and the patients they care for never again face the widespread supply shortages and uncertainty that plagued the U.S. during the pandemic. The legislation would require the Administration for Strategic Preparedness and Response (ASPR) to augment the Supply Chain Control Tower to establish an automated supply chain tracking application that provides insight into critical medical supplies across the country. The legislation also includes provisions that are designed specifically for rural providers to gain visibility and access to critical medical supplies, such as funding for rural hospitals to implement vendor managed inventory (VMI) systems. ***Premier urges Congress to include the Medical and Health Stockpile Accountability Act as part of the forthcoming Pandemic and All-Hazards Preparedness Act (PAHPA) reauthorization.***

Support Use of Technology and Workflow Solutions

Premier encourages Congress to support the adoption of technology in healthcare settings to optimize workflows, reduce administrative burden and stress on workers and permit healthcare workers to focus their time and energy on direct patient care. For example, Premier supports requiring greater payer adoption of electronic prior authorization procedures. The prior authorization process is burdensome to providers and patients and remains a manually-intensive process that requires healthcare professionals to take time away from caring for their patients to engage with payers. Additionally, it can delay access to care. Because of prior authorization time lags, 94 percent of providers responding to a recent survey of more than 1,000 practicing physicians reported treatment delays, 80 percent reported that prior authorization can sometimes lead to treatment abandonment, 25 percent said these delays resulted in hospitalization and 19 percent said delays led to a life-threatening event or required intervention to prevent permanent impairment or damage.

Congress can vastly improve the prior authorization process for Medicare Advantage beneficiaries by passing policies contained in the Improving Seniors' Timely Access to Care Act, which has broad bipartisan, bicameral support in Congress and is supported by more than 500 organizations. The House unanimously passed the legislation in the 117th Congress and, on July 26, 2023, the House Committee on Ways and Means approved legislation that incorporates the Improving Seniors' Timely Access to Care Act, with minor technical corrections. The bill would streamline, standardize and implement automation of the prior authorization process for certain Medicare Advantage services and procedures. Transitioning to fully electronic prior authorization transactions could save the health system $449 million annually, improve patient safety, end harmful care delays and remove provider burden.

Interoperable Health Information Technologies and Artificial Intelligence (AI)

Premier encourages Congress to support wider adoption of interoperable health information technologies across the spectrum of care that can further ease provider burden and streamline data collection and reporting, particularly in long-term care and post-acute care (LTPAC) settings. Inequitable access to and use of interoperable health IT persists across the LTPAC continuum. As a result, it is more difficult to broaden data exchange between stakeholders, especially during instances of shared care and transitions of care between hospitals and the LTPAC sector. These challenges can be especially acute in rural areas. Moreover, these providers face the same labor challenges, including shortages and burnout, as acute-care settings. Greater use of interoperable technology, such as interoperable electronic infection control and remote surveillance technologies, would enable more seamless patient care and also help alleviate administrative burden. Congress should empower LTPAC providers to work more effectively and maximize their workflow by providing financial incentives through the Medicare program to adopt interoperable health information technology that can standardize patient data, improve care quality and reduce costs.

Furthermore, with advances in Artificial Intelligence (AI), many innovative health providers are utilizing this technology to improve care, lower costs and deliver care more efficiently. ***As Congress considers policy proposals related to the use of AI in healthcare, it is critical that the rural perspective is carefully considered. Congress should ensure rural providers are not disadvantaged in the push for HIT and AI so they are able to leverage this technology to care for their patients effectively***. The adoption of technology and AI cannot further the divide between rural and underserved areas versus others – it cannot create additional haves and have nots in healthcare as all patients in all areas deserve to be treated with modern day technology advancements.

Hospital at Home

In November 2020, in response to COVID-19 pandemic-related hospital capacity concerns, CMS promulgated the Acute Hospital Care at Home waiver. The waiver provides a hospital diagnosis-related group payment to hospitals that provide hospital at home care. Premier supports providing current ACOs the flexibility to implement hospital at home programs that can benefit patients in rural and underserved areas. In addition, Premier supports the evaluation of the current requirements for hospital at home to determine if additional flexibilities can be leveraged to best care for patients in the home setting. However, the hospital at home program as currently designed is not sustainable in rural communities as the onerous requirements for multiple in-person visits to the patient's home are extremely difficult to operationalize absent geographical density. Therefore, ***Premier believes it is critical that Congress examine alternatives and refinements to the current hospital at home waiver to permit expansion into rural and underserved areas.***

Clinical Trial Diversity

Traditional clinical trials pose significant financial and logistical challenges to potential participants, many of which make it difficult for the trial to recruit a diverse patient population from geographically diverse areas. As a result, trial data may not be representative of a device or drug's efficacy across all patient populations. Premier supports the elimination of barriers that prevent patients in rural areas from participating in medical clinical trials. Trial site location may be a barrier to trial enrollment for patients from rural areas or from a low socioeconomic background, for example, due to the burden of travel, lodging for family or caretakers and other expenses. ***Efforts to recruit a more diverse patient population for trials will be significantly bolstered by the widespread adoption of decentralized clinical trials*** and therefore Premier urges Congress to work with the Food and Drug Administration (FDA) to ensure it swiftly implements necessary guidance to permit the uptake of decentralized clinical trials as required by the Consolidated Appropriations Act of 2023.

LTC Pharmacy at Home

The number of Americans needing long-term care (LTC) services will double by 2050[1], and the vast majority of those individuals will rely heavily on prescription medications. Individuals in rural and underserved areas can rely on LTC pharmacies to provide a broad array of medications, services and care coordination to achieve the best outcome – including from hospital discharge to the transition back to the home. Unfortunately, federal policies are currently structured in a way that does not sufficiently pay for LTC pharmacy services provided in the home setting. ***Premier suggests Congress work with CMS to pursue a pathway to ensure adequate payment for patients receiving LTC pharmacy services in their home to promote greater access in rural and underserved areas.***

VII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the Rural and Underserved Health RFI. Please consider Premier, and our significant cohort of rural hospital and continuum of care members, a resource as you continue this important work. If you have any questions regarding our

comments or need more information, please contact Shara Siegel, Senior Director of Government Affairs, at shara_siegel@premierinc.com or 646.484.0905.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.