Ways and Means Member Day
Sept. 14th, 2023
Testimony of Chairman Mark Green (TN-07)

Thank you Chairman Smith and Ranking Member Neal for this opportunity to testify to the committee about my bills addressing the concerning condition of our rural health systems.

I know that many of you have heard the same sobering stories from constituents, physicians, hospital administrators, and parents – our rural hospitals are entering a financial and workforce crisis. As an emergency care physician and former CEO of a medical staffing company, I know first-hand how desperate the situation has become and it's only gotten worse in recent years.

My home state of Tennessee is greatly impacted by rural hospital closures and limited access to emergency medicine. According to US News and World Report, Tennessee has seen more hospital closures than any other state besides Texas. In fact, the Tennessee Hospital Association estimates that 45% of Tennessee hospitals are at risk of closure. This is an impending disaster for my constituents.

In order to combat this worrying trend, I have introduced three pieces of legislation as part of my broader rural healthcare initiative.

Firstly, let us start with HR 1128, the Rural Health Care Access Act which is endorsed by the National Rural Health Association and the National Association of Rural Health Clinics. This bill targets rural hospital closures by expanding the federal definition of "Critical Access Hospitals."

According to the American Hospital Association, over 130 rural hospitals across the country closed their doors from 2010 to 2021, and according to a GAO report from December 2020, the median distance of travel rural patients drive to receive care increased by 20 miles – adding an ever-expanding barrier to essential inpatient and emergency care.
The Rural Health Care Access Act repeals the "35-mile rule" that prevents many rural hospitals from receiving a Critical Access Hospital designation if they are less than 35 miles away from another hospital.

This bill does not change any other requirement for hospitals to receive Critical Access designation – the 35-mile rule is the only change we are making to federal law. Hospitals that wish to receive this designation will still have to be designated as "rural", only provide acute care, and primarily host patients for less than 96 hours.

These Critical Access Hospitals receive cost-based reimbursement from Medicare, greater flexibility for staffing and service requirements, and access to a variety of grant opportunities. This bill will help reduce the financial vulnerability of these critical hospitals, which often provide essential medical services in rural communities like the ones I represent.

My second piece of legislation targets a specific issue in the hospital system – ER departments. HR 1129, the Rural ER Access Act would repeal a federal regulation that prohibits free-standing emergency departments from operating more than 35 miles from a hospital.
This 35-mile perimeter rule was I'nstituted in the 1990s to monitor the safety of ER patients. HHS was concerned that if ERs operated too far from a self-standing hospital, then that emergency patients would not have other medical options should the self-standing ER department fail in its mission to treat and triage.

However, speaking as an ER physician who practiced medicine in rural Tennessee, I know how advanced our medical technology is, and I know how desperate some situations are. This antiquated rule is now hindering patient access rather than saving patient lives.

By eliminating this mileage requirement, free-standing ERs would be able to provide frontline emergency care to the rural communities that most desperately need it. During an emergency, these facilities can provide a crucial lifeline, especially in rural communities where the nearest hospital is many miles away.

We also need to address the workforce burnout amongst our medical providers by enacting HR 5213, the Reducing Medically Unnecessary Delays in Care Act.

This legislation is endorsed by the Medical Group Management Association and the American Academy of Family Physicians, and it seeks to unburden our doctors from the bureaucratic red tape that is prior authorization.

According to the Medical Group Management Association, "72% of medical groups report that the clinicians assigned to complete their peer-to-peer reviews by the plans are not from a relevant specialty to the treatment or disease in question — resulting in dangerous delays and flat-out denials."

In order to combat this worrying trend and reduce these unnecessary delays in care, this bill would reform the practice of prior authorization in Medicare and Medicare Advantage. If my legislation becomes law, only board-certified physicians in the relevant specialty would be the ones making these important decisions about care. Specifically, it would also direct Medicare, Medicare Advantage, and Medicare Part D plans to comply with requirements that restrictions must be based on medical necessity and written clinical criteria.

And I am going to break from my script for just a second to say this: when a physician reaches out to a health insurance or Medicare for permission to do a procedure that it wants to do for its patient, they are often times talking to someone who has no medical license or no care, and that individual makes the medical decision to take something off the table that the physician can use to heal that particular disease process. That is a medical decision. If there are five ways to heal something and the insurer or the Medicare or Medicaid administrators at three of those away, that is a medical decision. What this bill does is it says that a physician that normally treats that type of disease should be the one making that decision at Medicare and Medicaid.

What all these bills aim to do is to restore our rural health system and save our doctors from needless paperwork. With this committee's help, I am excited to get our medical system back on track.

Finally, Mr. Chairman, as a representative of Music City, USA, I want to mention the Help Independent Tracks Succeed (HITS) Act which I have cosponsored the past three Congresses and is so crucial for independent creators in Nashville who author and produce the hits we know and love. This bill makes much-needed reforms to the tax code to ensure these creators receive same treatment that other creative industries already get. I hope the Committee can markup this legislation in the near future.

Thank you and I yield back.