INFRASTRUCTURE INVESTMENTS CRITICALLY NEEDED IN HEALTH CARE AND WORKFORCE DEVELOPMENT INITIATIVES

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The COVID-19 pandemic has demonstrated that hospitals and long-term care facilities are essential components of the nation's infrastructure. America's hospitals and not-for-profit and public nursing homes have heroically met the challenges of COVID-19. They rapidly added surge, critical, and acute care bed capacity to care for the influx of COVID-19 patients and swiftly adopted innovative clinical protocols to improve COVID-19 outcomes.

But the financial cost from the dual impacts of increased expenses and lost revenues was staggering. While Federal relief blunted the impact in 2020, hospitals and nursing homes face major financial challenges in 2021.

As a result, hospitals and nursing homes have deferred critically needed capital investments. Health care provider infrastructure continues to deteriorate, especially in inner-city urban and rural communities where access to care is a constant concern. As drivers of economic growth in their communities, hospitals directly employ nearly 5.9 million individuals, support 16.5 million jobs in their communities, and spur almost $3 trillion in economic activity.[1] The financial challenges facing hospitals and other providers puts these investments at risk. The COVID-19 pandemic has made it clear that the nation's provider infrastructure must be more flexible to better respond to pandemics and other disasters and better meet Americans' basic health care needs.

As Congress addresses the nation's infrastructure needs, GNYHA has identified three priority areas for health care investments:

- **Capital Access:** Financially struggling safety net hospitals have tremendous difficulty securing capital to support health care access and delivery system reforms, leading to a rapidly deteriorating hospital infrastructure in rural and urban communities. In addition, the nation's aging nursing home infrastructure must be updated to address the health care needs of the elderly population. Any plan to stabilize health systems and other providers serving vulnerable communities depends on capital support. It is the only way they can transform into less costly integrated care models and continue to deliver essential services to their communities.
- **Workforce Development:** To ensure a hospital and long-term care workforce stocked with well-trained personnel, the nation needs continued and enhanced support to educate and train nurses and other frontline workers. Training the next generation of physicians in particular will allow the US to avoid a doctor shortage and ensure care delivery during and after the COVID-19 pandemic.
- **Health Information Technology (HIT):** As hospitals and health care providers become increasingly digitized, particularly in response to regulatory requirements and the COVID-19 pandemic, they must continually upgrade and enhance their HIT systems. But with scarce financial resources, urban and rural safety net hospitals' HIT infrastructure is often outdated and sometimes obsolete. They need financial support to address these basic needs and cybersecurity threats. They also need investments to support telehealth start-up costs to expand innovative care delivery models.

1 American Hospital Association, https://www.aha.org/system/files/2018-06/econ-contribution-2018_0.pdf.

CAPITAL TO SUPPORT AN EVOLVING, FLEXIBLE DELIVERY SYSTEM

The COVID-19 crisis has highlighted the nation's deteriorating health care infrastructure. Hundreds of rural and inner-city hospitals are at risk of closure, threatening a major source of employment and economic vitality as well as access to critically needed primary and specialty care services, including obstetrics, mental health and substance abuse services, and trauma.

While some segments of the nation's health care delivery system are experiencing rapid redesign and innovation, scarce access capital threatens to leave vulnerable communities behind. In New York, nearly 30 hospitals are on a State "watch list" for closure with dozens more in severe financial condition. New capital investments in innovative care delivery models, such as freestanding emergency departments, urgent care centers, and telehealth platforms (as described below) are essential to ensuring continued access to care in underserved areas.

As the COVID-19 pandemic continues, hospitals and long-term care facilities with limited access to capital are struggling to maintain and modernize aging facilities, including basic upgrades to HVAC systems needed for infection control and energy efficiency.

Congress should:

- Adopt policies to increase hospital and nursing home access to capital including grants for new projects, loan forgiveness for existing debt, credit enhancement programs to support enhanced access to loans, and innovative public-private partnerships to support infrastructure projects.
- Reestablish and fully fund the Hill-Burton program. The US House previously passed the Moving Forward Act (H.R. 2), which would reestablish the Hill-Burton program and allocate $10 billion for the construction and modernization of hospitals and medical facilities. GNYHA supports this proposal but believes Congress should allocate $100 billion to meet the hospital and health care community's extraordinary needs. This funding would allow for critical upgrades to fortify health care providers and ensure readiness for future public health emergencies.

WORKFORCE DEVELOPMENT

An infrastructure of appropriately educated and trained personnel is critical to the US remaining a world leader in biomedical and health care innovation. A robust pipeline of doctors, nurses, and ancillary staff of diverse backgrounds will not only promote innovation but also strengthen the health care safety net infrastructure in urban and rural areas. The COVID-19 pandemic has demonstrated the need to invest in a larger supply of qualified health workers who are ready to respond to the next emergency.

The physician component of the nation's health care infrastructure must be further developed. A national doctor shortage would impact academic medical centers, small urban and rural hospitals, and other components of the health care system. The Association of American Medical Colleges (AAMC) projects that the United States will face a shortage of between 54,100 and 139,000 physicians by 2033. Given the considerable time it takes to "make a doctor," coupled with the aging of the nation's physician workforce—more than two out of five currently active physicians will be 65 or older within the next decade—the time to act is now. Moreover, the AAMC found that the COVID-19 pandemic magnifies the need to address shortfalls in both primary care and specialty care doctors.

Training a new doctor requires a minimum of three training slots and as many as eight slots, depending on the specialty. Medicare provides payments to teaching hospitals to support these training slots. But the Balanced Budget Act of 1997 included a provision that limits the number of doctors for which teaching hospitals can receive Medicare reimbursement to provide training (the "doctor cap"). The Resident Physician Shortage Reduction Act would fix this outdated policy by

providing 14,000 additional "cap slots" to teaching hospitals over a seven-year period (2023–2029). Each cap slot would translate to one year of training for a new doctor and, when fully phased in, would produce approximately 4,000 additional doctors per year, enough to offset the AAMC's projected shortfall and ensure the physician research and care delivery infrastructure is maintained.

The nursing and ancillary staff component of the nation's health care infrastructure, including those in both clinical and non-clinical roles, must also be further developed and supported. All members of the care team—including nurses, physical therapists, technicians, transporters, nutrition staff, and environmental staff—play a crucial role in an efficient health care delivery system. But safety net hospitals and not-for-profit and public nursing homes in underserved urban and rural areas often struggle to recruit, train, and retain qualified staff to fill these important roles. An investment in "unskilled" people at the lower end of the economic spectrum in particular would strengthen the health system, build the economy, and provide an abundance of middle-class jobs.

Congress should:

- Pass the Resident Physician Shortage Reduction Act and add new residency slots to the physician training pipeline.
- Invest in health care workforce recruitment and training funding in urban and rural areas so that safety net hospitals and long-term care providers can develop the workforce they need to care for their communities.

HEALTH INFORMATION TECHNOLOGY (HIT) NEEDS

The use of telehealth technology has grown in recent years as health care providers expand patients' access to remote providers and enhance access to services. The COVID-19 pandemic created an urgent need to significantly expand telehealth services. With the explosion of COVID-19 cases in the New York region, health care providers closed their extensive ambulatory networks and turned to telehealth to help maintain continuity of care and respond to new demands such as an increased need for mental health services.

During the COVID-19 pandemic, several Federal agencies enacted telehealth expansions and removed barriers to help hospitals and health care providers navigate the crisis. The Centers for Medicare & Medicaid Services offered a number of waivers to existing telehealth rules that allowed providers to expand access to Medicare beneficiaries. Many GNYHA members were immediately able to bill Medicare for telehealth services. A White House executive order also directed Federal agencies to identify temporary flexibilities extended during the public health emergency (PHE) and consider whether they should be made permanent to support economic recovery.

Even before the pandemic, hospitals spent hundreds of billions of dollars on electronic health record (EHR) and other technologies over the past decade, largely in response to the Federal "meaningful use" program. But safety net hospitals have struggled to make critical technology sys-tem updates and enhancements due to increasingly stringent EHR requirements, higher vendor costs, and cybersecurity threats. Hospitals and health care providers must continue to invest in HIT to improve their EHRs, which currently do not easily share data to support care, engage patients, or provide the data and analytics to support new models of care. Additional capital would allow safety net hospitals in particular to keep pace with the evolving landscape.

Moreover, hospitals and health care providers have become primary targets of cyber criminals, compromising sensitive patient data while impacting the delivery of patient care. The US has seen cyber-attackers, often foreign government entities, exploit vulnerabilities in hospital and health care provider networks to gain access to health information and intellectual property. During the COVID-19 pandemic, health care providers continued to be the most targeted sector for cyber-attacks

as remote work and telehealth created new technology challenges and increased cybersecurity threats. As the HIT environment grows and hospitals become more connected to patients and others via telehealth and other means of access, so does the need for infrastructure and technology to support cybersecurity concerns.

Congress should:

- Codify the wide range of emergency telehealth coverage and access measures enacted during the PHE.
- Pass legislation to help hospitals and health care providers, particularly safety net hospitals, further develop their telehealth capacities. Any legislation should:
    - Reimburse providers for telehealth services if those same services are covered when delivered in-person
    - Include audio only, where clinically appropriate, within the definition of telehealth
    - Allow providers to prescribe controlled substances via telemedicine without a prior in-person exam
    - Allow hospitals to bill for the originating site facility fee and practitioners to bill for the professional fee, and permit hospitals to bill the Outpatient Prospective Payment System or other applicable payment system when services are delivered to Medicare beneficiaries in their home
- Lift all geographic site restrictions for providers and patients for telehealth, allow providers and patients to be anywhere it is reasonable (taking into account privacy and security concerns) to deliver telehealth services, and expand the list of practitioners eligible to deliver telehealth and be reimbursed to all providers who can bill Medicare for in-person services
- Establish capital investments, grants, and subsidies to ensure wider patient access to telehealth services for specialty care—telehealth capacity requires investments in significant start-up costs for videoconferencing equipment, reliable connectivity to other providers and patients, staff training, and other resources to manage services
- Provide financial support for hospitals and health care providers to build and upgrade their information technology systems that contain patient data to support evolving cybersecurity needs.

CONCLUSION

As Congress considers investments in infrastructure, GNYHA strongly urges legislation to include provisions that address hospital and nursing home needs in the areas of access to capital, workforce development, and HIT to support an ever-evolving health care delivery system and ensure access to care in vulnerable communities. We also look forward to working with the Administration on payment reforms that would align hospital and other provider payment structures to incentivize delivery system reforms that enable health care providers to better prepare for future public health emergencies.