

October 4, 2023

The Honorable Jason Smith  
Chair  
Committee on Ways and Means  
United States House of Representatives  
Washington, D.C. 20515

The Honorable Richard E. Neal  
Ranking Member  
Committee on Ways and Means  
United States House of Representatives  
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

The Association of State and Territorial Health Officials (ASTHO) is pleased to provide comments in response to the House Ways and Means Committee's "Improving Access to Health Care in Rural and Underserved Areas" Request for Information. ASTHO is the national nonprofit organization representing the public health agencies of the 50 states, five U.S. territories, three freely associated states, and the District of Columbia. ASTHO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to ensuring excellence in public health practice. Our comments below reflect these priorities and perspectives.

It is important to note that on Dec. 2, 2019, ASTHO responded to a similar RFI about this same topic and our member presented at a congressional roundtable focused on rural health. Attached for your reference is a copy of our 2019 comments. We would appreciate the opportunity to learn how responses to the previous RFI are informing your critical work on this topic. Given the similarities between the two RFI's, ASTHO is using this opportunity to highlight the important work of our territorial members.

ASTHO appreciates the committee's intention to identify solutions that can bring new access to care for rural and underserved areas. ASTHO's membership includes states with large rural and underserved areas, as well as the U.S. territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands) and freely associated states (Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia). These island jurisdictions are often overlooked in discussions of rural health but share many of the challenges faced by rural and underserved communities in the contiguous United States. Territorial residents are U.S. citizens, and freely associated state citizens serve at high rates in the U.S. military and maintain a special and strategic relationship with the United States.

Many island and state-based communities lack access to high-quality health care, particularly for mental health and substance misuse treatment, dental care, and veteran care. Patients must travel long distances for specialized services, often at significant cost to the health agency. In some instances, patients may forgo treatment until it is more serious and interferes with their daily lives, costing the healthcare system more than if the ailment was prevented in the first

place. We urge the Committee to include island jurisdictions in their evaluation of rural and underserved healthcare challenges and opportunities.

Thank you for the opportunity to support policy development and solutions benefitting the health of rural and underserved communities across the nation. To reduce health and social inequities in these areas, please consider ASTHO's recommendations in response to four themes identified in the request for information.

### Geographic Payment Differences

More than 1,000 miles of ocean separate any given territory or freely associated state (T/FAS) from its nearest neighboring state. This geographic isolation has stark repercussions for access to care: island residents are often referred off-island for specialized care, which can mean thousands of dollars in associated airfare and lodging expenses—or lack of care altogether for those who cannot afford it. Several steps can help islands develop vibrant and comprehensive systems of care, thereby improving local access to care and reducing the need for off-island travel.

ASTHO appreciates recent [Congressional action](#) to increase the territorial Federal Medical Assistance Percentage. To sustain this increase in territorial communities' access to care, we encourage Congress to also eliminate the territorial Medicaid cap, established in Section 1108 of the Social Security Act. Section 1108 of the Social Security Act establishes an annual ceiling on federal financial funds available for the Medicaid programs in the territories. Historically, territories often exceed the annual cap, after which they must fund their programs using unmatched territorial or local funds. This results in dramatic [cutbacks](#) to Medicaid services in the final months of the fiscal year. It also forces territories to ration care to ensure Medicaid dollars remain available for emergencies late in the fiscal year. Removing the territorial Medicaid cap will allow territorial health agencies to more efficiently and cost-effectively manage the Medicaid programming that improves access to care.

Another step to reduce inequities affecting territorial communities is to enable the Veterans Benefits Administration to provide care for veterans living in the freely associated states (FAS). FAS communities serve in the U.S. armed forces at higher per-capita rates than most U.S. states, but veterans based in the FAS are not able to access VA care within their jurisdictions. Territories also often lack local veterans care facilities capable of meeting community needs, requiring off island referrals for veterans' care. The significant distance, expense, and delays associated with T/FAS veterans' travel for care at state-based VA facilities significantly reduce this underserved community's access to care. We encourage the Committee to consider recommendations from the Government Accountability Office's upcoming assessment of T/FAS veterans' access to care, as it evaluates opportunities to improve access in rural areas (as requested in the [PACT Act](#)).

## Sustainable Provider and Facility Financing

T/FAS facilities are not able to access many of the federal programs designed to support medical providers and facilities in rural and underserved areas.

For example, the Medicare and Medicaid disproportionate share hospital (DSH) payments are available only to hospitals located in the fifty states or Washington, D.C. The Critical Access Hospital designation is also not available to T/FAS hospitals. Furthermore, island hospitals are not eligible for programs like the Medicare Electronic Health Record incentive program and the 340B drug discount program, which support state rural hospitals as they serve low-income populations.

Without access to these programs, territories are particularly reliant on Medicaid funding, which is inconsistent and often insufficient to meet territorial health needs. Expanding T/FAS eligibility for rural health care financing programs (particularly the HRSA Rural Health Program and HRSA 340b Drug Pricing program) would significantly improve access to care in the T/FAS.

## Health Workforce

According to a [recent study](#), governmental public health agencies lost nearly half of all employees between 2017 and 2021, a figure that rises to approximately 75% of employees under age 35 who had been with the agency fewer than five years. Low pay, limited career advancement opportunities, work overload, and burnout were common reasons employees under 35 cited for leaving their agency.

Chronic underfunding of public health before the pandemic resulted in staffing levels that were insufficient for maintaining foundational public health services such as preventing and managing communicable disease outbreaks, ensuring food safety, and linking communities with clinical care. A [2021 study](#) estimated that state and local health departments needed to hire 80,000 additional staff to have adequate infrastructure to provide these foundational public health services—an 80% increase in staffing levels overall.

T/FAS healthcare workforce shortages are shaped by these islands' small populations, limited educational pipelines, low salaries relative to the mainland, and extreme geographic isolation. As with facility financing, the T/FAS also lack access to many of the programs that states use to supplement and strengthen their rural and underserved provider network.

For example, FAS are not eligible to receive placements from the U.S. Public Health Services Commission Corps and have not recently hosted National Health Service Corps members. T/FAS struggle to recruit for Service Corps positions, in part due to match requirements and logistical challenges. The territories also rely on programs like the National Health Service Corps loan repayment program, but this program can be jeopardized if there are shifts in a jurisdiction's geographic Health Professional Shortage Area (HPSA) designation.

Several promising practices may help to address these challenges:

- Expanding T/FAS access to the key workforce development programs available for states—including Service Corps programs—and reevaluating HPSA designation metrics to reflect an island context can help to supplement and strengthen T/FAS workforce capacity. The healthcare workforce in the T/FAS should have the same financial incentives that are available to state-based providers.
- Scholarship, loan repayment, apprenticeship, internship, and fellowship programs have been effective in recruiting, distributing, upskilling, and strengthening health professionals in the T/FAS. Increasing funding to federal agencies such as CDC and HRSA to support these programs and incentivize individuals to pursue training and careers is useful to address workforce shortages.
- Community health workers (CHWs) are important players in rural areas with limited health services. CHWs come from the communities they serve, so they may speak the same language, share lived experiences, and have the same socioeconomic status as the clients they serve. Healthcare delivery systems' interest in CHWs has increased greatly in recent years, and a recent [systematic review](#) of CHW interventions show these programs consistently and cost-efficiently improve access to care for rural and underserved communities. ASTHO encourages the committee to consider solutions that recognize the value of CHWs in promoting access to care in rural and underserved areas.
- In December 2022, Congress passed the Consolidated Appropriations Act of 2023 (Public Law 117-328), which included language authorizing the Public Health Workforce Loan Repayment program to improve the supply of public health professionals and eliminate critical public health workforce shortages across the country. Under this program, which will be administered by the Health Resources and Services Administration (HRSA), public health professionals that agree to serve three years in a state, local, or territorial health department will be offered up to \$150,000 in loan repayment. Not only will this program support governmental public health departments in their recruitment and retention efforts, but it will also support ongoing work to address current and future public health challenges. ASTHO requests that Congress appropriates the necessary funds to support the development and implementation of the program and ensure eligibility of T/FAS in the program.

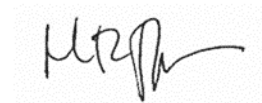
### Innovative Models and Technology

Telehealth has the potential to radically change how healthcare is delivered in isolated island communities. However, without strong telecommunications infrastructure, T/FAS may struggle to fully leverage the innovative telehealth programs coming out of HRSA, CDC, and the VA. Additional support should be made available to incentivize all jurisdictions, including the T/FAS, to undertake foundational efforts to improve broadband coverage in rural areas.

The Tax Equity and Fiscal Responsibility Act (TEFRA), which shapes Medicare reimbursements to hospitals, can also be used to support improved technology uptake. ASTHO's member from the U.S. Virgin Islands (USVI), Commissioner Encarnacion, has highlighted to CMS ways in which USVI's TEFRA base and reimbursement rates do not accurately capture and reimburse for current healthcare costs, including those associated with building maintenance and improved technologies. For example, during the pandemic, USVI Governor Albert Bryan [highlighted](#) that the TEFRA's "outdated methodology" results in the under-reimbursement of millions of dollars for USVI's two hospitals, which had not received updated TEFRA bases since 2011. Improving territorial TEFRA base rates will enable their hospitals to better embrace technological solutions.

As you assess policy solutions to improve access to care in rural and underserved areas, we hope you will consider the needs of the U.S. territories and freely associated states. Thank you for the opportunity to contribute to this important work, and we look forward to continuing the conversation. Please reach out to Jeffrey Ekoma ([jekoma@astho.org](mailto:jekoma@astho.org)), ASTHO's senior director of government affairs, with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Fraser", is placed over a light gray rectangular background.

Michael R. Fraser, PhD, MS, CAE, FCPP  
Chief Executive Officer  
Association of State and Territorial Health Officials