



November 27, 2019

Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Richard Neal, Ranking Member Kevin Brady, and Representatives Brad Wenstrup, Terri Sewell, Jodey Arrington, and Danny Davis:

The Bipartisan Policy Center (BPC) appreciates the opportunity to provide comment for the Rural and Underserved Communities Health Task Force's Request for Information.

In 2018, BPC's health program released a report that reviewed the challenges of providing health in rural communities in seven upper Midwestern states.¹ That work led to the creation of the BPC Rural Health Task Force, led by former Senate Majority Leader Tom Daschle, former Sen. Olympia Snowe, former Gov. Ronnie Musgrove, and former Gov. and HHS Secretary Tommy Thompson. The task force is currently considering proposals designed to increase access to quality, affordable health care in rural communities.

The recommendations on the following pages reflect the current thinking of BPC's health program directors and are consistent with the direction of the task force discussions. They do not necessarily represent the formal positions of BPC or its leaders.

Sincerely,

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1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Rural communities face significant health-related challenges. Dwindling populations and an uptick in the number of small rural hospital closures often result in fewer local providers, which can significantly reduce availability of both primary care and certain critical services in rural communities, such as maternal care. This is coupled with ongoing challenges around rural populations tending to be sicker, older, and less insured than their urban counterparts.

Since January 2010, a total of 107 rural hospitals have closed, and an additional 647 rural hospitals are at risk of closing. These closures not only impact access to care, but also rural economies. On average, the health sector makes up 14% of employment in rural communities.

Hospital closures have a direct impact on a patient's ability to seek needed care, particularly for those who are geographically isolated, elderly, or low income. Of the rural hospitals that closed from 2005 through 2017, 43 percent were more than 15 miles away from the next closest hospital. According to the GAO, rural residents delay or forgo care after a rural hospital closes if they have to travel longer distances to access hospital services.

Additionally, rural hospital care has historically centered on inpatient hospital services and reimbursement systems have been tied to this care; however, this model is no longer as financially viable as health care has shifted increasingly to the outpatient setting. Rural providers have expressed a strong desire to engage in health care transformation that makes it financially feasible for them to provide the services most needed in the community, which is increasingly emergency and outpatient services.

Outpatient care reimbursement rules also create barriers for patients. Medicare prohibits billing for same-day visits by a provider or group of providers treating a single condition.ⁱⁱ The policy is at odds with the current health care landscape of increased specialization, integration, and consolidation. In fact, there are instances when same-day visits are warranted. Although RHCs and FQHCs may bill some medical and mental health visits on the same-day, the provision of care in rural areas extends beyond specific diagnoses and facility designations. This prohibition is unnecessarily burdensome for patients receiving subspecialist care, integrated mental health or substance abuse treatment, and those traveling significant distances. Although CMS acknowledges the need for greater flexibility, no action to address this issue has been undertaken.ⁱⁱⁱ

Finally, consistent access to quality care cannot be attained without a stable workforce. Rural communities have long faced unique workforce challenges and shortages have led to decreased access to care for rural residents. In a [poll](#) that

Morning Consult conducted for BPC and the American Heart Association in August of 2019, more than half of rural voters (54 percent) said access to medical specialists, such as cardiologists or oncologists, is a problem in their local community, compared to 33 percent of voters in non-rural areas. More than one-quarter (27 percent) of respondents said it is difficult to access behavioral health professionals, compared to 16 percent of non-rural voters.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

The state of Alaska had the highest infant mortality rate in the 1980s. To increase access to obstetric and perinatal services and encourage integrated care, the state joined forces with the Indian Health Service to institute an all-payer perinatal regionalization model. Providers from a regional medical hub train local caregivers and travel to rural areas regularly during the prenatal period. Women are then transported and housed near a medical hub one month before their expected delivery. Ultimately, Alaska became the state with the lowest post-neonatal mortality rate.^{iv}

Electronic health records (EHR) are pivotal to care coordination for appropriately targeting services. In fact, the Centers for Medicare and Medicaid Services (CMS) requires that providers attest to the use of up-to-date certified EHR technology (CEHRT) in order to receive payment for care management services.^v Additionally, MACRA requires CEHRT for participation in any APM.^{vi}

In April 2019, the Office of the National Coordinator reported that rural hospitals were among the lowest utilizers of an EHR and that there was little change in use between 2015 and 2017.^{vii} This is not surprising, considering that the broadband necessary to support EHR and mobile monitoring is not available to 39% of the rural population.^{viii} However, the infrastructure costs, user training time, and availability of technology support also limit EHR uptake.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Many rural hospitals simply do not have the volume required for financial sustainability, even when considering higher payments for certain rural hospital designations. In South Dakota, BPC heard that the Average Daily Census (the measure that hospitals use to track the number of patients per day), was around 5 individuals for Critical Access Hospitals (CAHs). Stakeholders indicated that small populations and low patient volume not only threaten the financial sustainability of hospitals, it also precludes most rural health care organizations from participating in

transformation initiatives more generally: an exclusion that they perceive will tangibly widen the gap between them and the more urban systems.

Under current law, low-volume hospitals receive a sliding scale, “low volume payment adjustment” starting at 25 percent for fewest discharges down to 0 percent for those at 3,800 discharges and higher. These payment adjustments have helped stabilize rural hospitals with low-patient volumes but are set to expire.

Additionally, beyond the CAH designation, there are also other categories of rural hospitals that have been established in statute, including the Medicare Dependent Hospital (MDH) and Sole Community Hospital (SCH) designation as well as certain payment adjustments for Low Volume Hospitals, among other designations. For each of these rural hospital designations, certain aspects of their Medicare reimbursement or their entire rural designation must be reauthorized or renewed by Congress every few years. This lack of certainty has contributed to the financial instability of certain rural hospitals. To address this concern, rural facilities could be taken out of the ongoing “extender” and “needing to be renewed” cycle by offering rural hospitals payment and designation stability, until which time they may decide to transition to a new payment or delivery model.

Consideration should also be given to making MDH designation a permanent hospital payment category. As such, MDHs would be required to continue meeting current law eligibility rules to maintain the MDH designation, including being located in a rural area, having 100 inpatient beds or fewer and having a patient caseload of at least 60% of Medicare patients.

Additionally, SCHs could permanently receive additional payment (7.1%) for outpatient services. This payment adjustment was authorized pursuant to study by Congress, which found rural SCHs have substantially higher costs.^{ix} Making this adjustment permanent would provide financial stability and is in-line with broader policies to support the delivery of outpatient care in rural communities.

High overhead and a low volume of billable services also result in tight margins and insufficient funding to meet operating costs for rural providers operating outside of the hospital setting. Priorities most effectively managed in high-volume settings often translate poorly to rural areas and can impede ensured access in these communities. Although there may be a willingness to participate in process improvement exercises, rural providers are disadvantaged by limited opportunities for eliminating process inefficiencies to attain cost-savings.

Rural providers also have difficulty keeping pace with the transition towards value-based payment because they can’t make the necessary investments in infrastructure and additional staff to satisfy program requirements. Impracticalities are magnified when considering the ability to take on two-sided risk. While stakeholder engagement, increased care coordination, and more streamlined processes should be pursued, these activities should be undertaken with the expectation that there may be limited effect on cost-saving in rural settings.^x

Rural bypass exacerbates the low-volume challenges. Residents bypassing local services are more likely to be commercially-insured.^{xi} On the other hand, residents seeking care for an acute illness, such as sepsis, are more likely to stay local.^{xii} Together, these statistics demonstrate both a loss of higher revenue patients and an increase in costlier episodes. Some hospitals lose volume to patients choosing to receive care at distant sites of service, particularly when local services are unavailable. A 2017 study of CAHs demonstrated a 48.8 percent rural bypass rate for elective surgical procedures. The authors suggested that increasing availability of outpatient surgical services could aid in patient retention.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?

The movement of services to an outpatient setting heavily relies on care coordination. These activities have the potential to reduce hospitalizations and emergency department visits for high-utilizers.^{xiii} Providers who actively manage care in concert with collaborating providers will undoubtedly improve both care quality and the patient experience. Specialists, local skilled nursing, and home health providers are necessary to provide care locally and in the most appropriate setting. However, the success of care coordination is inextricably linked to access to various types of care providers and community organizations to support care plans, particularly when addressing social determinants of health. Moreover, the technology required for successful care coordination and the workforce to sustain that technology are also often unavailable in rural settings.

b. there is broader investment in primary care or public health?

c. the cause is related to a lack of flexibility in health care delivery or payment?

Burdensome reporting requirements necessitate the hiring of additional staff. Ultimately, the ability to generate savings is less certain for rural providers than the likelihood of financial penalties under a risk-based contract.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

BPC staff met with MaineHealth and Northern Light Health in Portland, Maine, and visited Stephens Memorial Hospital (SMH) in Norway, Maine to discuss the challenges and opportunities the groups face. MaineHealth and Northern Light

Health offered new perspectives on regional coordination to address access and specialty services, without relying on ownership options. In their proposal to CMS, MaineHealth illustrates their regionalization model which organizes providers by region and includes multiple types of ownership (independents, health systems, private practices, etc.). This model incorporates an oversight structure which will establish a role for each organization, and agreed upon by the organization, in delivering the care for the region. The level of care includes prevention, primary care, specialists, and end-of-life, and support for establishing the regional care model would require federal investments in primary care and capital, including a potential “Hill-Burton II” program. Moreover, this regional coordination model would be supplemented by a statewide system for specific needs, such as obstetrical/gynecological care and general surgery, based on collaboration with Maine DHHS.

As previously highlighted, Alaska has instituted an all-payer perinatal regionalization model for tribal communities. Providers travel to rural areas regularly during the prenatal period and women are transported and housed near a medical hub up to a month before expected delivery. Despite having the highest infant mortality rate in the 1980s, Alaska saw drastic improvements under this model.^{xiv}

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The Conrad State 30 J-1 visa waiver program (Conrad 30) provides states with up to 30 J-1 visa waivers to authorize international medical graduates (IMG) to stay in the US for an additional 3 years to practice in health professional shortage areas. Qualifications for the Conrad-30 program include completing a U.S. residency, securing a full-time employment offer providing care to underserved populations, and committing to that service for a minimum of three years. Physicians must seek approval through the state, which in turn recommends a waiver to U.S. Citizenship and Immigration Services. The Conrad 30 program research shows that 82% of states gave waiver priority to primary care slots.^{xv} However, the need for primary care continues to increase and the current workforce is not sufficient to meet that need. The Conrad State 30 & Physician Access Reauthorization Act (S.948) reauthorizes the program until 2021 and increases state waivers from 30 to 35.^{xvi}

Additionally, The Teaching Health Center Graduate Education (THCGME) program was established through the ACA to address primary care provider shortages in nonhospital and community-based settings. The program has yielded promising results, as 69 percent of physicians and dentists are practicing in a primary care setting, despite the short supply nationwide.^{xvii} However, of the 82 percent training in medically underserved areas, only 20 percent of residents practice solely in rural settings.^{xviii} Funding for the THCGME program expires at the end of 2019, but current legislation (S. 1191, H.R. 2815) would extend the program through 2024

and expand the number of available positions.^{xix} Additional consideration must be given to address the minimal cohort of trainees receiving placement in rural areas.

HRSA has additional programs that address the health workforce pipeline by engaging students as early as middle school. The Health Careers Opportunity Program provides grants to increase and support opportunities for individuals from disadvantaged backgrounds to enter health professions. State initiatives should serve as models for federal programs. The FORWARD NM: Pathways to Health Careers program provides hands-on experience in clinical settings and college credit for high school and college students to foster interest in rural primary care.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

The growing need for behavioral health services and the shortage of behavioral health providers has highlighted the need to broaden the workforce. In general, telehealth and virtual care services have been successful in improving access for communities lacking sufficient workforce. This has been accomplished through direct care as well as additional training for providers.

Project ECHO offers training opportunities to family practice providers to expand services available in rural areas without access to a specialist. The ECHO Act (S. 1618), which was also incorporated into S. 1895, authorizes grant funding for collaborative learning.^{xx} The Rural MOMS Act (S. 2373) supports similar activities specific to obstetric care in rural areas. Technology can also aid retention at hospitals with few physicians on staff by alleviating the frequent overnight call responsibilities.^{xxi} Hospitalist coverage through interactive telemedicine allows distant physicians to address off-hour issues and admissions.

To increase access to treatment in areas facing shortages of providers, Congress is considering legislation to expand the treatment workforce. The Opioid Workforce Act of 2019 (H.R. 3414, S.2892) is bipartisan legislation that provides support for additional GME positions in hospitals with residency programs in addiction medicine, addiction psychiatry, or pain medicine.^{xxii}

Treating opioid use disorder with FDA-approved medications (M-OD) is the standard of care for opioid use disorder treatment. One of the forms of M-OD, buprenorphine, requires a waiver from the Drug Enforcement Administration (DEA) before a health care provider can prescribe it, thereby creating an additional barrier to treatment for thousands of people with opioid use disorder. Efforts have been made to expand access by increasing the types of providers able to prescribe and dispense buprenorphine and the number of patients a provider can treat under waivers. However, for many practitioners the need for a separate DEA waiver is duplicative. Tribal communities utilize community health aides and community

health practitioners to provide care at the direction of distant providers through telehealth.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

When addressing social isolation, several necessary structures are already in place, allowing some programs to initiate quickly. Actions include encouraging seniors to utilize local community and care navigators, encouraging local community and healthcare resources to collaborate, and ensuring that programs already connecting with seniors in their homes include screening for social isolation.

In the public policy domain, including social isolation among the social determinants of health and requiring the Healthy People 2030 report to specifically address the issue, would increase awareness of the issue. Other solutions such as providing computer training to seniors and their caregivers; leveraging internet-based supports for health care, transportation, and education; and prioritizing broadband access in rural areas could expand communications and help keep seniors connected.

Larger solutions could be explored at the health system level, and there is plenty of fertile ground in the health care delivery and payment reform arena. An important first step would be to analyze whether it is appropriate to modify federal health care programs to allow payment for social support services that can improve social connectedness. Policymakers would need to develop models and functioning mechanisms to shore up rural health care systems and develop a valid screening tool to track social isolation. Such a tool could be implemented during Welcome to Medicare and annual Medicare exams to minimize inconvenience. Other potential solutions include analyzing whether programs such as Medicare Advantage need reform to increase flexibility and examining whether there are appropriate opportunities to address social isolation through Medicaid waivers or CMS Center for Medicare and Medicaid Innovation (CMMI) models.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

Under current law, CAHs and some small, rural hospitals are not required to report on quality performance and, therefore, payment is not tied to tracking quality performance or to quality of care delivered. Rural health clinics are also not subject to quality reporting requirements. Historically, rural hospitals have not reported on

quality because of statistical issues around low-volume or lack of “rural relevant” measures in the field. However, rural hospital quality measure reporting has increased in recent years. As of 2019, 100% of CAHs are reporting “at least one” quality measure, according to HRSA. In addition, quality measurement has advanced in recent years, including the recent approval by the National Quality Forum (NQF) of a “rural relevant” set of quality measures.^{xxiii} Requiring rural hospitals to report on a core set of measures should be phased up over time as rural hospitals build their internal administrative structure to collect and report quality outcomes data.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

As noted above, CAHs and some small, rural hospitals are currently not required to report on quality performance and, therefore, payment is not tied to tracking quality performance or to quality of care delivered. Rural health clinics are also not subject to quality reporting requirements. Recently, the National Quality Forum (NQF) of a “rural relevant” set of quality measures.^{xxiv} Requiring rural hospitals to report on a core set of measures should be phased up over time as rural hospitals build their internal administrative structure to collect and report quality outcomes data. However, it would be important not to inundate rural hospitals and clinics with requirements that they are unable to meet. For instance, CMS could consider sharing claims data with providers, regardless of participation in CMMI demonstration projects.

Notably, offering similar feedback to individual providers operating outside of the facility setting should be considered. CMS could provide information on a core set of measures to assess a provider’s progress towards value-based care.

Citations

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