

November 27, 2019

The Honorable Danny Davis,  
The Honorable Terri Sewell,  
The Honorable Brad Wenstrup, and  
The Honorable Jodey Arrington,  
Co-Chairs,  
Rural and Underserved Communities Health Task Force  
Committee on Ways & Means  
United States House of Representatives  
1102 Longworth House Office Building  
Washington D.C. 20515

Submitted via email to Rural\_Urban@mail.house.gov.

RE: Task Force Request for Information

Dear Representatives Davis, Sewell, Wenstrup, and Arrington:

Thank you for seeking input on how the Task Force and Committee could improve health care delivery and health outcomes in rural and underserved communities. National efforts to improve healthcare access, quality, and affordability have primarily focused on expanding availability of insurance coverage, rewarding high-quality care, reducing overutilization of services, and controlling the prices charged by hospitals and drug manufacturers. While these are very important issues, residents of many rural areas face a more fundamental problem: essential healthcare services may not be available in the community at all.

As you know, dozens of rural hospitals have closed in recent years, and many more are at risk of closure. The primary reason for this is that Medicare and other payers pay less for services than what it costs to deliver those services in rural areas. Most rural hospitals are classified as Critical Access Hospitals, which enables them to receive cost-based payment from Medicare for their services; however, under federal sequestration rules, Medicare only pays a Critical Access Hospital 99% of its eligible costs. Under this system, no matter how much the hospital reduces costs, it can't break even on its Medicare patients. Most rural hospitals receive even lower payments for Medicaid patients, and if the hospital also receives low payments from commercial insurers and has no mechanism for covering deficits through local tax revenues or grants, it will have no choice but to close.

In rural areas, hospital closure means far more than the loss of traditional hospital services. Many rural communities are only able to attract and retain primary care providers if they are employed by the rural hospital, so losing the hospital can mean losing access to primary care

services as well as inpatient and emergency services. In addition, many rural hospitals are also the sole provider of long-term care services because those services are only feasible to deliver through the hospital, so loss of the hospital also means loss of long-term care services.

## **Improving Health Outcomes in Rural and Underserved Areas Must Start By Preserving Essential Services**

It will be impossible for the Task Force to improve health outcomes in rural and underserved communities unless you take steps to preserve the health services they currently receive. Indeed, if essential services such as primary care, emergency care, and basic outpatient and inpatient services are not preserved, outcomes will continue to deteriorate, and there will be no mechanism for addressing social determinants of health or delivering enhanced services that could improve on the outcomes achieved in the past.

For example, telehealth services represent an important opportunity to extend specialized services to rural and underserved communities, but they can only be effective if there are essential services available in the community that telehealth can build on. A remotely located specialist can provide critical guidance on diagnosis and treatment during emergencies, but the patient still needs to be in an emergency room with the minimal staffing required for hands-on care and with access to the necessary equipment for basic radiology and laboratory services.

## **Eliminating Inpatient Services Isn't a Solution**

Several proposals have been made to increase payments to rural hospitals if the hospitals stop delivering inpatient services. These are based on the false premise that the hospitals' problems are due to the high cost of delivering inpatient services to a small number of patients. However, in contrast to urban hospitals, rural hospitals are already primarily outpatient facilities. More than two-thirds of rural hospitals' revenues come from outpatient services, not inpatient care, with an even higher percentage in the smallest rural hospitals.

Many of the outpatient services at rural hospitals are primary care services – half of the hospitals in small and isolated rural communities operate Rural Health Clinics, and others deliver primary care services through their Emergency Departments. Analyses performed by the Center for Healthcare Quality and Payment Reform have found that a large part of the operating losses at many small rural hospitals is due to low payments from Medicare for Rural Health Clinic services and underpayments from Medicaid and commercial insurance companies for both clinic and Emergency Department services, not because of losses on inpatient services. In fact, our analyses found that eliminating inpatient services would make the hospitals worse off, since most of the same administrative overhead would have to be supported by an even smaller revenue base.

In addition, nearly three-fourths of rural hospitals and almost all of the smallest rural hospitals in the country have “swing beds” that enable use of inpatient beds for skilled nursing services or long-term care as well as acute admissions. These services are delivered in the hospital because Medicaid payment rates are too low to cover the costs of operating a separate long-term care facility and families who do not qualify for Medicaid cannot afford to pay the full cost.

Requiring rural hospitals to give up inpatient services would not just affect the small number of patients who are admitted for acute care, but could result in the loss of rehabilitation services and long-term care services in communities that cannot support a freestanding Skilled Nursing Facility.

Moreover, even with the most effective primary care and chronic disease management programs, some individuals with a chronic disease exacerbation or an uncomplicated acute condition such as pneumonia will need to stay overnight in a hospital for a few days before it is safe for them to return home, particularly if they live alone or in an isolated area, and it would be undesirable if they could only receive that care in a distant hospital. Seniors are also more likely to need inpatient rehabilitation services following a surgical procedure, and it would be undesirable if they had to receive both the procedure and post-acute care services far from home. Consequently, all but the very smallest rural communities will need a hospital with the ability to deliver at least some inpatient services as well as essential emergency and other outpatient services.

### **“Global Budgets” Will Not Solve the Challenges Facing Small Rural Hospitals**

The Center for Medicare and Medicaid Innovation (CMMI) has been promoting the idea that “global budgets” would be a better way of sustaining rural hospital services than either the cost-based payment system used for Critical Access Hospitals or fee-for-service payments. Under the global budget approach, a hospital would receive a fixed amount of payment regardless of how many or what types of services it delivers. The payment amount would be based on the total amount of revenue the hospital received prior to the global budget, and the payment would be increased annually based on inflation.

This approach could be attractive for a hospital that has been delivering a large number of unnecessary services in order to cover its costs, since the hospital could eliminate those services without losing all of the revenue associated with them. However, the smallest rural hospitals are not delivering large numbers of unnecessary services; many don’t have enough revenue to sustain a minimum level of *essential* services. Rather than solving this problem, the global budget model would lock these hospitals into their current deficits.

Moreover, because small rural hospitals have difficulty attracting and retaining physicians, nurse practitioners, nurses, and other staff, their costs vary from year to year, often dramatically, because of the need to use expensive locum tenens physicians and temporary staff. One of the strengths of the cost-based payment system for Critical Access Hospitals is that it adjusts payments automatically for these kinds of uncontrollable changes in costs. In contrast, under a global budget payment, the hospital’s revenue would remain fixed, resulting in even larger deficits for the hospitals.

### **How “Standby Capacity Payments” Can Sustain Rural Healthcare Services**

The best way to support high-quality healthcare services in rural and underserved areas is to create “standby capacity payments” that will support the fixed costs of essential services, and then pay smaller service-based fees tied to the variable costs of individual services.

In a small rural community, the amount that a hospital or clinic spends on most essential services will not change significantly regardless of how many patients receive services or the number of services the patients receive. For example, the hospital Emergency Department will need to have one provider available at all times to handle emergencies, regardless of whether there are 5 emergency department visits per day or 50. If there are 5 emergency department visits per day, the cost per service will be 10 times as high as if there are 50 visits per day. Under the current fee-for-service system, the hospital with fewer emergency department visits would have to charge 10 times as much for a visit, even though the service was exactly the same as in the hospital with more emergencies. All of the residents of the community benefit by having the emergency department there, even if they are lucky enough not to have an emergency, but all of the money to pay for the emergency department must come from the few who are unlucky enough to have an emergency. We don't support the cost of fire departments by charging people who happen to have a fire, and it doesn't make sense to support an emergency department that way.

Emergency departments and other essential hospital services are typically referred to as “standby services” (i.e., the personnel and equipment needed for the service must be standing by in case a patient needs them), and the cost of maintaining the minimum capability to serve an unknown number of patients can be described as the “standby capacity cost.” The logical way to support standby capacity cost is to charge everyone in the community who benefits from having the service available, not just those who use the service.

To do this, Medicare and other payers would simply need to pay the hospital a specific amount of money each year for each of their insured members who live in the community. The aggregate amount of these “standby service payments” would be set so that they cover the fixed costs of the essential services. The payers would then pay an additional amount if one of their members actually used the service, but this additional amount would be much smaller than the fees paid today, since it would be designed to cover the incremental, out-of-pocket costs associated with a higher volume of services. The combination of the standby service payments for all residents of the community and the fees for individual services would cover the combined fixed and variable costs of the essential services. The revenue for the hospital would more predictably cover the hospital's costs, and each payer's spending would also be more predictable. (Traditional fees would still be paid for the non-essential services.)

This approach also would represent a better way of supporting primary care services. The primary care clinic in a rural area needs to have a physician or other provider available to see patients even if there aren't enough patients living in the community to fill up the physician's full day. Charging high fees to cover the costs of primary care in small communities is counterproductive since primary care helps reduce the use of other, more expensive services. If a primary care clinic in a rural area has to charge more per visit to cover its costs, patients will be less likely to use the clinic, and this could lead to delayed diagnoses and higher treatment costs. In addition, the fewer patients who visit the primary care practice, the less fee revenue there will be to support the services, creating a vicious cycle that leads to loss of the service altogether. A standby service payment would cover the fixed cost of having primary care services available in the community and enable the clinic to charge visit fees that are affordable for patients.

This same approach would also help to address the financial challenges faced by hospitals and primary care clinics in inner-city areas where many patients don't have insurance or have needs requiring far more time and assistance than traditional payments will support.

Standby capacity payments could also be used to support telehealth services in rural areas, since there is a significant fixed cost to install and maintain the equipment needed for telehealth services and to pay the telehealth specialists to be available when needed. In communities with small numbers of patients, the average cost per patient to deliver the telehealth services is far higher than the amounts Medicare and other payers pay for telehealth services. As a result, it can simply be financially infeasible to deliver this highly desirable service. Standby capacity payments could be used to support the fixed costs of telehealth services, and then small fees could be charged when individual patients use the service.

Finally, the standby capacity payment approach can be used to support long-term care services in rural areas. A rural community needs to have a combination of nursing facility, assisted living, and home care services, and as with acute care services, there is a minimum cost to supporting these services that is the same regardless of how many seniors in the community actually need each of the services at any point in time. Standby capacity payments would ensure there is sufficient funding to maintain each of these services so they are available for seniors when they need them.

### **More Details Available on Request**

I hope that the Task Force will be interested in examining how this approach could help sustain hospitals and clinics in rural and underserved areas. I can provide analyses showing the reasons why rural hospitals and clinics are losing money; a detailed description of how standby service payments would be implemented for emergency services, inpatient care, primary care, and long-term care; and quantitative simulations of the impacts of different payment models on hospitals and clinics of different sizes. I would also be happy to answer any questions you may have about the concepts, and I can explain how the concepts have been developed and refined with the input of rural hospitals in several states over the past several years.

Thank you for your interest in these important topics and for providing the opportunity to submit comments.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Miller", written in a cursive style.

Harold D. Miller  
President and CEO