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November 29, 2019

To: Honorable Chairman Richard E. Neal and Ranking Member Kevin Brady, Ways and Means Committee, and the Co-Chairs of the Rural and Underserved Communities Health Task Force Honorable Reps. Danny Davis, Terri Sewell, Brad Wenstrup, and Jodey Arrington

Subject: Rural and Underserved Communities Health Task Force Request for Information on Priority Topics that Affect Health Status and Outcomes

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On behalf of the National Coalition on Health Care (NCHC), we applaud the Committee's efforts to address the health needs of complex underserved areas. NCHC is a nonpartisan, nonprofit organization of members dedicated to advancing health system reform for an affordable future.[1] Our growing Coalition represents more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities and persons with disabilities. Collectively, our organizations represent, as employees, members or congregants, more than 100 million Americans.

We appreciate the opportunity to comment on this RFI regarding rural and underserved communities . We will address questions 1, 3, 4 and 5 and focus primarily on the importance of social determinants of health and the unsustainability of rural hospital payment. Additional resources of potential interest on rural health not cited can be found in Appendix 2.

Please reach out to Michael Budros (mbudros@nchc.org) with any questions.

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?

Addressing factors outside the health system would likely provide the greatest marginal benefit to rural and underserved urban communities. Policy intended to improve health outcomes through the traditional health system tend to face social barriers to success or further exacerbate disparities between urban and rural areas. For example, education and income are associated with differential use of health information technology.[2] These findings suggest that

[1] http://nchc.org/
[2] https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12358

technology-focused reforms, which are common, are likely of less value than social interventions (e.g. transportation, literacy, nutrition, housing) – especially given providers in underserved areas have limited internal capacity to successfully implement complex technology.

Underserved areas are prone to social determinants unlikely to be solved medically or through technology development, and are primarily a function of socio-economic or cultural factors.

- Social isolation, for example, is especially common for rural populations and known to contribute significantly to negative health outcomes.[3]
- The opioid epidemic created or exacerbated numerous non-medical barriers to achieving positive health outcomes for poor Americans, especially in rural areas (e.g., substance use disorders, lower earnings, criminal justice encounters, and unemployment).[4]
- Rural communities are especially prone to unhealthy behaviors (e.g., smoking), even when controlling for socio-economic factors.[5] These findings imply that unique cultural differences between urban and rural areas contribute to negative health outcomes.

The CMS rural health strategy details several key points for this question.[6]

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

The fundamental problem with rural hospitals is that revenue is still driven by volume rather than meeting community need. The predominant fee-for-service model with complex adjustments (e.g., wage index, critical access, etc.) is generally unsustainable. Along with an aging, poorer, and shrinking population, this financing has contributed to the accelerating closures in primarily rural and southern states.

The Maryland[7] all-payer rate setting system and the, still nascent, Pennsylvania[8] rural health CMMI demonstration are potential models for change. In Maryland, hospital costs and rural hospital closures are below the national average. In addition to managing costs, a specific benefit of all-payer rate setting is the management of cost-shifting – privately insured patients are not forced to subsidize reductions by public payers. Predictable and consistent payment, a popular element of both models, theoretically gives rural hospitals the incentive to streamline service lines that are of most value to the community (e.g., expanded primary care services paired while maintaining limited emergency services), and provide patients with resources (e.g., telehealth and transportation assistance) to seek more advanced care at centers with the

[3] https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks
[4] https://www.hrsa.gov/advisorycommittees/rural/publications/opioidabuse.pdf
[5] https://nnphi.org/wp-content/uploads/2019/02/AdvancingTobaccoPreventionControlRuralAmerica.pdf
[6] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf
[7] https://hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf
[8] https://innovation.cms.gov/initiatives/pa-rural-health-model/

economies of scale to justify a greater mix of services. Hospitals could sustainably reduce inefficient inpatient beds, if payment were not based on filling them for revenue.

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?***
- ***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?***

In order to achieve the rural health reimbursement and infrastructure change needed, hospitals primarily need the flexibility to:

1. expand scope of practice for non-physician providers to cover primary care needs (e.g. nurse practitioners)
2. change their scope of services based on the needs of the community – to do so the Committee should investigate ways to reduce incentives for rural hospitals to gain critical access hospital designation (and be reimbursed by cost for inefficient inpatient beds), and instead grow outpatient and social services that fit the community's need

A 2016 Kaiser Family Foundation Issue Brief on rural hospital closures includes several additional state and national models of delivery reform worth considering.[9] A key finding: at the state level, not expanding Medicaid was strongly correlated with rural hospital closures.

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?

If left to current fee-for-service market forces, hospital closures based on low volume will not lead to desirable community benefit. Typically, closures have resulted in care gaps and a burden on the patient to seek care long distances away. Simply increasing Medicare reimbursement for rural hospital has been historically unsuccessful and contributes to perverse incentives today. Rural health reimbursement and infrastructure both need to fundamentally change.[10]

However, there are emerging models of consolidation that have promise (albeit too new to offer much evidence). In February 2018, Mountain States Health Alliance and Wellmont Health systems merges to create the multi-state "Ballad Health" system.[11] The system spans a 29-

[9] http://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care
[10] https://bipartisanpolicy.org/blog/addressing-rural-hospital-closures-through-infrastructure-reform/
[11] https://www.balladhealth.org/news/Mountain-States-Health-Alliance%2C-Wellmont-Health-System-boards-authorize-final-approval-of-merger%2C-Ballad-Health-to-celebrate-launch-Friday

county rural stretch of four different states. The merger provides one example of regulated and regional consolidation designed, ostensibly, to improve care and prevent rural hospital closings by reconfiguring service delivery and streamlining care administration.

Importantly, the new regionally monopolistic system – the sole provider system for nearly 1.2 million people – has state (Tennessee) statutory requirements with respect to outcomes and milestones to obtain. Through the state Certificate of Public Advantage process, the merger was able to bypass Federal Trade Commission rules that would normally prevent such a merger. Ballad is required to invest in public health and keep rural hospitals open. The merger came with local controversy[12] and should be closely monitored, but the model begins to address issues with volume adequacy in a more intentional manner than traditional health care market forces would.

In closing, the National Coalition on Health Care thanks you for the opportunity to comment on the Request for Information. We look forward to working alongside you and your staff to address these critically important issues.

Sincerely,

National Coalition on Health Care

[12] https://www.modernhealthcare.com/providers/ballad-health-odds-community-over-controversial-changes

Appendix: Additional resources of potential interest on rural health (not cited above)

1. E. Moy, M.C. Garcia, B. Bastian, et al., "Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, vol. 66, no. 1, pp. 1-8, January 13, 2017. Available: https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm

2. P. Mendel, C. Buttorff, P. Chen, et al (2019). "Perspectives of Physicians in Small Rural Practices on the Medicare Quality Payment Program." RAND Corporation. Available: https://www.rand.org/pubs/research_reports/RR2882.html.

3. Centers for Medicare and Medicaid Services. (2018). "CMS Rural Health Strategy." Available: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

4. Pew Research Center. (2018). "How Far Americans Live From the Closest Hospital Differs by Community Type." Available: https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/

5. Health Resources and Services Administration, National Center for Health Workforce Analysis. (2013). Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Available: https://bhw.hrsa.gov/health-workforce-analysis/primary-care-2020

6. P.A. Weigel, F. Ulrich, C.N. Finegan, and M.M. Ward. (April 2017). "Rural Bypass for Elective Surgeries." Journal of Rural Health. Available: https://www.ncbi.nlm.nih.gov/pubmed/26625274

7. J.J. Liu, G.R. Bellamy, and M. McCormick. (Winter 2007). "Patient bypass behavior and critical access hospitals: implications for patient retention". Journal of Rural Health. Available: https://www.ncbi.nlm.nih.gov/pubmed/17300474

8. B. Kaufman, G. Pink, M. Holmes. (2016). "Prediction of Financial Distress among Rural Hospitals". NC Rural Health Research Program. Available: https://www.ruralhealthresearch.org/alerts/106?utm_source=alert&utm_medium=email&utm_campaign=20160201northcarolina

9. American Hospital Association. "RURAL REPORT Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care" 2019. Available: https://www.aha.org/system/files/2019-02/rural-report-2019.pdf

10. http://www.medpac.gov/docs/default-source/reports/chapter-7-improving-efficiency-and-preserving-access-to-emergency-care-in-rural-areas-june-2016-repo.pdf?sfvrsn=0

11. M. J. Noles, K. L. Reiter, J. Boortz-Marx, & G. Pink. (2015). “Rural Hospital Mergers and Acquisitions: Which Hospitals Are Being Acquired and How Are They Performing Afterward?” Journal of Healthcare Management: (2015); 60(6); 395-407. Available: https://www.ncbi.nlm.nih.gov/pubmed/26720983