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Committee on Ways and Means
U.S. House of Representatives
Improving Access to Health Care in Rural and Underserved Areas
By electronic submission at: WMAccessRFI@mail.house.gov

Dear Chairman Smith and Members of the Committee,

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to the Committee on Ways and Means Request for Information regarding Improving Access to Health Care in Rural and Underserved Areas. Our comments focus on all five topics included in the RFI.

Geographic Payment Difference

We recommend that changes to existing payment methodologies include elements addressing historical payment inequities affecting rural providers and reducing opportunities for abuse. The Medicare Rural Hospital Flexibility Program (Flex) establishes a lifeline for rural hospitals through cost-based reimbursement to address financial challenges. This program uses cost-based reimbursement to support adequate payments to Critical Access Hospitals (CAHs), an approach to address the inherent challenges of covering fixed costs in hospitals serving small to modest population areas. As an evolution of the Flex program the panel supports a tripartite approach that includes a fixed-cost payment, a performance-based payment, and a fee-for-service payment. Further evidence and discussion is provided in "Modernizing payment to critical access hospitals: A proposal for the next iteration of the Flex Program," which can be found here: https://onlinelibrary.wiley.com/doi/10.1111/jrh.12750.

Similarly, a mechanism relying on the combination of funding including grants, direct federal and state funding, state funding, commercial insurance plan considerations, and tax districts, could create a baseline for value-based payment. This mechanism also relates to sustainable provider and facility financing below, as it may support long-term sustainability of the provision of medical services, including provider supply and facility upkeep.

The Panel recommends revamping processes of the Relative Value Scale Update Committee to value cognitive services more appropriately when compared to surgical services. Such a process may include, for example, reconsidering budget neutrality to raise primary care services without lowering surgical services. The panel also recommends moving the process from the American Medical Association (AMA) to the Centers for Medicare & Medicaid Services (CMS).

Continued attention to these payment policies should be considered within a context that enrollment in Medicare Advantage (MA) plans is above 50% overall of Medicare recipients (53% in metropolitan areas, 44% in micropolitan areas, and 40% in rural areas in 2023). The MA share of enrollment varies significantly across the country, but in much of rural American it exceeds 25%. The per-member per-month payment to MA plans is based on "benchmarks," tied to projected FFS spending in each county in which the MA plan is offered, with adjustments. As a consequence Medicare payment to MA plans is higher in historically high-expenditure counties, creating greater likelihood of additional benefits (beyond Traditional Medicare) being offered in those counties, which are unlikely to include rural counties where historical FFS expenditures are lower. Further, payment to providers is determined by the MA plans, creating scenarios in which rural healthcare are paid less per encounter than they receive from Traditional Medicare, and issues in timeliness of payment.

When discussing recommendations regarding adequate payments to providers without creating unjustified disparities, health equity must be incorporated into the conversation. To avoid exacerbating disparities, a critical point of discussion should include providing adequate provider payments and cultural sensitivity. Several approaches could be employed; for example, recruiting and retaining providers who are representative of the rural populations they serve or developing training for international medical graduates may enhance provider recruitment and retention.

Sustainable Provider and Facility Financing

Financing health care organizations through patient-generated revenue is currently dependent on volume, which puts rural systems at a disadvantage. There must be different payments based on value in rural systems. A new payment design must reward the value rural providers provide patients and community populations, while still providing sufficient revenue to cover fixed cost. Payment and delivery models need move away from the historical methodologies (volume-based) that created inequities between rural and urban facilities. A new design should be based on the cost of maintaining access with rewards for meeting community needs. Rural healthcare organizations would benefit from an all-payer and single administrative structure that includes a universal set of quality measures appropriate in rural settings. While we cannot respond to specifics, we offer the same encouragement to design a value-based payment with flexible use of resources.

Aligning Sites of Service

Efforts to implement site neutrality in payment systems may place rural hospitals in financial jeopardy. Current payments for hospital-based services that exceed payment for the same service in an ambulatory setting may be disadvantageous. For example, some hospitals with service centers losing money can make up those losses elsewhere. This revolves back to the discussion of fixed and variable costs – with the need to address standby costs. In rural settings, the fair approach to preserve a safety net is to establish fixed costs then assess the price per service after the first condition is met.

When discussing how Congress should reinvest savings into Medicare to correct reimbursement disparities, the panel suggests that one way to use those dollars is to create revenue that addresses the issue of cost-shifting. Providing revenue directed to cover fixed costs of low-volume facilities would obviate the need to recover those costs through higher charges per encounter. One means of accomplishing this objective would be to direct some portion of program savings resulting from site-neutral payments to a fund dedicated to assuring local access to high-quality essential services. As new

value-based payment policies are developed, current healthcare expenditures should be repurposed away from unnecessary uses (including avoidable utilization, costs of compliance with unduly complex regulations, and administrative costs of complying with multiple payment systems) to services contributing to access to services such as transportation and support for clinically-integrated networks.

Health Care Workforce

The Panel realizes workforce shortages affect all aspects of health care delivery. Our comments in this section will focus principally on workforce issues concerning delivery of long term supports and services (LTSS) in rural locations. When discussing policies like nursing home staffing mandates at the state or federal level, we must acknowledge how they will affect the health care workforce in rural and other underserved areas. We offer four areas of comment regarding potential policies intended to increase improve staffing ratios in skilled nursing facilities, commenting on how to implement those policies in the context of revitalizing the health care workforce in underserved areas.

1) Allow lead times to meet the set standards.

   The panel commends the committee and agrees that an increase in quality care is necessary, however, mandated policies will put rural facilities at risk. Mandates such as the nursing home staffing requirement may lead to potential closures as rural facilities are unable to attain staffing in general, let alone maintain the minimum staffing level requirement. As of 2023, fewer than 1 in 5 nursing facilities currently meet the required number of hours for RNs and nurse aids nationwide, which means over 80% of facilities would need to hire nursing staff. Allowing rural facilities lead time to meet the new regulations will help prevent potential closures in those areas. Additionally, the panel suggests providing a sufficient glide path for achieving standards, such as a timeline. This approach may be particularly helpful in supporting rural facilities meet set standards and guidelines.

2) Create a policy focus to increase the staffing pool and balance it in a way that does not pull resources from elsewhere.

   To increase the staffing pool in rural communities, the panel suggests addressing the issue of the finite pool of personnel available. We encourage decentralizing training programs into rural environments, and pooling staff in geographic regions. This may include setting personnel per resident standards for that region including all providers (such as licensed practical nurses). While this comment is directed to primarily meet LTSS staffing needs, we encourage the Committee to consider healthcare workforce in an all-inclusive manner. Specifically, we recommend a focus on all skill levels appropriate to staff care teams constituting person-centered health homes. As payment systems create incentives to address the health of populations by focusing on in-home needs and use of community-based services, the role of community health workers (CHW) will be critical. These workers, particularly CHW and others trained in addressing behavioral health needs, should be a focus of policy incentives designed to increase their numbers.

3) When setting quality standards in rural and other underserved areas, we must think about addressing the kinds of services facilities need and who can deliver those services.

Nationwide, there is a higher percentage of nursing homes meeting licensed practical nurse (LPN) requirements than those meeting RN requirements. However, LPNs were excluded in the new ratios and standards regulation. In rural communities, we must consider including all staffing categories to deliver services available to and needed by these underserved areas. These categories include LPNs, particularly in rural communities as there are more training opportunities for LPNs than RNs in underserved areas. The panel suggests including LPNs in the new regulations and policies regarding staffing mandates. Similarly, to address barriers preventing health care professionals at all levels from providing care services, the panel encourages states to allow professionals to practice to the highest level of their license.

4) Seek greater investment in state surveyors.

The panel suggests greater investment in state surveyors and better coordination between state surveyors and the CMS-designated Quality Innovation Network Quality Improvement Organizations (QIN-QIOs). State surveyors are capable individuals who can provide guidance in quality assurance and make referrals and work in coordination with their QIN-QIO, who are experts in quality improvement. Together, they can provide the needed technical assistance to nursing homes to identify and address potential quality issues before a problem occurs and continuously improve care and services. A coordinated approach will allow providers to spend more time on patient care than paperwork by utilizing upstream tactics and improving quality standards.

Innovative Models and Technology

We appreciate the committee addressing the need for policies that advance technology and innovative care models, especially those that improve access to care in rural and underserved areas. Regarding technology, we encourage the use of telehealth to supplement (not supplant) existing rural health services in creative ways, including primary care. Based on experiences during the Public Health Emergency, we have seen new applications of telehealth technologies and potential improvements in rural health services delivery. However, there are unintended consequences that could impede access to services in rural and other underserved areas. Rather than relying entirely on telehealth for delivering services to underserved populations, new technology should be used to support local health care professionals in ways that enable them to serve additional patients. This approach would maintain access for all persons in the community without relying on their abilities to access and use technology.

The appropriate use of telehealth will continue to advance high performing rural health systems, including the potential to improve opportunities for rural providers and patients to build and sustain new relationships that advance the principle of health equity and support the pillars of a high-performing rural health system. Pillars include access, affordability, community health, and quality. The panel states that telehealth can be a beneficial supplement to existing elements of a high performing rural health system, with further evidence and discussion provided in "The Role of Telehealth in Achieving a High Performing Rural Health System: Priorities in a Post-Pandemic System" https://rupri.org/wp-content/uploads/The-Role-of-Telehealth-in-Post-Pandemic-HP-February-2023.pdf

Similarly, the panel supports Electronic Health Record (EHR) interoperability requirements in addition to the seamless flow of information within Electronic Health Information Exchanges (HIE). These suggestions may improve patient outcomes in rural and other underserved areas by creating easier access to patient records between providers, as rural providers are limited. Additionally, the panel suggests including Rural Health Clinics (RHCs) in innovation discussions – examples include payment for telehealth extension into rural locations and approaches like the Making Care Primary Model.

Regarding innovative models, the panel recommends considering systems such as Intermountain Health that are solidifying access to services locally. Services such as same-day access that is consumer-driven may be replicable nationally for providers with limited resources. Additionally, there must be a discussion of innovation regarding assisting rural providers to meet requirements that show progress in meeting Social Determinants of Health (SDOH) needs. We must consider the unique SDOH contexts within rural communities, and support clinical providers in their efforts to address SDOH in underserved areas.

Respectfully submitted,

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