October 5, 2023

Chairman Jason Smith
House Ways and Means Committee
WMAccessRFI@mail.house.gov

RE: Response to Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith,

On behalf of the Louisiana Rural Health Association (LRHA), thank you for the opportunity to provide a response to your request for information about improving access to rural health care sent to stakeholders on September 7, 2023.

LRHA is a membership association that is made up of Louisiana rural health care providers. This includes rural health clinics (RHCs); federally qualified health centers (FQHCs); and rural hospitals across the state. LRHA works to provide a unified voice that promotes and enhances the quality of rural health in Louisiana.

LRHA appreciates the opportunity to provide input on behalf of our members towards improving access to health care for residents in rural areas.

You will find our response to your question areas below.

Question Area 1: Geographic Payment Differences

Low Wage Index: Rural hospitals have significantly lower wage indices than urban hospitals. When controlling for number of beds, net patient revenue, Medicare payment classificaiton, average daily census, and percentage of Medicare paients, rural hospitals have a wage index that is, on average, 0.1261 points less than urban hospitals. Small rural hospitals have the lowest hospital wage indices in the nation, and the highest wage indices are found among urban hospitals. The median wage index is lowest for rural hospitals with 25 or fewer beds, less than $25 million in net patient revenue, and in more remote areas, and highest for urban hospitals in every Census region.

The low wage index policy has closed disparities between high, predominantly urban, and low, predominately rural hospitals. Congress should codify CMS' low wage index policy, which increases payments for hospitals falling below the 25th percentile of the IPPS wage index. CMS finalized this policy in 2019 to help mitigate disparities between hospital operating in high- and low-wage areas. This policy is temporarily extended through FY 2024 pending decisions from two appellate courts where CMS' authority to promulgate this policy is being examined. Congress should take steps to protect the low wage index policy by affirmatively giving CMS authority to implement the policy through FY 2030. Extending the policy will help CMS and Congress evaluate its effectiveness without being skewed by COVID-19 wage data. Relatedly, H.R. 3635, the Save Rural Hospitals Act, would ensure fairness in Medicare payments by establishing a national minimum wage index floor to ensure that rural hospitals receive fair payment for the care they provide.

Question Area 2: Sustainable Provider and Facility Financing

Public Payer Mix: One factor that contributes to lower payment for rural hospitals and providers is a predominantly public payer mix with less employer-sponsored coverage. Because rural areas skew older, Medicare is a dominant payer. Additionally, Medicaid and CHIP cover 32% of all Lousiana residents.[i] Because the Louisiana rural poverty rate is 24%, compared to 18.7% in urban areas[ii], our rural providers are taking care of a large portion of these Medicaid patients, as well as higher rates of uninsured and self-pay patients, contributing to more uncompensated care. When Medicare and Medicaid rates are not sufficient to cover the cost of care, this has an outsized impact on rural providers. Further, the lower volume of services rural facilities provide put further strain on facilities due to: 1) the need to spread fixed costs associated with providing care over fewer patients and 2) considerably more instability from year to year in demand for inpatient services than larger hospitals.

Unfunded Access Services: Many providers in rural areas provide unfunded services to their patients to increase access to care, such as transportation to and from medical appointments. CMS funding to support these programs would increase provider capacity to provide these services, and allow providers to utilize that funding to ensure the sustainability and continued improvement of core services. Also, with the shift to value-based care and focus on social determinants of health, providers need sufficient financial support via incentive programs and effective reimbursement models to implement services and create or participate in programs that support better health outcomes outside of sick care. Due to the overall lack of resources and infrastructure in many rural communities, more support is needed for both rural providers and their partners who are working to address health-related social needs in their communities.

Rural Health Clinic Modernization: Rural Health Clinics (RHCs) are a bedrock of the rural health safety net. Over 5,300 RHCs across 45 states provide vital access to primary care services to rural residents. RHCs serve 37.7 million patients per year which is more than 11% of the entire population and over 60% of the 60.8 million Americans that live in rural areas. Louisiana alone has 224 RHCs serving our rural residents as of the date of this letter. The RHC statute has not been updated since Congress passed it in 1977 but health care practice and delivery have signficantly changed. H.R. 3730/S. 198, the RHC Burden Reduction Act, includes several important updates to help RHCs operate with less administrative burden and better serve patients. This legislation comes at little or no cost to taxpayers but would have significant impacts on RHCs.

Medicare Advantage (MA) Concerns: Nationally, MA enrollment has surpassed traditional Medicare enrollment this year, with the rate of MA growth is higher in nonmetropolitan counties than in metropolitan counties. MA penetration in rural areas vary by community, with nationally 40% of rural Medicare beneficiaries are enrolled in an MA plan. This growth in MA plans, which are considered commerical payers, is contributing to higher administrative burden for rural providers and a dismantling of the critical rural provider designations previously discussed.

MA plans are not required to adhere to Medicare provider designations and are treated as commercial payers. For rural cost-based providers, like Critical Access Hospitals (CAHs), MA reimbursement can be worse than their traditional Medicare rate of 101% of reasonable costs. RHCs face similar reimbursement challenges with an estimated 55 – 60% of RHCs receiving significantly less from MA plans than traditional Medicare. CAHs and RHCs have fewer resources to negotiate payment with the plans and have rates are typically below what traditional Medicare pays. The difference in reimbursement degrades the value of these safety net designations as MA beneficiary shares grow. Federally Qualified Health Centers (FQHCs) are largely protected from inadequate MA payment. FQHCs receive wrap-around payments from Medicare to make up for the difference between MA plans' rates and their traditional Medicare rate. Congress must consider a similar solution for CAHs and RHCs to protect their viability as safety net providers. Another option is to mandate floor payments that MA plans must pay to rural cost-based providers to ensure parity between MA and traditional Medicare reimbursement. Further, MA patient days should be considered as Medicare days on CAH, RHC, Medicare Dependent Hospital (MDH), and Low Volume Hospital (LVH) cost reports and settlements.

The Committee must consider legislation to set minimum standards for MA plans to help limit rural provider burden. Rural providers are currently expending significant time and resources on MA-related issues, taking away valuable time from already limited staff. Small, rural providers do not have the bandwidth or leverage to negotiate properly with MA plans to get adequate reimbursement. Beyond low reimbursement rates, rural providers struggle to get paid. Medicare pays providers within 30 days; however, MA plans do not have to abide by a timeline. Providers have noted that they may wait as long as 90 days – or three times as long – to receive payment from MA plans. For rural safety net providers that are operating on thin margins, this lag in payment is unacceptable. Currently, staff are expending significant time that should be spent on other activities ensuring their facility is paid by MA plans, especially around claims denial. Even after receiving prior approval and providing beneficiaries services, our members have noted that MA plans are denying claims. Bigger, more well-resourced facilities likely have dedicated staff to deal with these complexities, but rural providers do not. Our rural providers have also noted significant issues in attempting to work with MA plans regarding medical necessity, causing claims to be unjustly denied.

Lastly, LRHA has received complaints from our members that MA plans steer beneficiaries away from their local and long-serving healthcare providers. They have shared that patients, not being fully informed/not understanding the impact of transition to a new MA plan, are finding themselves "out of network" with the facilities and providers from whom they have received care for many years – sometimes their entire lives. This disrupts the patient's historic patterns of care and makes it difficult, if not impossible, for patients to continue to receive necessary care given the barriers to access to care in rural areas that are well known and discussed in this letter. Keeping care local is a key goal in rural health care delivery and ensuring rural health equity. MA plans should not attempt to drive beneficiaries to urban settings to receive care or treatment.

340B Drug Pricing Program: The 340B Drug Pricing Program is a lifeline that allows rural safety net providers to keep their doors open and furnish critical services by stretching scarce federal resources. Rural hospitals and clinics operate on thin margins and 340B savings help them keep needed services local for patients. LRHA urges Congress against any limitations on the number and location of contract pharmacies with which rural covered entities work. Our members have shared that these limitations would significantly impact their patients, especially those at greatest risk, as they would be unable to partner with many of the local pharmacies that patients utilize for their medications. Patients with limited resources and limited access to care and transportation, which are often the patients in need of the 340B medications, are not able to travel outside of their communities for care or medications. Dispensing drugs at contract pharmacies allows our rural 340B providers to ensure patients are able to obtain needed prescriptions timely

Second, Critical Access Hospitals and Sole Community Hospitals (SCHs) require relief from the orphan drug exclusion, only applies to rural hospitals and thus comes at an unfair cost for rural patients that require lifesaving treatments such as oncology treatments. LRHA supports clear statutory restrictions on pharmaceutical benefit managers (PBMs) and payers' ability to treat 340B covered entities differently as outlined in H.R. 2534 PROTECT 340B Act. These actors have increasingly discriminated against 340B patients, covered entities, and contract pharmacies.

For more information on the 340B Program and it's importance to our rural providers and communities, we encourage you to review LRHA's Response Letter to the Senate Bipartisan Request for Information on the 340B Program dated June 16, 2023. We would also refer you to the NRHA developed set of principles that should guide Congress in any 340B reform to ensure rural access to the program is protected.

Question Area 3: Aligning Sites of Service

Aligning Sites of Service: Site neutral payment policies will disproportionately disadvantage rural providers. While addressing the cost of care for rural residents is critical, it is essential that rural provider viability is not inadvertently impacted. Paying off-campus rural providers less than the full OPPS rate contributes to destabilizing rural health care delivery. Outpatient provider-based departments (PBDs) may be the only source of care in many rural communities and thus are critical to keeping care local and ensuring that rural patients can receive the services that they need. Any decline in payments threatens a rural provider's ability to keep their doors open. Higher costs of PBDs in rural hospitals may be attributed to the need to spread fixed costs across a lower volume of services. Additionally, hospitals often furnish more complex care and must meet more stringent regulatory requirements than physicians' offices. Site neutral rate does not account for the type of care furnished nor the resources needed at outpatient PBDs. Hospitals are highly regulated and the burdens that are associated with compliance should be accounted for in payment. Also, Critical Access Hospitals are designed to serve as "safety nets" for our sickest, poorest, and most vulnerable patients, and payment rates must account for increased financial burden of indigent care and high patient acuity.

Reimbursement and Infrastructure for Telehealth Services: Reimbursement for telehealth services requires examination to ensure it accounts for associated costs. Current reimbursement is not adequately provided to all sites. Telehealth site compensation needs to reflect technology costs and clinician services incurred by each telehealth session.[iii] Further, studies have shown that telehealth equipment costs for remote sites range from $20,000 to $95,000, as well as costs associated with setting up connectivity between hub and remote sites and ongoing costs related to maintenance and/or service fees.[iv] While some initial and ongoing investments may be required, stakeholders have speculated that telehealth could ultimately decrease the cost of health care by providing access to specialists and mitigating the cost of inpatient care associated with a lack of access to specialists.

Question Area 4: Health Care Workforce

Grow Your Own Programs: Evidence suggests physicians from rural areas or physicians with exposure to rural areas are more likely to practice in rural communities long-term.[v] For this reason, many rural communities are touting the success of grow-your-own programs. Grow-your-own programs encourage folks to join the health care workforce by increasing exposure to health careers early on. Career exploration opportunities, K-12 apprenticeships, nursing, and other health-allied education at community colleges keep rural students engaged in the health care system at a low cost for the community. Federal programs, like Area Health Education Centers, play a fundamental role in providing critical resources to rural communities to support grow-your-own programs. Increased funding, support, and resources for these types of "grow-your-own" programs to make them more feasible to implement for rural communities and small community organizations could contribute to increasing the availability of these programs and, eventually, increase the number rural healthcare professionals.

Scope of Practice: Nurses and non-physician practitioners (NPPs), like nurse practitioners (NPs) and physician assistants (PAs), are a crucial component of rural health care. Emphasizing practice autonomy is a proven strategy to recruit NPs to rural areas. We urge you to review the Improving Access to Nurses and Care Act (H.R. 2713/S. 2418). This bill allows APRNs to practice at the top of their licensees to provide certain services by modernizing Medicare and Medicaid policies to remove barriers to practice for nurses and NPPs while also lowering costs. Expanding the scope of practice for these providers is essential in wake of the physician shortage. We also support modernizing Medicare payment policies and repealing unnecessary barriers to care such as physician supervision requirements for Physician Assistants (PA). PAs are indispensable providers to rural areas; they are one of three health care professions providing primary care in rural areas along with physicians and APRNs.

Community Health Workers (CHW): We encourage you to expand the CHW workforce in rural areas. Community Health Workers may be known by many names, including, but not limited to, Health Navigators, Patient Navigators, Outreach Workers, Peer Specialists, Promotoras/Promotores, Community Health Representatives, etc. Whatever they are called, they are important partners in the work of increasing healthcare access, improving overall health, and reduction of health disparities.[vi] We recommend that you review legislation like S.2210, the Better Care Better Jobs Act. This bill funds state Medicaid programs to improve home and community based services (HCBS). Additionally, you should consider legislation to Support and advocate for the training and recruitment of more CHW in emergency preparedness, surveillance, and public health to better support rural communities in times of crisis.

Question Area 5: Innovative Models and Technology

Extend Telehealth Flexabilites: We suggest that you permanently extend the telehealth flexibilities enacted at the beginning of the COVID-19 public health emergency. Coupling the continuation of flexibilities with investments in rural broadband is crucial to expanding access to care for rural patients. Specifically, you should permanently extend the ability of RHCs and FQHCs to serve as distant site providers and update the reimbursement methodology so it is comparable to reimbursement for an in-person visit. For RHCs and FQHCs, providing reimbursement for telehealth services at a lower rate than in person makes telehealth unsustainable in the long-term given their cost-structure and volumes of services. RHCs and FQHCs maintain a brick-and-mortar location in addition to furnishing care via telehealth, meaning that they must continue to pay the overhead of operating a physical location plus staff regardless of the mode of care delivery, as well as pay for a telehealth platform. In order to increase access, there must be payment parity between telehealth and in-person. We recommend review of the previously introduced CONNECT for Health Act (H.R.4932/S.2741).

Audio-only services have provided to be an important tool for our rural providers in recent years to reach patients, especially those who have both technological literacy and transportation barriers. Our providers have shared that many of their older patients have difficulty attending clinic visits, especially follow-up visits, due to transportation and mobility limitations. These patients also have difficultly utilizing the audio-visual technology that is typically utilized for telehealth services. These patients often request, and are able to receive appropriate follow-up care, via audio-only methods. In addition, rural areas still face broadband access challenges. Nearly 1 in 4 rural Americans cite internet access as a problem in their community. Even where broadband is built out, it may not be affordable for residents or may not have the capacity to support synchronous, audio-video technology. Keeping audio-only leaves the option open for practitioners to decide that it is clinically appropriate to use this technology for beneficiaries who otherwise would not be able to access care. These patients and their providers should have the capability to utilize this modality of services when the provider deems they can provide appropriate care in this manner.

Innovation Models: Value-based care, or population-based payment models, have the potential to solve for rural low-volume challenges that come along with FFS payment. However, CMS' Innovation Center (CMMI) has struggled to properly include rural providers in its models, in some circumstances due to statutory barriers. In particular, Congress charged CMMI with developing and testing new payment and service delivery models that must achieve cost savings. The decades of underinvestment in rural health care delivery makes achieving cost savings virtually impossible. Rural providers alternative payment methodologies and higher acuity patient mix can create additional barriers to model integration. CMMI has explicitly excluded some rural providers from taking part in their models. Most recently RHCs were cut out of the new Making Care Primary model. Additionally, the requirement on the number of attributed beneficiaries for providers which cuts out rural because of sparsely populated patient populations and lower volumes.

Congress should direct investments to building out and supporting rural providers in value-based care. The Committee should grant greater authority to the Secretary of Health and Human Services, through CMS, to develop and implement voluntary alternative rural payment models. Such models should include a global budget or enhanced cost-based reimbursement. In addition, exempting rural providers from CMMI's cost-savings mandate may alleviate some barriers to entry in innovative demonstration projects. Congress must equip CMMI with the authority to waive the cost savings requirement in order to develop rural-centric models or to allow rural providers to engage in CMMI models broadly without achieving cost savings at the outset.

Conclusion

LRHA is thankful for the opportunity to provide input on this request for information. If you would like additional information, please contact Denaé Hebert at dhebert@lrha.org or 337.366.5915.

Sincerely,

Denaé M. Hebert
Executive Director
Louisiana Rural Health Association

[i] Kaiser Family Foundation, Medciaid in Lousiana (June 2023).
[ii] USDA-Economic Research Service, 2021
[iii] National Consortium of Telehealth Resources Centers, 2017. Telehealth 101 the basics. [online] Setrc.us
[iv] A. Clinton MacKinney, Marcia M. Ward, Fred Ullrich, Padmaja Ayyagari, Amanda L. Bell, and Keith J. Mueller.Telemedicine and e-Health.Dec 2015.1005-1011.
[v] American Academy of Family Physicians, Filling the Rural Gap With Good Recruiting, Telemedicine (2019).
[vi] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2007)