National Organization of
State Offices of Rural Health

October 31, 2023

# NOSORH Comments for House Ways and Means Committee Hearing Access to Health Care in America: Challenges in Rural and Underserved Communities

## Introduction

On October 17, 2023, the United States House of Representatives Committee on Ways and Means will be holding a public hearing examining access to health care and the challenges associated with providing and receiving health care services in rural and underserved America. The Committee has solicited live and written comments on this topic.

In this communication, the National Organization of State Offices of Rural Health (NOSORH) provides its input on this issue. NOSORH's comments highlight a health system-wide approach to the issues of rural health care. The comments also suggest approaches to assure the sustainability of lower volume / higher unit cost health care that is common in rural communities. NOSORH was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. NOSORH and its members work closely with rural healthcare providers nationwide, including Rural Health Clinics, Federally Qualified Health Centers, and rural hospitals. NOSORH brings its knowledge of rural essential community providers to the concerns of this hearing.

NOSORH is encouraged that the Committee on Ways and Means is exploring issues related to health care in rural and underserved areas. NOSORH believes that new approaches are needed to combat the ongoing contraction of services in Rural America. NOSORH appreciates the opportunity to provide comments and stands ready to provide additional assistance in the future.

## Background – Rural Health Care Access Problems

**NOSORH and others have identified substantial disparities in accessible health care between rural and urban areas.** While the nation's rural population comprises less than 20% of the total population, the vast majority of designated Health Professional Shortage Areas (HPSAs) are either rural or partially rural. A recent data analysis conducted by NOSORH indicated that **84.0%** of all ***geographic primary medical care HPSAs*** are in rural or partially rural locations. Similarly, **81.9%** of all ***geographic mental health HPSAs*** are in rural or partially rural locations. Finally, **88.0%** of all *geographic dental HPSAs* are in rural or partially rural locations.

Geographic HPSA designations of an area's *total* population are the best indicator of underservice. When an area cannot be designated for its total population, it can be designated for the needs of *subpopulations*, including low-income and Medicaid-eligible populations. Rural and partially rural areas comprise a disproportionately large percentage of all the nation's population-designated HPSAs.

NOSORH data analysis showed that **69.4%** of all the nation's ***population-designated primary medical care HPSAs*** are in rural or partially rural areas. Similarly, **54.7%** of all the nation's ***population-designated mental health HPSAs*** are in rural or partially rural areas. Lastly, **72.3%** all the nation's ***population-designated dental HPSAs*** are in rural or partially rural areas.

The substantial extent of underservice for rural populations highlights this massive health service access problem. It is one of the nation's most serious health equity issues.

Several recent studies have highlighted the issue of ***health care deserts***. These are the most severe areas of underservice - locations with ***no*** available health care. Studies have highlighted multiple types of healthcare deserts, including:

- Physician deserts,
- Hospital deserts,
- Ambulance deserts,
- Dental deserts,
- Behavioral health care deserts,
- Pharmacy deserts, and
- Maternity care deserts.

The majority of these deserts are in rural areas. See a recent summary here:

- https://hitconsultant.net/2021/09/10/healthcare-deserts-goodrx-report/

Maternity care deserts – locations without hospitals providing obstetric care, birthing centers, OB/GYN physicians, or certified nurse midwives – are increasingly recognized as being a challenge to the nation's health. See the following descriptions of the problem:

- https://www.pbs.org/newshour/show/why-the-problem-of-maternity-care-deserts-is-getting-worse
- https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx

36% of all the nation's counties - home to 2.2 million women of childbearing age and almost 150,000 babies – are maternity care deserts.

The number of maternity care deserts is growing, as hospitals and obstetric care providers, many in rural areas, are unable to sustain these services financially. ***Two out of three maternity care deserts are rural counties, and only 7% of obstetric providers serve rural communities.***

This emphasizes the fact that the problem of maternity care deserts is disproportionately a rural population issue.

Maternity care deserts often result in poor pregnancy outcomes including pregnancy-related deaths. A disproportionate percentage of these poor outcomes are in rural areas. As many of these poor outcomes are preventable, they become an important target for public policy.

A major impact of the health care access disparities described above is ***foregone or postponed care for rural populations*** – including screening and preventive care. A second impact is ***discontinuous care***, with poor or non-existent care coordination. The subsequent impact of these access disparities is more costly care resulting from delayed interventions and poorer health outcomes.

These access issues are compounded for Medicaid/CHIP program enrollees. Not all providers in rural communities accept Medicaid. This is routinely verified by SORHs who conduct surveys to designate Low-Income Population HPSAs. As part of this effort, SORHs routinely uncover provider practices that are inaccessible to Medicaid patients. Communities that might otherwise have adequate capacity to meet the needs of the total population may have practice restrictions that make them shortage areas for low-income and Medicaid residents.

The problem of inadequate rural health care systems has several components:

- **Inadequate rural health care *capacity*** - including capacity for both preventive and clinical services.
- **Inadequate rural health care *workforce*** – including both clinical and non-clinical workers.
- **Inadequate regional health care *systems*** - including the formal structures needed to assure that a rural resident can have ***coordinated care*** from both local community service providers and out-of-area service providers. These regional structures would allow rural community providers to refer to specialists, not available locally, in out-of-area communities. The structures would also allow rural community service providers to make referrals and arrange for the admission of local residents into inpatient facilities in out-of-area communities. Finally, these structures would ensure that there is a coordinated care plan for rural residents bridging local and out-of-area providers. This would include appropriate discharge plans from inpatient facilities that assure that rural community providers are aware of needed follow-up.

Assuring adequate capacity for rural health care is a complex task. It will require a multifaceted approach. Appropriate payment levels and supplemental support will be an important part of the needed response. NOSORH's specific recommendations are detailed in subsequent sections of these comments.

NOSORH notes that in any response to capacity needs, it is not enough to focus on support for *existing* services. There must be initiatives to ***rebuild service systems in areas void of care***. This will require capital investments, startup funding, and enhanced operating support. This is also discussed in greater detail below.

## Rural Health Care Capacity and Financial Sustainability

**Discussion**: NOSORH believes that any effort to improve rural health care adequacy must address the question of ***adequate financial support for low-volume essential health care providers***. Generated revenues from patient care may not be adequate to sustain essential health care in many rural communities. The relatively low volumes of demand in these communities make this a particular challenge for higher-cost operations such as hospitals. Low volumes also make outpatient practices less likely to be as profitable as similar practices in high-volume urban locations.

While not all health care services can be expected in all small communities, there are many which are deemed essential, and which most people would expect to be available. Studies of health care deserts are grounded in expectations that these services should be reasonably accessible to all communities. At a minimum, these would include emergency medical services, primary care – medical, dental, and behavioral - and pharmacy services.

Two basic policy approaches can improve financial support for essential rural health care:

- **Enhanced reimbursement rates** for rural providers delivering health care, and
- **Direct financial support** for essential health care providers.

Currently, **enhanced reimbursement rates,** as implemented by Medicare and Medicaid, take several forms. *Medicare Physician Health Professional Shortage Area Bonuses* are payment enhancements to physician fee-for-service payments for services delivered in a designated HPSA. Medicaid and Medicare also reimburse several categories of health care providers in rural and underserved areas at higher, cost-related rates. This includes payment rates for Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). CAHs are, in general, reimbursed by Medicare for most inpatient and outpatient services provided to patients at 101% of reasonable costs. RHCs and FQHCs are reimbursed by Medicare and Medicaid on a per visit basis typically higher than fee-for-service rates. REHs are reimbursed for outpatient services at an enhanced Outpatient Prospective Payment System level plus 5%.

All these payment enhancement arrangements have the same aim – to provide additional revenue to essential community providers to improve their sustainability. They all have the same deficiency – they are patient volume-dependent. This means that in low-volume situations, there is likely to be insufficient total revenue, even at the enhanced reimbursement rate.

**Direct financial support** is currently provided to certain essential health care providers by the Federal government. Most FQHCs receive supplemental grant support under the Consolidated Health Center Program. These grants are a fraction of total health center operating budgets and support core health center operations not covered by generated revenue. In contrast, REHs receive, monthly, a supplemental Additional Facility Payment (AFP). The AFP is a type of global

budget for core REH operations. The annual AFP for each REH is currently more than $3 million. There are few restrictions on the use of these funds.

NOSORH notes that REH designation and the direct financial support attached to it are only available to select hospitals that are currently in operation. This designation and support is not available to rural communities where hospitals have closed. It is also not available to communities without hospitals seeking to assure emergency department services – for example, an FQHC wishing to add these services. With this limitation, the REH is not a candidate for meeting the needs of health care deserts. NOSORH believes that any direct funding mechanism seeking to address health care deserts must allow the development of new services in these locations.

NOSORH also notes that the recent COVID-19 pandemic highlighted the need for *standby health care capacity* in rural communities. Many rural hospitals could not manage the number of COVID-19 patients in their communities. Patients were transferred to regional hospitals, overloading those facilities. This circumstance led to national health policy discussions about establishing standby capacity in rural areas. Policy discussions also examined the need to create surge capacity at rural hospitals in preparation for future public health emergencies – capacity above what could be sustained by generated revenues and other regular sources of funding. When considering additional direct financial support for rural essential services, the cost of maintaining this standby and surge capacity must be included.

**NOSORH Recommendations**: NOSORH presents below specific recommendations for how the Federal government could improve the adequacy of sustainable rural health care:

> **Scarcity Area Payment Incentives**: ***NOSORH recommends that CMS establish requirements for Medicaid, Medicare, Medicare Advantage (MA) and ACA-exchange plans to create new payment incentives for the provision of key health services in defined scarcity areas, including rural scarcity areas.*** NOSORH believes that these incentives should supplement the current Health Professional Shortage Area Physician Bonus Program.
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> ***Payment incentives should be designed to attract increased service provision by all types of providers to scarcity areas – including the establishment of telehealth-centered services.*** Separate payment incentives could be established for areas with primary care shortages, key specialist shortages, behavioral health care shortages, dental care shortages, and areas with a shortage of health facilities/staffing. **Payment incentives should be established for a broad range of health care providers**, not just physicians in primary care shortage areas.
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> **Hospital Reimbursement Increases**: Rural hospital sustainability will require sufficient financial resources. ***NOSORH believes that compensation levels for rural hospitals, both from Medicare and other payers, must be set at a level that is on par with urban hospitals. In line with this goal, NOSORH recommends that the Centers for***

***Medicare and Medicaid Services (CMS) adjust the Hospital Wage Index for rural hospitals* in a manner that will allow them to improve their viability.**

**Telehealth Reimbursement**: NOSORH believes that the telehealth waivers and expansions permitted during the current COVID-19 Public Health Emergency have demonstrated the potential for these technologies to provide improved access to key services for rural residents. ***NOSORH recommends making these waivers and expansions permanent***. ***NOSORH further recommends that CMS work with key program partners, including the Federal Office of Rural Health Policy (FORHP) and Office for the Advancement of Telehealth, to identify additional policy, program, and reimbursement changes that could expand access of rural residents to important services.***

**Direct Financial Support for Rural Health Care Providers in Underserved Areas**: ***NOSORH recommends expansion of existing grant programs for essential rural community health care providers such as FQHCs. NOSORH also recommends the establishment of new global payment programs similar to the REH program for other rural health care providers in underserved areas.*** These providers could include CAHs, small rural hospitals, rural EMS programs, and RHCs***. NOSORH recommends that a portion of such support be targeted to health care deserts***, and that support be made available to existing providers as well as new providers seeking to fill in a health care void.

## Rural Health Care Workforce

**Discussion**: A comprehensive integrated approach is needed to address rural health workforce shortages. This should include ***expanded programs to train, finance, recruit/place and retain the health workforce needed in rural health care systems***. Current Federal and state programs are successful but unable to produce the health workforce needed for rural underserved areas.

The national undersupply of health care providers must be addressed by the expansion of appropriate training programs. The response should include an expansion of rural-oriented training programs – particularly those that produce generalist primary care health providers and providers of key specialties such as obstetrics/gynecology, general internal medicine, general surgery, cardiology, endocrinology, urology, pulmonology, and psychiatry. The key specialties are those required for addressing prenatal care, delivery, and chronic disease treatment for rural communities. The response should consider the expansion of the number of Medicare-supported residency slots in primary care and the key specialties.

There are multiple models which have shown success in preparing health care providers for practice in rural areas. Programs which have rural rotations are important in helping providers-in-training understand the nature of rural practice. Other programs focused upon helping rural residents train to be providers in their own communities have also been successful.

Placement incentives for rural areas should be expanded. This could include support for completely subsidized health professional education conditioned upon commitments to serve in underserved rural areas. The National Health Service Corps and multiple state program models have demonstrated their value as successful approaches of this type. Loan repayment programs are particularly useful. These can include Federal, state and community-based programs. The Arkansas Community Match Rural Physician Recruitment Program is an excellent example of a hybrid state/local incentive program:

https://medicine.uams.edu/admissions/rural-practice-programs/community-match/

The Conrad J-1 Visa Waiver program should also be expanded beyond the 30 physicians per state annual limit, allowing additional numbers of foreign physicians to work in rural underserved areas.

Finally, there is a need for ***new and expanded retention incentives*** for rural health care providers. Most current programs, such as loan repayment programs, give incentive to the placement health care providers early in their careers. Few programs provide incentives to health care providers to *continue* practice in rural underserved areas later in their careers.

State programs, such as rural provider tax credit programs in Oregon and New Mexico, have shown success in helping to retain health care providers. No similar program exists at the Federal level. Such programs would be cost-effective, as it is normally less expensive to retain existing personnel than to train and place new providers. NOSORH believes that, in addition to tax credit incentive programs, it would be equally cost-effective to implement Federal retention *stipend* programs that make actual bonus payments to health care providers who remain in practice in rural underserved areas.

NOSORH notes that it is important for workforce programs to directly target health care professionals. Enhanced reimbursement programs making higher payments for health care delivered in rural underserved areas may not have an impact on individual providers. Many health care providers are salaried, and increased revenue for a practice may not translate into any incentive for a provider. Retention tax credit or stipend programs would directly benefit all health care providers in rural underserved communities, even if they are salaried.

**NOSORH Recommendations**: NOSORH presents below specific recommendations for how the Federal government could improve the adequacy of the workforce:

> **Expand Rural Health Care Workforce Training, Educational Finance, Recruitment, And Placement Programs**: ***NOSORH recommends substantial expansion of Federal programs designed to train, provide educational financing to, and recruit/place rural health care workers.*** These programs should target underserved rural communities nationwide and include support for health care providers of all disciplines, including medical, behavioral health, dental, and other health services. Programs should

also support expansions of nursing, health care support, and other ancillary rural health workers.

**Implement New Rural Health Care Workforce Retention Programs**: ***NOSORH recommends the establishment of new Federal programs designed to retain critical health care workforce in rural underserved areas***. These programs could include tax credit and stipend incentives that would help retain health care workers in these areas. Programs should include support for health care workforce in all health care disciplines.

## Regional Health Care Systems

**Discussion**: It is not to be expected that *all* health care services be made available in every rural community. It should be expected, however, that all rural community members have access to a full range of services through referrals from health care providers in their local communities. This is particularly important for certain types of health care, including chronic disease management and maternal and infant care.

As an example, pregnant mothers should be able to receive basic prenatal care in their local community while at the same time having access to specialists outside that community if they have complicating conditions. Similarly, if a local community does not have delivery capacity, there needs to be a seamless transition from a local prenatal care provider to the delivery site.

While many rural health care providers have referral relationships with other health care providers in their region, there are often continuity gaps. There is limited support for comprehensive care coordination integrating providers in rural communities into a larger regional health care system. There are models, however, that show how independent providers can be linked into such a system.

Community Care of North Carolina (CCNC) is a statewide program that has been successful in establishing regional care coordination systems:

https://www.communitycarenc.org/what-we-do/care-management

CCNC has care coordination managers embedded within hospitals and local practices assuring continuity of care. It has demonstrated a substantial return on investment and is a good candidate for replication in other states.

Oregon has taken another approach to regional health care through its Coordinated Care Organization (CCO) initiative:

https://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx

This is a value-based care system which uses a global budgeting approach emphasizing the prevention and management of chronic disease. There are multiple regional CCOs covering the

entire state. Each CCO includes both rural and urban health care providers and is governed by a partnership between health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk. The CCO model is also worthy of consideration for replication in other states.

**NOSORH Recommendation**: NOSORH presents below a specific recommendation for how the Federal government could improve the development of coordinated health care systems integrating rural health care providers into regional networks:

> **Develop and Fund Regional Coordinated Health Care Systems**: ***NOSORH recommends the creation of new Federal programs designed to establish and support the operation of coordinated regional health care networks.*** These networks would provide care coordination across a region's health care system and ensure the integration of rural health care providers into larger systems of care. NOSORH also recommends that these new networks prioritize care coordination for chronic disease management and maternal/infant care.

We appreciate the opportunity to submit comments on this important Request for Information and hope you find value in the recommendations outlined.

Let me know if you have questions, would like discussion, or if I may be of assistance.
Thanks so much.

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