



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

November 27, 2019

The Honorable Danny Davis
U.S. House of Representatives
Co-chair, Rural and Underserved Communities
Health Task Force
2159 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Terri Sewell
U.S. House of Representatives
Co-chair, Rural and Underserved Communities
Health Task Force
2201 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
Co-chair, Rural and Underserved Communities
Health Task Force
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
U.S. House of Representatives
Co-chair, Rural and Underserved Communities
Health Task Force
1029 Longworth House Office Building
Washington, DC 20515

***SUBJECT: Committee on Ways and Means Rural and Underserved Communities Health Task Force's
Request for Information Regarding Priority Topics Affecting Health Status and Outcomes***

Dear Co-chairs Davis, Sewell, Wenstrup and Arrington:

On behalf of our more than 400 member hospitals and health systems — 63 of which are small and rural hospitals, including 34 designated as critical access hospitals — the California Hospital Association (CHA) is pleased to comment on the Rural and Underserved Communities Health Task Force request for information to inform bipartisan legislation to improve health care outcomes in rural and underserved communities.

While California's urban and metropolitan centers are its most high-profile areas, 36 of the state's 58 counties have rural hospitals, and several of those are the only hospital in their county. Those hospitals are essential to the health and economic vitality of their communities, yet access to care in rural areas is constantly under threat as hospitals strain to meet increasing financial demands.

Your work to preserve access to care in rural communities is important, and CHA looks forward to working with you. If you have any questions, please do not hesitate to contact me at (202) 488-4494 or aorourke@calhospital.org.

Sincerely,
/s/
Anne O'Rourke
Senior Vice President, Federal Relations

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?

For many rural communities, a single local hospital is the only provider of health care services — from emergency care to childbirth and life-saving treatment, such as chemotherapy and dialysis. Yet, in California most rural hospitals receive more than half of their reimbursement from Medicare and Medi-Cal, which pay approximately 80 cents on the dollar for the true cost of care. Compounding the problem for rural hospitals, both Medicare and Medi-Cal pay based on population size.

Rural hospitals are disproportionately affected by the opioid epidemic, behavioral health care coordination, an aging population, and shrinking communities. Their patients' health outcomes are likewise disproportionately affected by social factors such as poverty, lack of transportation, and a shortage of affordable housing.

One of the greatest challenges rural health care providers face is the ability to recruit staff at every level of the organization. For instance, less than 12% of US physicians practice in rural areas. According to the [California Future Health Workforce Commission](#), the state does not have enough of the right types of health workers in the right places to meet the needs of its growing, aging, and increasingly diverse population.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Risk-sharing models such as accountable care organizations (ACOs) have been successful for some rural hospitals in California, allowing groups of providers to form relationships that tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. Several rural and critical access hospitals were early participants with the National Rural ACO Consortium and have transitioned to Caravan Health — a company helping ACOs manage successful population health programs to achieve savings, exceed quality scores, and take on Medicare risk.

Expanding broadband infrastructure and service will also expand access to care by helping to deliver necessary 21st century telehealth services to patients in rural communities.

Implementation of a “global budget” model could have a substantially positive impact on rural hospitals' financial viability and long-term ability to provide essential services to their communities. With this model, hospitals would receive a pre-determined, fixed amount of revenue for the treatment of a defined population and a specified set of services, rather than being paid on a fee-for-service basis. Because revenue is separated from the actual volume

produced by a given provider, the incentive to drive volume is eliminated and population health improvement is rewarded. Under fixed budgets, hospitals are able to reduce the costs of caring for their population can improve their financial performance.

Finally, because people in rural areas tend to be older and have more complex health needs, with fewer financial resources, hospital staff who serve assist in care coordination are a valuable resource to an extended network of care programs within their communities, including free health screenings, wellness education programs, referrals to needed social services, and more. Recognizing the value of care coordination to provide patients with the right care at the right time is crucial to any future policy making.

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

In addition, the low-volume hospital payment adjustment should not only be continued but expanded. Congress created the program to help cover the high costs of operating a hospital in areas of low usage volume, related to inpatient payments. Many rural hospitals depend on the low-volume hospital payment adjustment, but currently the program faces congressional approval for extension on an annual basis. The program should be protected and updated to include an add-on adjustment for increasing usage of outpatient services.

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?

- b. While a broader investment in primary care and public health improves patient outcomes in certain ways, in rural areas the tradeoff of eliminating a service line – due to limited resources – is of utmost consideration. For instance, in the absence of obstetric care or dialysis services, patients in rural communities could be forced to travel long distances for care. In emergency situations, that travel could risk lives and well-being.
- c. Even though they face the disadvantages of being in remote areas with reduced revenue streams, rural hospitals still must provide the same care as their counterparts in other geographic areas – and comply with the same complex state and federal regulations. With more flexibility in areas such as direct medical supervision, rural hospitals could better respond to their patients' needs in the context of their unique communities and ultimately improve patient outcomes.

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?

We are currently not aware of any rural regional networks of care in California.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Programs such as the National Health Service Corps provide federal funding to recruit, retain, and support clinicians serving in high-need areas, including rural communities. The program should not only be continued but enhanced with greater incentives.

Additionally, improved funding is needed for community colleges to offer medical assistant, associate degree nursing, and other health career training programs in partnership with hospitals and health care providers to increase the supply of health care workers in rural areas.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

The California Future Workforce Commission, established in 2017, promotes three strategies in implementing a vision for California's workforce:

Strategy 1: Increase opportunity for all Californians to advance in the health professions

Strategy 2: Align and expand education and training to prepare health workers to meet California's health needs.

Strategy 3: Strengthen the capacity, effectiveness, well-being, and retention of the health workforce.

These essential strategies to bolster the health care workforce statewide will create a greater pipeline of workers from which rural hospitals can draw.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Rural hospitals are uniquely positioned to provide services to aging residents in their communities. Many California facilities in rural communities have assumed responsibility for the operation of home health agencies, in most cases at a financial loss. The Distinct Part Skilled Nursing Program (DP/SNF) supports critical access hospitals providing SNF services in their communities and receiving reasonable reimbursement for provision of this service. Federal policy should continue to support the DP/SNF Program and swing bed program, as they are vital to providing post-acute care in underserved rural communities.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

The data elements needed to help identify the causes of health disparities in rural areas are those related to the disparities themselves: we know, for instance, that suicide is disproportionately a problem in rural communities. More data are needed to explain the cause of those suicides — and similarly, opioid addiction, poverty, isolation, and myriad other social factors unique to rural populations — if we are to identify policies that will relieve their damaging effect on individuals.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

In general, protecting access to health care services in rural communities requires solutions that address their hospitals' unique circumstances. Complying with the same complex state and federal regulations as their non-rural counterparts is particularly burdensome with the smaller staffs and leaner budgets faced by most rural hospitals. A one-size-fits-all approach to health care policy ignores rural hospitals' needs and jeopardizes their ability to provide care.

In terms of specific programmatic efforts, policy makers should recognize the importance of the 340B Drug Pricing Program in creating cost savings for many small, rural hospitals — a savings that significantly contributes to their ability to comply with patient safety and care quality activities.