October 5, 2023

The Honorable Jason Smith
Chair, House Committee on Ways & Means
1139 Longworth House Office Building
Washington, DC 20515

Submitted via WMAccessRFI@mail.house.gov

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

Dear Chair Smith,

United States of Care (USofCare) is pleased to submit the following response to the House Ways & Means Committee's ("the Committee") Request for Information (RFI) entitled "Improving Access to Health Care in Rural and Underserved Areas" to expand access to comprehensive, affordable health care in rural and underserved communities. We appreciate the opportunity to provide insights on how people across the country are confronted with rising costs due to increased hospital and health system consolidation nationwide, as well as the unique challenges facing health clinics, physician offices, and other sites of care in rural and underserved communities.

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal levels in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we identify and amplify unique perspectives from people on the ground to inform state and federal policy change. Where possible, we uplift the voices of real people engaging with the health care system at the patient level whose perspectives have shaped our advocacy work – listening work that confirms that health care affordability is people's foremost concern with the health care system.

Throughout 2022, our Research and Community Engagement team worked with various rural communities in South Carolina to learn about their experiences with the health care system. Common challenges that emerged included a lack of quality health care options, discrimination and bias in health care settings, inability to afford health insurance coverage and the high prices of prescription drugs, navigating a confusing health care system, and avoidance and mistrust of doctors. Access to high-quality, affordable health care, regardless of social status, need, or income is not adequate in these areas of rural South Carolina. These communities cited an increase in the amount and quality of health care specialists and health care professionals as a critical need.

> *"[Expensive] costs keep a lot of people from seeking care, even if they have insurance. Most people won't go in until it gets more serious than they have to go in."*
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> *~ Black man, rural Georgia*

USofCare's response to the Committee's RFI captures our unique expertise listening to people in rural communities such as those mentioned in South Carolina and elsewhere. We appreciate the Committee's commitment to understanding and addressing the unique health care access needs faced by people living in rural and underserved communities. As the Committee notes, health care access has decreased in recent years as rural hospitals close their doors and providers relocate to more populous or better-resourced areas. **This is causing immediate harm to rural patients. Rural Americans, on average, have to drive twice as far to the nearest hospital; those without access to reliable transportation often bypass care entirely.**

While national in scope, the challenges people face in accessing health care in rural and underserved areas are best understood at the state and local levels. The Chair's home state of Missouri, like most states, faces difficulty in fully addressing the health care access crisis in rural and underserved areas. For example, between 2014 and 2020, 15 Missouri hospitals closed — 10 of which were in rural counties. Emergency medical care remains out of reach for many Missourians and every one of Missouri's 99 rural counties has a reported mental health professional shortage. Three-fifths of Missourians have cited cost as a barrier to care and rural Missourians face even more cost barriers, such as high out-of-pocket costs, when accessing health care.

While the RFI addresses six elements of focus for stakeholder input, USofCare's response focuses on two areas where our listening work, policy expertise, and state experience can uniquely inform future legislation from the Committee. Those components are (1) aligning site of service and (2) innovative payment models. We remain, however, available to serve as a resource across rural health generally as the Committee's progress on this issue moves forward.

Aligning Sites of Service

While there is a broad spectrum of health care access challenges in rural and underserved areas and many solutions proposed to address these challenges, USofCare is focused on aligning site of service payment, as outlined by the RFI, as a way to improve health care access and affordability issues faced by people living in rural and underserved areas. **We support federal and state policies to address high hospital prices by aligning sites of service, promoting site-neutral payment reform, and shielding people from unnecessary "facility fee" charges.**

Rural Patients Stand to Benefit from Reigning in High Hospital Prices

High hospital prices are one of the largest drivers of growing health care costs, accounting for nearly one third of all U.S. health care spending in 2021. This is largely the result of increased provider consolidation in a system where hospitals and health systems are incentivized to buy up independent facilities. Studies have shown that these mergers fail to translate into higher-quality care for patients and often increase costs for patients seeking the emergency and routine care they need. As independent hospitals and other facilities are acquired, health systems may close critical services, such as intensive care, obstetrics units, and behavioral health services, further limiting access to care. The impacts of health care consolidation are felt even more acutely by underserved populations, including people who live in rural areas and people of color, who already face significant health care access challenges.

> *"There are many barriers in getting people the right care they need; whether it's a stigma, whether it costs too much money, or several other [possible] reasons."*
> *~ White woman, rural North Carolina*

We realize that facilities that serve predominantly rural and underserved areas often operate on thin margins; however, we also know that people who receive health care at these facilities tend to have lower incomes and therefore stand to gain the most from policies to lower the cost of care. As the Committee continues to explore ways to craft policies that serve people in rural and underserved areas, special attention must be paid to providers in these areas. This is to ensure that these solutions are targeting the correct problems and not leading to adverse or unanticipated outcomes. **Addressing the high cost of care due to high hospital prices is critical to ensuring people can access and afford care in rural and underserved areas.**

Shielding Patients from Facility Fees is a Critical Step Toward Health Care Access and Affordability for Rural Communities

At the state level, health care consolidation is visibly and adversely affecting people's access to care through high "facility fees," or service changes from hospitals for a patient's use of their facilities and equipment, even when these health care services are not provided in a hospital setting. These fees, which often come as a surprise to patients and can run to more than $1,000, often exceed the underlying cost of care and can act as a significant deterrent to seeking care. USofCare actively supports legislative efforts in Indiana, Colorado, Maine, and states across the country to restrict hospitals' ability to charge facility fees and instead align payment policies regardless of where care is delivered.

People in Rural Communities Will Benefit from Federal Legislation Aimed at Transparency and Site-Neutral Payments

USofCare supports the Committee's work to pass the Lower Costs, More Transparency Act (H.R. 5378). The bill expands pricing transparency protections for consumers and establishes new hospital billing practices to ensure that people don't pay more for health care based on the site of service. While H.R. 5378 represents a solid first step towards site-neutrality, Congress must take further action to realign financial incentives in order to prevent people in rural and underserved areas from shouldering higher health care costs. Reforms, such as the USofCare-supported Site-based Invoicing and Transparency Enhancement (SITE) Act (S. 1869), would expand site-neutral payment policies to include most facilities to ensure that Medicare reimburses at the same rate for off-campus services and eliminates facility fees for some off-campus hospitals. Importantly, the SITE Act pairs savings generated from site-neutral payment policy with funding to create a graduate nursing education program. Not only will this address the nation's nursing shortage, but it will support health needs in rural communities as well.

Innovative Payment Models

It is also important to prioritize solutions that center people's unique health needs while keeping care affordable and accessible. USofCare supports a shift towards patient-first care approaches to ensure that our health care system prioritizes quality over quantity.

Public Opinion Research Confirms that Patients Across Demographics Desire Patient-First, Quality-Focused Care

Our current health care system largely incentivizes a fee-for-service system, in which providers prioritize the number of visits and treatments completed over the quality of those visits. Earlier this year, USofCare studied the existing yet limited body of public opinion research and patient perceptions related to patient-first quality care (also known as "value-based care") concepts. In our review, we identified several challenges, including significant misinterpretations and misunderstandings about what these models are, fears that people would be "guinea pigs" to test these models, worries that these models are cost-cutting measures that sacrifices quality, and

the feeling that providers wouldn't be incentivized to care for people with chronic health care needs.

USofCare supports expanding patient-first quality care arrangements to increase access to more coordinated patient care. **Our subsequent messaging findings indicate that when offered an alternative to the current fee-for-service health care system, people favor a patient-first (or "value-based") model that compensates providers for improving overall health, delivering superior care, and coordinating patient care by a 4:1 margin. People also crave more time with their doctors, better communication between their providers, and more personalized and customized care.**

Our Focus Group Findings Highlight How Rural Participants Experience Health Care Today
USofCare conducted targeted focus groups that included people from rural communities, as well as people who identify as lower-income and people of color. From our focus groups, we found that for people in rural communities, there was a clear desire for more coordinated care between providers. It was also evident that rural patients want whole-person care, rather than their care seeing them as symptoms or body parts.

> *"It goes back to they are on that time limit thing so how can they get a full aspect of what is going on within your body…and if you say you're coming in for such and such, well when you get there that is all they are going to talk to you about. If you have got anything else you have got to make another appointment for that."*
> *~ Rural participant who has had mostly negative experiences receiving health care*

Patients feel like too much time is spent waiting to see their doctors rather than actually meeting with their doctors. Participants wait too long to get an appointment time slot and in the waiting room when they arrive, only to feel rushed with the doctor once they are with them. As a result, some feel that, ultimately, they spend more time in the system because they aren't able to address everything in one appointment and end up making another one. A better system isn't just one where people can get in to see their doctor faster, but one where they feel they can address all their issues in the time they need. This underscores the importance of a shift to a patient-first care approach, which innovative models can directly address.

Innovation and Models that States Pursued Show Promise when Addressing Rural Health Inequities
States have led the way in pursuing solutions through innovative value-based care arrangements to bolster access to health care for rural or underserved populations. Examples of this progress include:

- **Pennsylvania**. Pennsylvania's Rural Health Model (PARHM) shows how adopting hospital global budgets and investments in primary care can improve health outcomes and reduce disparities in rural areas while also controlling costs to ensure that people across Pennsylvania's rural communities are able to receive care. This model is a noteworthy example that the Committee ought to consider as it promotes innovation and new models of care that address rural health disparities. Specifically, since implementation in 2019, PARHM has been credited with:
    - Keeping the 18 participating hospitals and health systems afloat during the pandemic when patient volume dropped;

    - Achieving lower Medicare spend per member per month than the national rural average; and
    - Improving quality across avoidable utilizations, lowering hospital-acquired conditions, and maintaining federal readmission rates.
- **Oregon**. In Oregon's rural and frontier communities, as is the circumstance in many states with significant non-urban populations, people are often disproportionately impacted by social determinants of health, like poverty, a lack of housing, and a lack of transportation. Oregon's Coordinated Care Organization (CCO) Model, which began in 2012 by establishing 16 CCOs across the state, targets Medicaid spending and enhances health access and quality. By integrating medical, behavioral, and oral health services via a "global budget," the model elevates care quality while saving an estimated $2.2 billion from 2013 to 2017.

While the Centers for Medicare & Medicaid Services (CMS) ended its Community Health Access and Rural Transformation (CHART) model earlier this year after limited participation, we are encouraged by the agency's focus on payment reform in rural hospital settings. By understanding the shortcomings of the CHART model, CMS and states can work together to promote rural hospital transformation and address the unique challenges faced by rural facilities, while improving health outcomes for people in rural and underserved areas. **We urge the Committee to work with CMS and state stakeholders to uplift other value-based and accountable care models that benefit rural and underserved populations and pursue legislative solutions to expand the applicability of these models to new states.**

Conclusion

In addition to its existing work, USofCare encourages the Committee to translate promising state-level solutions, where appropriate, to the federal level. This includes reimbursement for doula care to improve maternal health outcomes and incentives for medical providers to serve in rural or underserved areas.

We appreciate the opportunity to respond to the Committee's RFI by sharing our insights and recommendations about rural and underserved populations' access to health care.We are hopeful this information will assist the Committee in crafting future legislation that aligns with our mission of ensuring that everyone has access to high-quality, affordable, personalizable, and understandable health care. Please reach out to me, Lisa Hunter, Senior Director of Policy & External Affairs, at lhunter@usofcare.org with any questions.

Sincerely,

Lisa Hunter (she/her)
Senior Director for Policy & External Affairs
United States of Care