National Rural Health Association

Statement for the Record

National Rural Health Association
to the
United States House Ways and Means Committee

Health Subcommittee Hearing on *The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine*

June 6, 2024

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Submitted via email: WMSubmission@mail.house.gov

Chairman Jason Smith
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Re: Statement for the Record on Hearing on ***The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine.***

Dear Chairman Smith, Health Subcommittee Chairman Vern Buchanan, and Members of the Committee,

The National Rural Health Association (NRHA) thanks the Chairman and members of the Committee for the opportunity to submit a statement for the record on the financial and regulatory burdens facing independent rural medical providers and how continued challenges result in barriers to patient care. We appreciate the chance to provide information on how issues pertaining to independent medicine and private practice impacts rural health care and look forward to working together to increase access to quality care for rural residents.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. NRHA works to improve rural America's health needs through government advocacy, communications, education, and research.

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NRHA recognizes the importance of prioritizing and modernizing the healthcare system to empower medical professionals to effectively serve patients in rural communities. Within this statement, we discuss the vulnerability of rural hospitals and independent rural health clinics, the administrative burden and challenges faced by rural hospitals and clinics from Medicare Advantage, and the need to support GME programs to build the rural workforce.

Rural Hospital Vulnerability

Since 2010, over 175 rural hospitals have closed their doors or discontinued inpatient services.[i] Nationally, 50% of rural hospitals are operating with negative margins and therefore vulnerable to closure.[ii] When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin ends, affecting the larger community. Investing in a strong rural health infrastructure has massive impacts on health outcomes of rural residents, but also widespread effects on local economies as well.

The impacts of hospital mergers are mixed for rural facilities, providers, and their patients. Mergers and affiliations can affect the financial status of facilities, service costs (including out-of-pocket costs), access to high quality services, and community members' perspectives regarding healthcare delivery (including breadth of services available in their communities).

Quality of care for rural residents could be affected in multiple ways post-merger. For example, quality might improve with more direct access to specialty care through the system (both through telemedicine and rotating clinics) and more timely referrals.[iii] Additionally, acquisitions and mergers help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Affiliation may provide investment in local services, including some that were not previously sustainable, but it also may result in loss of local community services as a result of system decisions to consolidate services elsewhere. Quality could be adversely affected if a merger or consolidation results in closure of local services and loss of independent decision making. However, reports on the effects of hospital mergers or acquisitions consistently show higher prices for consumers/patients stemming both from price increases in merged hospitals as well as in competing hospitals.[iv]

Independent RHC and FQHC Vulnerability

Rural hospitals are primarily outpatient facilities. For example, the average critical access hospital derives 79.4% of patient revenue from outpatient services through provider-based Rural Health Clinics (RHCs)[v]. Further, in areas where a rural hospital has closed, some of the potential reductions in access to essential preventive and diagnostic services may be filled by Federally Qualified Health Centers (FQHCs) and RHCs[vi]. Independent RHCs and FQHCs that are not affiliated with a hospital system also serve as invaluable resources for rural communities, offering accessible, comprehensive, and patient-centered healthcare services. These clinics play a vital role in improving health outcomes, enhancing healthcare access, and strengthening the fabric of rural America[vii]. These clinics also help administer comprehensive services, provide patient-centered care, deliver cost-effective care, provide financial support, and establish community impact[viii]. As a result, NRHA encourages Congress to support legislation like S. 198, the RHC Burden Reduction Act. This is a piece of legislation that would make a significant difference on the day-to-day operations of RHCs by addressing outdated legislative barriers. This important bill would align RHC physician

supervision requirements with state scope of practice laws governing physician assistant and nurse practitioner practice, remove outdated laboratory requirements, allow RHCs to provide an increased amount of behavioral health services, among other technical tweaks.

Medicare Advantage Impact on Rural

The popularity of Medicare Advantage (MA) plans as an alternative to Traditional Medicare has grown significantly in recent years. Both rural and urban areas have seen MA enrollment become a larger fraction of total Medicare enrollment in the past decade, and rural beneficiaries have increasingly chosen MA plans over Traditional Medicare with the rate of MA growth in nonmetropolitan counties higher than metropolitan counties.[ix] About 45% of all rural beneficiaries are enrolled in an MA plan and current trends point to MA plans enrolling a majority of rural beneficiaries in two years.[x] NRHA members have increasingly voiced their frustrations and concerns with MA plans and how these issues affect beneficiaries' access to care. Rural beneficiaries already face access challenges given the unique characteristics of rural areas, and MA plan practices continue to compound such barriers to care. MA especially impacts rural independent medical clinics and private practices due to the strain of administrative burdens from prior authorization and quality reporting, restrictions to access of care for patients, and lack of physician reimbursement.

Administrative burdens: NRHA members have cited prior authorization as a major barrier to care for beneficiaries and an administrative burden to staff. Prior authorization is a common issue plaguing providers both rural and urban; however, NRHA members have raised administrative burden issues that are unique to rural. Rural providers do not have the staff needed to jump through MA plans' prior authorization hoops. Understaffed rural private practice physicians often are overwhelmed by these extra administrative burdens, which is time that they view should be spent on patient care instead. Additionally, extra duties with the few staff present in these rural private practices often drive rates of burnout as well as enable workforce loss to large hospitals instead.[xi] These challenges as a result of administrative burdens take away the opportunity to access quality patient care at private practices. Independent practices in rural areas enable the provider and clinical staff to develop meaningful and long-term relationships with patients, providing integrated services while practicing within the context of family and community. Access to a consistent and reliable independent primary care practice is associated with increased patient trust in the physician, more effective patient-provider communication, and an increased likelihood that patients will receive the care they [xii] Independent physicians who manage their own practices tend to have a closer connection with their patients and experience lower burnout rates.[xiii]

Physician Reimbursement Rates: NRHA members have voiced that payment-related challenges with MA plans have negatively impacted their patients, staff, and facilities. Payment challenges are heightened for providers with special rural designations and payment systems, like RHCs, because of their specific payment rates. NRHA members representing various facility types have raised concerns over payment timeliness, audits, negotiating power, and payment denials. As the proportion of MA beneficiaries compared to Traditional Medicare beneficiaries continues to grow, rural providers that are reimbursed on a different payment system are increasingly losing money. Growing MA enrollment in rural areas is diluting the original purpose of these rural designations and threatening their ability to support rural providers. RHCs are paid their specific all-inclusive rate (AIR)

through Traditional Medicare. Yet MA plans do not adhere to these Traditional Medicare payment rates and in turn RHCs receive worse reimbursement from the plans.

Medicare Physician Reimbursement Rates

Medicare physician payment is shrinking, dropping 29% since 2001, when adjusted for inflation, as practice costs have gone up by 54% at the same time.[xiv] The growing gap between the operational costs of independent practices and Medicare payments is tremendous in rural areas and affects the viability of these practices. Retention of staff is difficult in comparison to competing against local hospitals and retail entities raising prices. Practices find themselves caught between rising costs and declining reimbursement, and that gap has widened in the past two decades. Persistent inflation means higher expenses for staff, rent, and supplies. At the same time, Medicare rates have been flat or cut and MA and commercial health plans often squeeze payments as well.

To address this gap, reimbursement rates for primary care need to be looked at more in depth. Many private practice and independent rural physicians stress the importance of paying them for the excess work they do, especially primary care physicians that play a vital role in sustaining care in rural areas. The greatest challenge is that the Medicare physician fee schedule has not kept up with inflation, especially when physicians are only medical providers who do not get inflation increase. Costs increasing from inflation and Medicare reimbursement rates declining end up disproportionately affecting people who live in rural or low-income communities and leads to less healthcare options. Congress must adopt a permanent Medicare update while working toward long-term reform and increasing budget neutrality.

GME Programming to Support Rural Workforce

One solution to address the workforce shortages in rural areas is an investment in rural GME programming and increasing residency slots to continue practicing in rural communities. Only 2% of residency training occurs in rural areas, despite research showing that training physicians in rural areas increases their likelihood of practicing in a rural community.[xv]

To increase rural physician training in the short term, Congress must authorize the Rural Residency Planning and Development Program (RRPD). RRPD has shown incredible results as a pilot program by increasing the number of rural residency programs, standing up 44 new accredited programs and 563 additional residency positions since 2018[xvi]. It is essential that this very successful program is formally authorized in order to support rural residency capacity as outlined in H.R. 7855, the Rural Residency Planning and Development Act of 2024. Additionally, to correct these discrepancies in rural areas and genuinely support rural healthcare, the Committee should consider a companion bill to H.R. 8235, the Rural Physician Workforce Preservation Act. This bill would exclude reclassified hospitals from receiving the 10% of slots allocated to rural hospitals unless the hospital reclassified because they are in a rural Census tract of a metropolitan statistical area or are located in an area considered rural by state law or regulation. Further, NRHA supports H.R. 834/S. 230, the Rural Physician Workforce Production Act, which tackles the geographic maldistribution of physicians in rural areas stemming from the current structure of Medicare-funded GME. The bill would lift GME caps, remove Medicare limits on rural resident training growth, extend equitable federal funding to rural hospitals, and establish an elective per resident payment initiative. We also welcome state-level GME initiatives such as the establishment of the Office of Mississippi Workforce that assists

with startup costs for residency and starting DO programs in Mississippi discussed during the hearing.

Thank you for the opportunity to weigh in on this important issue. Please contact Alexa McKinley (amckinley@ruralhealth.us) with any questions or for more detail on any of the information above. NRHA would welcome a meeting with the Committee to discuss our response and put forth viable policy solutions to improve rural health care for patients and providers.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

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[i] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[ii] https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf
[iii] https://rupri.org/wp-content/uploads/Health-System-Affiliation-Landscape.Finalversion.April-2024.pdf
[iv] https://rupri.org/wp-content/uploads/Health-System-Affiliation-Landscape.Finalversion.April-2024.pdf
[v] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8522564/
[vi] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8522564/
[vii] https://orchardmedicalmgt.com/understanding-independent-rural-health-clinics-eligibility-and-benefits/
[viii] https://orchardmedicalmgt.com/understanding-independent-rural-health-clinics-eligibility-and-benefits/
[ix] Edmer Lazaro, Fred Ullrich, & Keith Mueller, Medicare Advantage Enrollment Update 2023, RUPRI Center for Rural Health Policy Analysis, University of Iowa, 2, November 2023, https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Medicare%20Advantage%20Enrollment%20Update%202023.pdf.
[x] Id. at 3.
[xi] https://www.medicaleconomics.com/view/rural-health-care-falling-behind-nationally-and-action-is-needed-now-ama-president-elect-says
[xii] https://www.elationhealth.com/resources/blogs/the-importance-of-independent-practices-in-rural-areas
[xiii] https://www.elationhealth.com/resources/blogs/what-are-the-benefits-of-independent-physicians-and-practices
[xiv] https://www.medicaleconomics.com/view/rural-health-care-falling-behind-nationally-and-action-is-needed-now-ama-president-elect-says
[xv] https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd#:~:text=Only%20two%20percent%20of%20residency%20training%20occurs%20in%20rural%20areas.&text=We%20partner%20with%20the%20Bureau,practicing%20in%20a%20rural%20community
[xvi] https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd