



## Implications of Proposed Changes to Rural Hospital Payment Designations

Policy Brief December 2012

*Editorial Note:* At its June 2012 meeting in Kansas City, Missouri, the National Advisory Committee on Rural Health and Human Services discussed the short-term policy implications of proposed changes to the designation and payment guidelines for small rural hospitals, as well as medium- to long-term visions for the future of rural health care infrastructure. Given the current fiscal and legislative environment, this first paper focuses on short-term questions related to possible revisions to the special payment designation criteria for rural hospitals, reserving consideration of broader systemic changes for the companion policy brief to be produced after the Committee's September 2012 meeting in Austin, Texas. In that companion paper, the Committee will attempt to look beyond incremental changes to rural health care infrastructure and use ideas introduced in this brief to take a more comprehensive approach toward prioritizing equitable access, encouraging consolidation and affiliation where appropriate, and simplifying systems of payment. The data referenced in this paper, unless otherwise indicated, come from a study conducted at the Committee's request by the North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina at Chapel Hill (Research Center<sup>1</sup>).

### INTRODUCTION

In recent months, plans to restrict or abolish special Medicare payment designations for categories of rural hospitals have been proposed by a variety of groups, including the Congressional Budget Office (CBO), the Administration, and the Medicare Payment Advisory Commission (MedPAC).

The current system of differential designations for paying rural hospitals has worked effectively to address the inequities and instability which followed the 1983 Medicare hospital payment reforms. The Committee agrees with the groups proposing reforms that these enhanced payment designations could be more efficiently targeted than under current law. It is concerned, however, that some current cost-saving proposals do not appear to accomplish this result in the most equitable or harmless fashion. In this paper, the Committee evaluates these proposals and examines additional principles and considerations that could guide more nuanced reform.

### SUMMARY OF COST-SAVING PROPOSALS

[Mandatory Spending Option 24](#). The CBO's proposal, known as Mandatory Spending Option 24 (Option 24), suggested eliminating special Medicare payment programs for critical access

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<sup>1</sup> The Research Center presented its findings to the Committee on June 14 and June 18, 2012. This research was funded by a grant from the Federal Office of Rural Health Policy, Award No. U1GRH0763-05-01.

hospitals (CAHs<sup>2</sup>), sole community hospitals (SCHs<sup>3</sup>), and Medicare-dependent hospitals (MDHs<sup>4</sup>). As reported by the CBO, about one-third of U.S. hospitals currently benefit from these special payment designations, although these hospitals account for one-tenth of total Medicare spending on hospital inpatient services. The Research Center found that CAHs, representing the bulk of rural hospitals contemplated in the CBO's proposal, comprise 28 percent of the nation's hospitals and two percent of overall Medicare spending. The CBO projected that Option 24 would reduce federal spending by approximately \$62.2 billion over the next 10 years. The CBO further argued that placing CAHs, SCHs, and MDHs under the Medicare Prospective Payment System (PPS) could force these facilities to provide inpatient care more efficiently. The Committee notes, however, that Option 24 is among a broad range of possible options laid out by the CBO to reduce government spending and recognizes that the CBO itself explicitly cautioned in presenting Option 24 that outright elimination of these enhanced payment systems without further considerations may cause small rural hospitals to convert to solely outpatient facilities or even to close, reducing access to health care in many rural areas. Costs from these potential closures could offset – if not outweigh – promised savings, and should be accounted for in proposed savings models.

[The Administration's proposal.](#) To “better align payments to rural providers with the cost of care,” the Administration outlined three revisions to the current CAH payment system in its proposed FY 2013 budget: first, it recommended eliminating add-on payments for hospitals and physicians in low-volume areas; second, it suggested reducing Medicare payments to CAHs from 101 percent to 100 percent of reasonable costs; and third, it proposed eliminating the CAH designation for CAHs within 10 miles of another hospital. According to the data presented by the Research Center, this final change would impact 4.2 percent of existing CAHs<sup>5</sup>, or 55 hospitals, in addition to 13 SCHs whose special payment designation would be revoked based on minimum distance requirements if those 55 nearby CAHs converted to PPS facilities. In its report, the Administration estimated that these three measures together would save approximately \$6 billion over the next 10 years, with the final two CAH-specific measures together accounting for an estimated \$4 billion in projected savings.

[Other Congressional proposals.](#) Various other congressional proposals have included the Administration's mileage requirement or suggested alternative distances and similar criteria that

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<sup>2</sup> As established in the Balanced Budget Act of 1997, CAHs must be located in a rural area at least 35 miles from another hospital by primary roads, or 15 miles by secondary roads or in “mountainous terrain.” Until 2006, states could waive these distance requirements by classifying a CAH as a “necessary provider” of health care services for residents in the area. CAHs must supply 24-hour emergency services, have no more than 25 inpatient beds, and provide inpatient care for an average of no more than 96 hours per patient. CAHs receive Medicare payments equal to 101 percent of their allowable costs. See 42 *USC* §1395i-4(c).

<sup>3</sup> SCHs in rural areas must be (1) located at least 35 miles from the nearest like hospital (excluding CAHs); (2) located between 25 and 35 miles from the nearest like hospital and meet certain patient admission requirements demonstrating high regional dependence; or (3) located between 15 and 25 miles or 45 minutes in driving time from the nearest like hospital in particularly rugged areas. SCHs receive enhanced Medicare payments based on the greater of their own historical costs or the inpatient prospective payment system (IPPS) rate. See 42 *CFR* §412.92.

<sup>4</sup> Authorized through September 30, 2012, MDHs were rural hospitals (not SCHs) with fewer than 100 inpatient beds and with at least 60 percent of inpatient days attributable to beneficiaries entitled to Medicare Part A. MDHs received enhanced payment based on the greater of a hospital-specific base year or the IPPS rate. See 42 *CFR* §412.108.

<sup>5</sup> Data current as of December 31, 2010.

could further reduce federal outlays to CAHs. In its 2012 Rural Report, MedPAC questioned the necessity of maintaining the current levels of enhanced payments for CAHs. Conceding that special payments are still needed to maintain access in areas with low population density and low patient volumes, MedPAC argued that “higher costs at CAHs may not always be necessary, given that 16 percent<sup>6</sup> of CAHs are within 15 miles of another hospital.”<sup>7</sup> While MedPAC did not endorse revoking enhanced payments for CAHs within a certain driving distance from the nearest hospital, it did assert that “Medicare should not pay higher rates to two competing low-volume providers in close proximity.”<sup>8</sup> In arguing that the CAH program should be re-targeted to only those low-volume facilities essential to guaranteeing equitable access to care, MedPAC appears to have assumed that nearby hospitals generally compete in overlapping service areas to attract inefficiently small patient volumes (see Table 2 for data). While the Committee supports MedPAC’s effort to allocate enhanced payments only where they are necessary to ensure equitable access to health care in rural areas, it disagrees with the assumption that consideration of driving distance alone can determine which rural hospitals are essential.

### **EXAMINATION OF DISTANCE-BASED RE-DESIGNATION PROPOSALS**

Since cost-saving proposals most often use driving distance from the nearest hospital as the primary re-designation criterion, the Committee asked the Research Center to conduct a data-driven examination of the effects of distance-based re-designation proposals and the correlation of driving distance with other characteristics of rural health care providers. Table 1 shows the direct effects that re-classification of CAHs under increasing minimum driving distance requirements from the nearest hospital would have on the broader rural health care system. Revocation of their CAH status would likely lead former CAHs to enter the PPS system, which would in turn cause SCHs within a minimum distance from these former CAHs also to revert to PPS hospitals. Using a 15-mile cut-off, 284 CAHs and SCHs would most likely convert to PPS facilities, more than four times the total number of hospitals (68) affected under the Administration’s 10-mile scenario. This illustrates how seemingly small changes in distance criteria can mean significantly increased impact on rural health care infrastructure. Indeed, revoking the CAH designation for CAHs within 20 miles of the nearest hospital could involve converting nearly half of existing CAHs around the country to PPS facilities.

A substantial influx of CAHs into the PPS system may also have an impact on other rural hospitals due to the structure of the hospital wage index. CAHs tend to have lower overall wages, and as this subset of CAHs moves back into the PPS system it may end up lowering the statewide rural wage index.

While the numbers presented in Table 1 represent a significant portion of rural hospitals, they do not account for the additional stress potential hospital closures may cause which could further stretch already strained rural health systems. The Committee believes projected cost-saving from the proposed measures described above may have failed to incorporate possible indirect

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<sup>6</sup> Data from the Research Center indicate that in fact 18 percent of CAHs are within 15 miles in driving distance from the nearest hospital.

<sup>7</sup> Medicare Payment Advisory Commission. (June 2012). “Chapter 5: Serving Rural Medicare Beneficiaries.” *Report to the Congress: Medicare and the Health Care Delivery System*, p. 121.

<sup>8</sup> *Ibid*, p. 123.

consequences from the suggested changes and may therefore be overestimated. By encouraging closures and mergers of small rural hospitals, these measures may decrease immediate access to health care in rural areas by reducing the number of health professionals and health facilities attracted to and retained in rural areas; increasing the travel time to the nearest acute-care hospital; increasing the volume, and therefore cost, of transport from rural areas to the nearest acute-care hospital; and lengthening the amount of time elapsed before patients in critical condition can be properly evaluated by a health professional. As reported to the Committee during site visits to CAHs in Kansas and Missouri, transfers from rural hospitals to urban hospitals often take more than an hour and cost more than \$1,000 per trip; the cost of air transport in more remote frontier areas can easily exceed \$10,000 per flight.

**TABLE 1: NUMBER OF HOSPITALS AFFECTED BY CHANGES IN DISTANCE CRITERIA**

Cutoff for Driving Distance from the Nearest Hospital for CAHs	Number of CAHs Converted to PPS	Number of SCHs Converted to PPS	Total Number of Hospitals Converted
<b>&lt;5 miles</b>	13	4	17
<b>&lt;10 miles</b>	55	13	68
<b>&lt;15 miles</b>	245	39	284
<b>&lt;20 miles</b>	571	87	658
<b>&lt;25 miles</b>	872	135	1005

Source: The Research Center analysis of hospital data as of December 31, 2010, presented to the Committee on June 18, 2012.

Additionally, closure of these small rural hospitals could jeopardize the substantial financial and infrastructural investments communities have made to improve their local health services, as well as add stress to the EMS systems of surrounding hospitals forced to carry the caseload previously handled by the shuttered local hospitals. The EMS systems of small rural hospitals are often integral to the disaster planning of many surrounding communities and the preparedness of those communities to respond rapidly and effectively in emergency situations.

Increased patient volume at suburban and urban hospitals may in fact further decrease the expected Medicare cost savings because of higher PPS payment rates at those hospitals due to the higher wage index and cost of living in metropolitan areas. Estimated savings also do not consider the expenses incurred by patients in larger facilities who are often seen by multiple consultants in more sub-specialized practice environments with higher utilization and cost patterns.

MedPAC theorized that eliminating the CAH designation for CAHs in close proximity to other hospitals could have the positive effect of encouraging mergers between currently competing health care facilities, resulting in more efficient health care delivery. MedPAC's efficiency argument seems to assume that rural hospitals near other health care facilities are more likely to struggle to retain a sufficient average daily census of acute-care and swing bed patients (ADC). However, the data in Table 2 indicate that most CAHs in close proximity to other hospitals are already operating at a patient volume that allows these facilities to be more economically viable. Instead, it is the more isolated facilities, those CAHs 35 miles or farther from the nearest

hospital, that usually experience a lower ADC and narrower operating margin, despite a relative lack of nearby competition.

**TABLE 2: ADC DISTRIBUTION OF CAHs BASED ON DISTANCE FROM THE NEAREST HOSPITAL**  
Driving Distance in Miles to Next Closest Hospital

Acute+Swing ADC	Data Missing	<10	10 to <20	20 to <35	35+	Total
Data Missing	0	0	3	3	2	8
<2	2	2	33	50	34	121
2 to <5	0	8	123	180	65	376
5 to <10	0	17	222	182	69	490
10+	0	28	135	134	24	321
<b>Total</b>	2	55	516	549	194	1316

Source: The Research Center analysis of hospital data as of December 31, 2010, presented to the Committee on June 18, 2012.

The Committee acknowledges that some excess capacity likely exists in rural health infrastructure and recognizes the positive value of mergers between some nearby hospitals. It doubts, however, that the broad and imprecise changes to the distance or payment guidelines that have been suggested will target only those hospitals for which mergers are appropriate. Any changes should continue to help struggling rural hospitals improve without jeopardizing those which have succeeded under the current payment model. Given the historical purpose of the CAH status and the complex dynamics of the rural health care system today, wholesale revisions to CAH designation criteria could harm health care infrastructure in rural areas.

## THE ROLE OF SMALL RURAL HOSPITALS

### *RURAL MEDICARE BENEFICIARIES*

*The people served by rural hospitals are more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer than residents of urban areas.<sup>9</sup> Yet overall, the average cost per Medicare beneficiary is 3.7 percent lower in rural areas than in urban areas, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.<sup>10</sup>*

The patchwork system of protections created for rural hospitals since the mandated adoption of prospective payment by Medicare in 1983 has undoubtedly served an indispensable role in dramatically reducing the rate of closures among small rural hospitals. Many of these hospitals represent the sole access point to health care in their region, ensuring immediate delivery of urgently needed care and providing services that help retain physicians, pharmacies, clinics, and other health care resources in rural areas. Closure or relocation of a CAH has been observed to

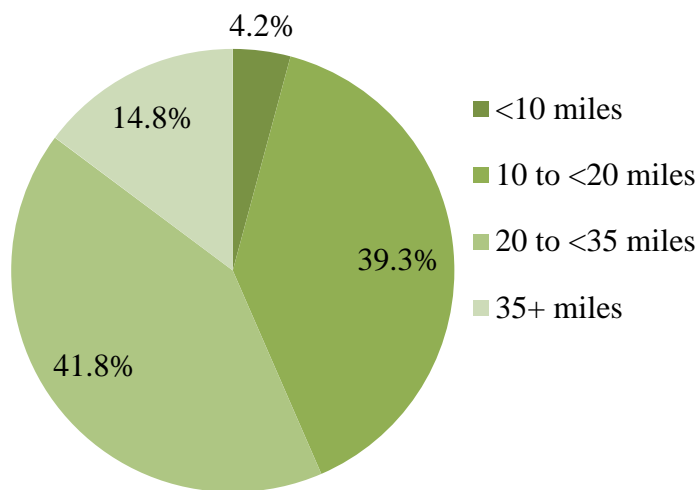
<sup>9</sup> Bennett, K., Olatosi, B. and Probst, J. (June 2008). *Health Disparities: A Rural-Urban Chartbook*. South Carolina Rural Research Center. This research was funded by a grant from the Federal Office of Rural Health Policy, Award No. 6U1CRH03711-04-01. Demographic data also obtained from the presentation to the Committee by the Research Center on June 14, 2012.

<sup>10</sup> iVantage Health Analytics. (June 2012). "Rural Relevance Under Healthcare Reform." *Thought Leadership, White Papers*, p. 6. <http://www.ivantagehealth.com/rural-relevance-under-healthcare-reform>. Accessed June 26, 2012.

increase the difficulties rural communities already face in attracting and maintaining physicians and non-emergency health care services locally and providing timely access to emergency services.<sup>11</sup> CAHs must deliver the same quality care under the same liability burden as urban hospitals, all with less capital and staffing on hand than are usually available among urban care facilities. Some CAHs cross-subsidize long-term care and manage rural health clinics at their own financial risk because there may not be alternatives in the communities they serve. Thus, closure of the local CAH may have a profound effect on the availability of local health care services, both inpatient and outpatient. CAHs in particular are usually located in the least densely populated areas of the country – often among the highest shares of elderly and chronically ill patients – but all types of rural hospitals with special payment designations continue to provide access to health care in medically high-need and underserved areas. Many of the benefits provided by these hospitals fall beyond the scope of traditional inpatient measures.

As of December 31, 2010, there were 1,316 CAHs<sup>12</sup> across the country. Eighty-one percent of CAHs are located between 10 and 35 miles in driving distance from the nearest hospital – with an additional 4.2 percent within 10 miles from the nearest hospital – meaning that nearly all CAHs fall below the general 35-mile classification requirement and received their designation either through the 15-mile “secondary road/mountainous terrain” or state-designated “necessary provider” provisions. Figure 1 shows the distribution of CAHs in terms of driving distance from the nearest hospital. While CAHs constitute 52 percent of rural hospitals, a combination of SCHs (17 percent), MDHs (8 percent), rural referral centers (7 percent), and standard PPS hospitals (16 percent) make up the remaining 48 percent of rural hospitals.

**FIGURE 1: DRIVING DISTANCE FROM CAHs TO NEAREST HOSPITAL**



Source: The Research Center’s analysis of hospital data as of December 31, 2010, presented to the Committee on June 18, 2012.

<sup>11</sup> CAH/FLEX National Tracking Project. (September 2003). “A Case Study of Six Critical Access Hospitals.” *Findings from the Field*, Vol. 3, No. 2.

<sup>12</sup> Data on hospital status and distribution are current as of December 31, 2010 and include all rural referral centers and acute, short-term hospitals, SCH, MDH or CAH designation, as well as PPS hospitals in RUCA-defined rural areas. This information was obtained from the OSCAR Provider of Service File, Medicare Hospital Cost Reports, and the Area Resource File and was compiled by the Research Center and presented to the Committee on June 14 and June 18, 2012. The Flex Monitoring Team reports that as of September 30, 2012, there were 1,330 CAHs in the U.S. <http://www.flexmonitoring.org/cahlistRA.cgi>. Accessed December 19, 2012.

Although operating margins<sup>13</sup> for rural hospitals have substantially improved since the 1980s, the financial health of these hospitals remains mixed. While more than three quarters of SCHs and rural referral centers operate profitably, only about half of MDHs, CAHs, and rural PPS hospitals have positive operating margins. These three types of hospitals also have narrower total margins<sup>14</sup> on average than other rural hospitals. As hospitals that generally serve a larger proportion of elderly patients, MDHs and CAHs respectively charge 10 and 20 percent more inpatient days to Medicare than all other rural hospitals. CAHs also charge a far greater proportion of outpatient services to Medicare. These numbers reflect the greater dependency of CAHs and MDHs on special federal payment structures, as well as the still fragile financial situations of CAHs, MDHs, and rural PPS hospitals. While some of these organizations are doing well enough to bring up the averages, many of them are losing money or managing to survive with thin margins. This is an instance where using averages to justify reductions could cause widespread damage to these hospitals.

#### **ALTERNATIVE DESIGNATION CRITERIA**

The deficiencies found in the cost-saving measures proposed by the CBO, Administration, and MedPAC have led the Committee to explore solutions beyond tweaking or eliminating rural hospital payment designations. This section therefore attempts to broaden the discussion by exploring other factors policy makers could consider and moving the debate beyond arbitrary, solely budget-driven concerns to examine the realities of rural health care. Without systematic, empirical analysis and careful deliberation, the fiscal debate over rural payment designations could continue year after year with issues of beneficiary access and quality of care consistently subordinated to simple cost-cutting proposals.

While the Research Center showed that the average CAH has lower margins, ADC, and debt service coverage than other rural hospitals, considerable variation across these indicators exists between CAHs remote from and CAHs closer to other hospitals. Data presented by the Research Center characterized CAHs various distances from nearby hospitals and surveyed criteria potentially more representative of the condition of rural hospitals than mileage. A higher percentage of CAHs within 10 miles of the closest hospital maintain an ADC greater than 10 when compared to CAHs 35 miles or more from the closest hospital (Table 2). These data contradict the assumption behind some cost-saving proposals that nearby hospitals are inefficiently competing for patients. Overall, CAHs nearer to other hospitals attract more acute and swing-bed patients than the average CAH, and CAHs farther from other hospitals attract fewer such patients than the average CAH. Allocation of enhanced Medicare payments to more remote CAHs underpins the importance of providing equitable access and equitable patient care despite lower patient volumes and lower profit revenues. At the same time, payments to more proximate CAHs help those facilities meet the demands associated with increased utilization.

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<sup>13</sup> Calculated by dividing operating income by operating revenue; measures control of operating expenses relative to operating revenues. Data presented by the Research Center to the Committee on June 14, 2012 from nine years of collection by the Flex Monitoring Team.

<sup>14</sup> Calculated by dividing the net income over net revenue; measures control of total expenses relative to total revenues. Data presented by the Research Center from nine years of collection by the Flex Monitoring Team.

Proportions of the county population above age 65 and of inpatient and outpatient care provided to Medicare beneficiaries are somewhat higher for more isolated CAHs, while operating margins, net patient revenue, and debt service coverage are usually lower in more isolated CAHs. CAHs farther from other hospitals must rely on supplemental sources of income in order to remain financially solvent. Yet, while CAHs within 10 miles of other hospitals on average have somewhat higher operating margins than more remote CAHs, their total margins average only plus-one percent, meaning that these currently viable CAHs depend greatly on special payment structures to maintain positive margins overall. According to a recent evaluation by the Flex Monitoring Team<sup>15</sup> of the financial health of CAHs nationwide, 19 percent of CAHs were rated at a mid-high to high risk of experiencing financial distress within the next two years. CAHs in sparsely populated frontier regions were found to be most at risk, but facilities that provide cost-intensive, essential care in every geographic area face significant financial challenges.

The Committee recognizes that the role of Medicare is not to make rural hospitals financially whole, but to ensure access for all beneficiaries to a basic level of inpatient, outpatient, and emergency care. However, the high Medicare utilization share in rural hospitals makes their economic survival dependent on Medicare policy. A major challenge in modifying rural hospital designations is to avoid policies that could impede access to care. More research is needed on the effects of merging two nearby CAHs with higher patient volumes and of sending more patients to urban PPS hospitals to properly evaluate proposed changes to designation criteria in a system already under considerable stress. Together with these data must be a comprehensive understanding of which levels of service and access are considered “critical” and deserving of special consideration.

## **BEYOND MILEAGE**

Including additional criteria beyond mileage could make it possible to target reductions more precisely. One option could be to include an exceptions process for hospitals that fall within a certain distance, allowing facilities which play a key access role in their communities to maintain either their CAH or SCH designation. For example, hospitals that provide obstetrics, rehabilitation, or mental health services,<sup>16</sup> have a large proportion of patients that qualify for Medicaid or supplemental security income, or experience exceptionally low bypass rates for their service area could be considered critical safety nets for rural populations, despite the physical proximity of these providers to nearby hospitals. Because the MDH designation was allowed to expire at the end of September 2012, the proportion of Medicare patients served could also factor into a possible exceptions process for rural hospitals. Precisely targeting health care spending in rural areas is fully consistent with the current patchwork system that provides crucial support to rural hospitals throughout the country.

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<sup>15</sup> Holmes, M. and Pink, G. (April 2011). “Risk of Financial Distress among Critical Access Hospitals: A Proposed Model.” *Flex Monitoring Team Policy Brief*, No. 20. The risk of experiencing financial distress was calculated using current financial performance and market characteristics.

<sup>16</sup> 39.6 percent of CAHs had at least one nursery day in the 2009 calendar year. One percent of CAHs had a rehabilitation unit and five percent of CAHs had a psychiatric unit as of December 31, 2010. Obstetrics data from Holmes, M., Karim, S. and Pink, G. (March 2011). “Changes in Obstetrical Services Among Critical Access Hospitals.” *Flex Monitoring Team Policy Brief*, No. 18. Rehabilitation and psychiatric unit data from the Research Center’s presentation to the Committee on June 14, 2012.



This paper has shown the considerable difficulty in developing a cost-effective, patient-centered plan for cutting rural Medicare and Medicaid expenditures that avoids significant damage and treats uniquely situated rural areas fairly. One way to accommodate the needs of each rural region could be to allow states to apply for a federal waiver that would allow them to set payment rates for rural hospitals under their jurisdiction. This is similar to the system currently employed in Maryland under its longstanding Medicare hospital payment waiver and consistent with the Administration's emphasis on place-based and locally targeted initiatives. The Committee recognizes, however, that states may not work consistently to achieve the potential benefits of this plan without federal supervision.

The Committee also fears that focusing analyses solely on inpatient measures such as ADC might overlook more important services provided by CAHs. The Research Center pointed out to the Committee that over 70 percent of CAHs' revenue comes from outpatient care, consistent with the emphasis on emergency services in the legislation authorizing CAHs. The Committee, however, knows of little data that describe the roles of CAHs in addressing emergency and outpatient needs, areas in which distance and transportation issues are perhaps more important than for inpatient services. There is no reason to assume that the distribution of inpatient indicators by distance directly corresponds to the need for geographically distributed outpatient services or emergency care. The various classes of rural hospitals have distinctive roles and missions for meeting local health care need. Analysis of their effectiveness requires distinctive data, another area for further research.

In those cases where the loss of a designation puts patient access to care at risk, the Secretary and other policy makers may want to examine whether some of the lessons learned in two current demonstrations jointly administered by Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration might reveal alternative ways to protect access to basic services. The Frontier Extended Stay Clinic demonstration, currently underway in Alaska, and the Frontier Community Health Integration Project demonstration, awaiting announcement by CMS, may offer important lessons in expanding and integrating rural health care. The Committee will look more intensively at these demonstrations and other new and emerging models for rural health care delivery at its September meeting and discuss them in the companion policy brief.

## **CONCLUSION**

The Committee recognizes that potential exists to improve current rural health care infrastructure. The concern is, however, that the system as a whole is too fragile to sustain the type of sweeping cuts presently under discussion. Revisions to payment designations must reflect a comprehensive and well-informed vision of the existing and desired health care systems in order to avoid a future rural economic and health care crisis. Although it shares the desire for a more efficient rural health care system, the Committee finds that the outlined cost-saving measures have not sufficiently considered the data and implications behind the proposals, nor articulated how the revisions will affect access to and delivery of rural health care.

At its September meeting, the Committee will continue its evidence-based approach to develop a framework to envision the future rural health care infrastructure and recommendations to confront the ongoing challenges of access, quality, affordability, and sustainability of health care in rural America in new and innovative ways. The Committee views this increased focus on costs in rural health care as an opportunity “not to choose between” but to improve both the efficiency and the effectiveness of our health care system for rural citizens.