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Matthew Eyles
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The Honorable Richard Neal
2309 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
1011 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

America's Health Insurance Plans (AHIP[1]) thanks the Ways and Means Committee and the Rural and Underserved Communities Health Task Force for the opportunity to provide feedback on the health of rural and underserved communities. With approximately 20 percent of the total U.S. population, or 60 million people, living in rural areas, it is crucial that we find ways to appropriately care for this population.

AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Visit www.ahip.org for more information. It is from this vantage point that we offer our insights and suggestions.

Americans in rural areas face greater health challenges than their contemporaries living in urban and suburban areas, including higher incidents of death from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke[2]. Children living in rural areas who have mental, behavioral, and developmental disorders face more community and family-related challenges than children with the same disorders living in urban areas.

Rural residents also face greater challenges accessing care because doctors and other health care providers are often burnt-out or in short supply, and rural hospitals are facing unprecedented rates of closure[3]. Health insurance providers employ multiple strategies to help people access quality health care in rural areas and to improve the health and well-being of their consumers, families, and communities.

Health insurance providers stand ready to work with policymakers at the state and federal levels to implement solutions that build on current efforts to increase the availability of rural providers,

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[2] https://www.cdc.gov/ruralhealth/about.html
[3] https://www.gao.gov/assets/700/694125.pdf; and https://www. shepscenter.unc.edu/programs-projects/rural-health/rural-hospitalclosures/

allow clinicians in rural areas to practice at the top of their licenses, and create environments where virtual care can flourish.

To better understand how to affect greater change and advancements in care, we must understand the problems contributing to disparities in rural health care. Our research, member examples, and recommendations below address key steps to improve health care in rural and underserved communities including:

- Identification of factors that influence patient outcomes;
- Examples of health insurer-supported models for extending care to rural communities;
- Incentives to address workforce shortages;
- Approaches to address critical access challenges for patients with behavioral and substance use needs and those in need of long-term services and supports; and
- Challenges that continue to plague rural communities.

Thank you again for your leadership on this important issue. AHIP and our member health insurance providers look forward to working with the Committee on addressing these unique challenges experienced by rural and underserved communities.

Sincerely,

Matthew Eyles
President & Chief Executive Officer

Request for Information Responses

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?
Health-Related Factors

Serving remote regions with small and geographically dispersed populations creates a unique array of challenges in delivering care to rural residents. These geographic challenges are exacerbated by shortages of providers which limit patients' access to preventive services resulting in lower rates of cancer screening, immunizations, blood pressure checks, diabetes screenings and higher rates of chronic conditions, including diabetes, obesity, and mental and behavioral health disorders, and higher risk of injury and complications from substance use disorder (SUD)[4]. This combination of challenges leaves people residing in rural areas not only sicker and but with far more limited access to care than people residing in more populous areas. One-quarter of all adults 65 and older live in rural areas[5]. With increased age often comes a variety of health care challenges including increased prevalence of chronic conditions requiring access to coordinated teams of physicians, nurses, social workers, family caregivers, and long-term care providers[6]. Additionally, like hospitals, nursing homes in rural areas are increasingly shutting their doors or merging, often leaving seniors without access to long-term care[7]. Finally, the demographic challenges of rural areas (small numbers and large distances) make the delivery of home based, long term services and supports for seniors and people with disabilities residing in rural areas significantly more challenging to deliver.

Non-Health-Related Factors

Other factors contributing to patient outcomes in rural and underserved communities include:

- Social barriers. Social Barriers, such as a lack of access to healthy foods, housing insecurity, limited access to transportation, poverty, and a lack of access to education or employment, are particularly acute in rural areas.
- Structural barriers. Insufficient public transportation[8], poor availability of broadband internet services[9], and lack of available childcare also make it difficult for people to seek the care they need.

[4] https://www.cdc.gov/ruralhealth/about.html
[5] https://www.census.gov/newsroom/blogs/randomsamplings/2016/12/a_glance_at_the_age.html
[6] https://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf
[7] https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html
[8] https://www.ncbi.nlm.nih.gov/pubmed/26025176
[9] https://annals.org/aim/article-abstract/2734029/limitations-poorbroadband-internet-access-telemedicine-use-rural-americaobservational

- Demanding and dangerous jobs. Rural residents are both more likely to be employed in physically demanding and dangerous jobs in the agricultural sector and more likely to be uninsured[10]
- Preventable injuries. High speed limits and poor-quality roads contribute to high rates of automobile accidents, the largest cause of unintentional injuries.

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?

To expand access to care and improve patient outcomes, health insurance providers have seen great benefits as a result of offering transportation services, housing support, food services, and telehealth and remote monitoring services[11]. These services allow Americans in rural and underserved areas to quickly and effectively access the care they need in their own communities. Health insurance providers are finding new ways to help people access healthy food, whether by engaging grocery delivery services or providing rides to grocery stores. Closing the transportation gap can also reduce the number of missed appointments and help make sure that patients are able to take their medication as directed.

- Plans and service providers are trying out services like Lyft and Uber to help patients get to their doctor or pharmacy[12].
- BCBS of Michigan created initiatives to provide vouchers or coupons to local farmers markets so that patients who may not otherwise be able to afford it can access fresh fruits and vegetables[13].

Approximately one-quarter of rural adults say they have used telehealth for health care within the last few years[14]. Many insurance providers contract with telehealth companies to connect patients with clinicians licensed in their states reducing the need to travel from their home or work[15] to access in-person care. These companies offer an existing telehealth infrastructure and an established network of doctors.

[10] https://www.census.gov/library/video/2019/rural-urban-uninsured.html
[11] https://www.ahip.org/healthy-food-transportation-to-the-doctor-are-new-frontiers-for-health-insurance-providers/ and https://www.ahip.org/new-programs-seek-to-address-social-barriers-to-care/
[12] https://blog.lyft.com/posts/2018/3/2/revolutionizing-patient-transportation-with-lyft-concierge-api and https://blog.lyft.com/posts/2018/3/2/revolutionizing-patient-transportation-with-lyft-concierge-api
[13] https://www.mibluesperspectives.com/2018/05/23/food-as-medicine-statewide-efforts-expanding-access-to-farmers-markets/
[14] https://media.npr.org/documents/2019/may/NPR-RWJF-HARVARD_ Rural_Poll_Part_2.pdf
[15] https://www.ahip.org/telehealth-connecting-consumers-to-careeverywhere/

The following examples show how health insurance providers offer telehealth to improve convenient access to quality care:

- Anthem awarded a $250,000 grant to the University of Virginia to expand specialty care via telehealth for people in rural, underserved areas of Virginia[16].
- Capital District Physician's Health Plan (CDPHP) recently announced plans to expand its telehealth offerings to the underserved North Country of New York[17].
- CareFirst was among the first plans to support reimbursement for services delivered via telehealth, connecting rural hospitals with Johns Hopkins Health System and other academic medical centers to ensure that patients have access to the best practitioners across the state, regardless of geography.
- Blue Shield of California has partnered with both telehealth companies (Teladoc) and providers (Adventist Health) to increase access to specialty care in rural areas[18].
- The Global Partnership for Telehealth (formerly the Georgia Partnership for Telehealth) links all 159 counties in Georgia via a telehealth network, providing connectivity for rural patients and providers throughout the state. Peach State Health Plan (Centene)[19] and WellCare[20] participate in the network.

Health insurance providers are also using remote patient monitoring to monitor patients who are managing chronic conditions like diabetes, high blood pressure, and cardiovascular disease from a distant location, directing the patient to in-person care when needed[21].

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

The Committee should consider ways to encourage providers to practice in rural areas. This may include financial incentives as well as the opportunity to care for people with a wide variety of health care needs.

Examples of some financial incentives health insurance providers are utilizing to encourage providers to practice in these communities, include:

- Geisinger in Pennsylvania offers free medical school for doctors who choose to practice primary care at Geisinger's rural hospitals.
- UMMC/Magnolia Regional Health Center in Mississippi is offering residency funding if the physician works at a rural hospital in the state after residency.

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[16] https://ir.antheminc.com/news-releases/news-release-details/anthemuva-partner-bring-cutting-edge-medical-technology-rural?field_nir_ news_date_value[min]=2018
[17] https://www.cdphp.com/newsroom/2018/06/18-cdphp-expands-toexpands-to-north-country
[18] https://news.blueshieldca.com/2016/07/13/investing-in-technology-toimprove-access
[19] https://www.pshpgeorgia.com/providers/resources/telemedicine.html
[20] https://www.wellcare.com/Georgia/Members/Medicaid-Plans/ Georgia-Families/Benefits/Georgia-Partnership-for-TeleHealth
[21] https://docs.fcc.gov/public/attachments/DOC-352472A1.pdf

- WellCare[22], Blue Cross Blue Shield of North Carolina[23], and Blue Cross Blue Shield of Oklahoma[24] are offering medical school scholarships to encourage clinicians to practice in rural areas.

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
b. health centers and federally qualified health centers?
c. there is broader investment in primary care or public health?
d. the cause is related to a lack of flexibility in health care delivery or payment?

It is critical to address the factors that limit access to care for Americans residing in rural communities. Please see our "policy recommendations" section under question 10 for some issues that we believe need to be addressed in order to ensure this access to care.

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?

Health insurance providers have worked to form regional provider networks to care for patients in geographically remote areas. California Health & Wellness, for example, created a comprehensive rural health program using local community health workers across 19 rural counties. The California MemberConnections provides local MemberConnections Representatives, or health plan navigators, to serve as liaisons between the insurance provider and its members, helping people navigate the health care system more easily and encouraging increased use of primary care.

Additionally, Moda Health, in partnership with Greater Oregon Behavioral Health, Inc. (GOBHI), created the Eastern Oregon Coordinated Care Organization (EOCCO). The CCO provides coordinated, integrated medical, behavioral health, and dental services. To engage providers, the CCO offered shared ownership with 4 large hospital systems in Eastern Oregon to participate. Moda, GOBHI, an independent physician association, and a Federally-Qualified Health Center each own a portion of the EOCCO along with the insurer partners. Each entity shares in the responsibility and risk for improving individual and population health, proportional to their ownership.

[22] https://www.prnewswire.com/news-releases/wellcare-announces180000-in-scholarships-aimed-at-improving-rural-health-300461266. html
[23] http://mediacenter.bcbsnc.com/news/blue-cross-nc-unc-chapel-hillcollaborate-to-expand-rural-primary-care
[24] https://www.bcbsok.com/company-info/news/news?lid=jpqulx73

Project ECHO (Extension for Community Healthcare Outcomes) is a guided practice telehealth model designed to enhance the health care workforce in underserved areas by providing community-based primary care providers with knowledge and support to manage patients with complex conditions[25]. It engages providers via weekly videoconferences and connects them with specialist mentors at academic medical centers, known as hubs. With the majority of ECHO-participating primary care providers representing federally qualified and other community health centers, patients with Medicaid coverage comprise the largest group that stand to benefit from improved quality and breadth of care provided in these safety net settings[26]. To date, four states have used Medicaid funds to finance Project ECHO activities: New Mexico, Oregon, California, and Colorado[27].

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

Health insurance providers have redesigned payment models with rural health care providers to focus on quality while minimizing the financial burden on patients. Examples include:

- Highmark, Gateway Health, Geisinger Health Plan, Medicare, and UPMC Health Plan participate in the Pennsylvania Rural Health Model, an innovative project launched in January 2019 designed to buoy the finances of rural hospitals. In this project, spearheaded by the Pennsylvania Department of Health, five insurance providers collaborate to provide global payments as a more consistent funding stream for rural hospitals[28].
- Blue Cross Blue Shield of Michigan designates small, rural acute care facilities eligible for Hospital Pay-for Performance incentives to give these hospitals the ability to demonstrate value to their communities and customers by meeting expectations for access, effectiveness, and quality of care. For the 2019-2020 program year, incentives can comprise up to 6% of a hospital's payment[29].

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?

Reasons for oral health disparities in rural areas parallel those seen from disparities in primary and specialist care, however they also derive from factors such as lower oral health literacy, prevalence of tobacco use, and lack of fluoridated water supply[30]. To address the lack of adequate oral healthcare in these underserved areas, models of oral health integration into

[25] https://www.sunflowerhealthplan.com/providers/project-echo.html
[26] https://www.chcs.org/media/ECHO-Medicaid-Financing-Brief_091217-2.pdf
[27] https://www.chcs.org/media/ECHO-Medicaid-Financing-Brief_091217-2.pdf
[28] https://www.health.pa.gov/topics/Health-Innovation/Pages/Rural-Health.aspx
[29] https://www.bcbsm.com/content/dam/public/Providers/Documents/ value/2019-2020-peer-group-5-hospital-pay-for-performance.pdf
[30] https://www.ruralhealthinfo.org/topics/oral-health

primary care and mobile oral healthcare delivery are being effectively deployed. For example, Delta Dental Mobile Program[31] provides oral health services to underserved children, utilizing mobile clinics (trucks) to provide preventive, diagnostic, and restorative care as well as dental hygienists and community health workers (CHWs) who are based in the state's American Indian reservations.

The opioid epidemic continues to hit rural America especially hard. According to the Centers for Disease Control and Prevention (CDC), opioid prescribing rates are significantly higher in rural areas compared to large metro counties, putting rural residents at greater risk of addiction and overdose[32]. The rates of drug overdose deaths are higher in rural areas than urban; over 7,300 drug overdose deaths occurred in rural areas in 2015, a 325% increase since 1999[33]. Community programs in rural areas are underfunded and understaffed. To address these unique issues, health insurance providers are using comprehensive approaches to ensure early interventions, and effective treatments and recovery plans.

In 2017, AHIP launched our Safe, Transparent Opioid Prescribing (STOP) Initiative© to support widespread adoption of evidence-based clinical recommendations developed by the CDC for pain care and opioid prescribing, and to capture and disseminate best practices. Other efforts by health insurance providers to address the opioid epidemic in rural areas include:

- Magellan Health deployed its digital cognitive behavioral therapy programs to support the delivery of services in rural and underserved areas, including the SHADE program, which is a 10-session exercise designed to help change behavior and thinking around substance use that is delivered via mobile and web-based technology[34].
- Cigna provided the St. Vincent Healthcare Foundation in Montana a $100,000 grant to help improve outcomes of Native American women and babies through increased access to prenatal care, drug education, and healthy lifestyle information[35].
- UPMC is administering a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to expand access to MAT by recruiting clinicians and hosting training for those interested in receiving a Drug Enforcement Administration (DEA) waiver to prescribe MAT, targeted to rural counties in Pennsylvania[36].

[31] https://www.ruralhealthinfo.org/project-examples/626
[32] https://www.cdc.gov/mmwr/volumes/68/wr/mm6802a1.htm
[33] https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm
[34] https://www.magellanhealthcare.com/employer/behavioral-healthsolutions/computerized-cognitive-behavioral-therapy-ccbt.aspx
[35] https://www.cigna.com/newsroom/news-releases/2018/cignafoundation-grant-to-help-improve-health-of-native-american-momsand-babies-through-prenatal-care-drug-and-addiction-education-andrecovery
[36] https://www.upmchealthplan.com/pdf/ReleasePdf/2018_12_10.html

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?

Numerous states and federal agencies have created specialized committees and task forces to define and address the challenges faced by rural seniors. In their work, these stakeholders have identified areas for action to address depression and loneliness[37], physical inactivity[38], medication management[39], and dental health[40]. The Agency for Healthcare Research and Quality (AHRQ) has issued grants to pilot programs designed to solve these unique issues[41]. With over half of all rural veterans aged over 65, the Veterans Administration has also issued recommendations to address some of the challenges faced by rural veterans[42].

In addition to these public efforts, private stakeholders—including health insurance providers—are working to develop and implement programs to assist rural residents to live healthier lives and to sustain the health of rural communities.

- Aetna's Resources for Living Program aims to fill the gaps in caring by providing access to at-home services such as cleaning and cooking, caregiver support services such as help with childcare and respite care, and social activities such as transportation and classes for skills and interests[43].
- Tufts Health Plan in Massachusetts works with local chapters of age-related disease associations, like the Alzheimer's Association, to help patients directly connect to resources such as referrals to community resources, care planning, educational materials, answers to disease-related questions, information on support groups, and more[44].

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?

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[37] https://www.ohsu.edu/xd/outreach/oregon-rural-health/about/events/ aging-forum/upload/Depression-Suicide-Aging-in-Rural-CommunitiesARBORE.pdf
[38] https://www.health.state.mn.us/facilities/ruralhealth/pubs/ spotlight/2019/aging.html
[39] https://www.ohsu.edu/xd/outreach/oregon-rural-health/about/events/ aging-forum/upload/Pruning-the-Pills-A-Deprescribing-Strategy-forAddressing-Polypharmacy-KNOWER-HONSVICK.pdf
[40] https://ruralhealth.und.edu/assets/1123-4538/standardized-dentalscreening-for-new-nursing-home-residents.pdf
[41] https://healthit.ahrq.gov/ahrq-funded-projects/telemonitoring-ruralelder-nutrition-centers-demonstration-project-hypertension
[42] https://www.ruralhealth.va.gov/aboutus/ruralvets.asp
[43] https://www.aetnamedicare.com/en/live-well/resources-for-living.html
[44] https://www.tuftsmedicarepreferred.org/members/caring-loved-one/alzheimer%E2%80%99s-association-partnership-tufts-health-plan-members

Reliable data is essential to public health research and understanding persistent disparities in disease rates and health outcomes between people of differing race, ethnicity, socioeconomic status, and area of residence. These types of data are not consistently collected and reported. Certain racial and ethnic minority groups have a lower life expectancy, but these groups also bear a disproportionate disease burden from diabetes, hypertension, AIDS, low birth weight, and very low birth weight, when compared to the white majority population. Data challenges include variation of age distribution within different racial/ethnic groups, differences in cause-specific death rates for different racial/ethnic groups, racial/ethnic misclassification, and intra-ethnic variation among subgroups.

The pending report on Social Risk Factors and Performance from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) can help to potentially identify more data issues that need to be resolved, similar to their previous 2016 report[45]; however, in addressing the issue of disparities in rural health and data integration, we believe it is essential for key stakeholders to convene a conference to further determine the data issues in rural health and what can be done about them.

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?

Policy Recommendations

While innovative approaches are helping to address the unmet needs of rural communities, AHIP supports comprehensive legislation to drive more systemic improvements. Together we can improve access to care and health outcomes for residents in rural communities that need it most. We recommend the following to improve the health care in rural and underserved communities:

1) Offer programs and incentives to encourage clinicians to practice in rural and underserved communities.

- The federal government should authorize loan repayment and other incentive programs, already used to recruit clinicians, for physician assistants and nurse practitioners to further expand the capacity to deliver care to rural communities.
- To address provider shortages in rural areas, the federal government can create grants for clinicians to practice in rural areas on a volunteer basis, either through the expansion of the National Health Service Corps or through the creation of new programs.
- Remove the caps on the number of residents funded by Medicare and increase Medicare-funded residency positions. By removing this cap, rural hospitals could use Medicare payments to offset costs associated with training physicians during residency[46].

[45] https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf
[46] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html

2) Expand access to care through telehealth.

- Establish multi-state licensure compacts. Allowing multi-state licensure compacts can expedite licensure for physicians and/or reciprocity for certain providers across multiple states, increase the types of specialists offering services, and expand provider networks available to consumers.
- Enhance innovation and flexibility by avoiding state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use. Inconsistent state laws and mandates can make providing access to telehealth services difficult for health insurance providers, hindering flexibility to design benefits that meet the needs of consumers.
- Designate telehealth as a means of satisfying health insurance network adequacy requirements. Under 45 CFR 156.230, the Department of Health and Human Services (HHS) should establish telemedicine as an option to meet federal requirements for network adequacy standards. In a 2016 revised model law, the National Association of Insurance Commissioners included the use of telemedicine as an option to meet network adequacy standards.
- Federal legislation should permit first-dollar coverage of telehealth services in HSA-eligible health insurance providers. Permitting health insurance providers to cover telehealth services with first-dollar coverage reduces overall costs to the system and allows greater flexibility and affordability for consumers.

3) Make insurance more affordable in rural areas.

For the millions of people living in rural areas who don't have access to employer coverage, Medicaid or Medicare, the individual insurance market is their only option for coverage that will protect them financially if they experience a serious illness. Nearly one-in-five HealthCare.gov consumers lived in a rural area in 2019[47]. Unfortunately, for Americans who don't qualify for help with individual market premiums, individual market coverage may be unaffordable.

- States can implement reinsurance programs for the individual market for expensive premiums. A permanent federal reinsurance program would provide the benefits of reinsurance nationwide without each state being required to seek a federal 1332 waiver.

4) Promote heath for individuals and communities.

Federal and state policymakers should engage with appropriate stakeholders to promote community-based efforts to address underlying issues that contribute to health, education, and income disparities in rural areas.

- Virtual prevention and public health initiatives have been proven effective in addressing issues faced by underserved rural communities, including American Indian and Alaska

[47] https://www.cms.gov/newsroom/fact-sheets/health-insuranceexchanges-2019-open-enrollment-report

Native populations[48]. Existing virtual prevention and public health programs that demonstrate effectiveness should be expanded to other high-risk rural populations and to other rural regions to further promote healthy living.

- Telehealth and virtual technologies should be used to deliver SUD treatment and increase remote access to specialists through Project ECHO and other programs. In addition, public education programs should be provided for patients, families, communities, and clinicians to better understand pain management options, the benefits and potential risks of prescription opioids, and potential risk factors for addiction.

Solutions to improve access to care require collaboration among a variety of stakeholders including health care associations, community-based organizations, state and local officials, the federal government, physicians and other clinicians, hospitals, academic centers, funders, and foundations. By working together, we can ensure that everyone in our communities can get the care they need at a cost they can afford – for improved health, well-being, and financial security.

[48] https://www.ihs.gov/hpdp/