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Corporation

November 29, 2019

The Honorable Danny Davis
The Honorable Terri Sewell
The Honorable Brad Wenstrup
The Honorable Jodey Arrington
Co-Chairs, Rural and Underserved Communities Health Task Force
U.S. House of Representatives
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

**RE: RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE
REQUEST FOR INFORMATION**

Submitted electronically at Rural_Urban@mail.house.gov

Dear Co-Chairs Davis, Sewell, Wenstrup, and Arrington,

Thank you for the opportunity to respond to the Rural and Underserved Communities Health Task Force Request for Information. Centene Corporation supports efforts to ensure better health outcomes for our members, including those in rural areas.

Founded in 1984, Centene Corporation (hereinafter "Centene") has established itself as a national leader in the health care services field with over 15 million members across the country, including about 1.4 million in rural areas. Centene provides health plans through Medicaid, Medicare, Health Insurance Exchanges, TRICARE and other health solutions through our specialty services companies. For over 30 years, Centene has been committed to transforming the health of the community, one person at a time. We offer a comprehensive portfolio of innovative, flexible solutions that demonstrate our commitment to delivering results for our stakeholders: the federal government, state governments, beneficiaries and their families, providers, and other health care and commercial organizations.

Thank you for the opportunity to comment. Centene broadly supports efforts to improve access to health care in rural areas and to improve disparities in outcomes. We would be happy to serve as a resource and partner to the Task Force on any of the issues we outline in this letter. If you have questions or need more information, please contact me at jdinesman@centene.com or 314. 505.6739 or Patti Barnett at patti.barnett@centene.com or 314.349.3086.

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Sincerely,

Jonathan Dinesman
Senior Vice President, Government Relations
Centene Corporation

COMMENTS

Centene supports the efforts of the Rural and Underserved Communities Health Task Force to improve access and health outcomes for our members in rural areas. We offer our feedback below in the order in which they appear in the Request for Information.

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?

Major health care factors include:

- Access to essential services, especially primary care, mental health care, and substance abuse programs
- Difficulty recruiting and retaining physicians, nurse practitioners, nurses and other clinical staff
- Geographic isolation and spread (lack of transportation, less broadband access for virtual care, limited access to community and social supports)
- Limited economies of scale and low patient volumes
- Significant regulatory and administrative burden
    - A lack of flexibility in health care delivery or payment, such as with virtual care or value-based arrangements
- Decreased access to affordable coverage
- Decreased access to community resources for health and wellness activities

It is important to keep in mind that many of these factors are inter-related and may even have a causal impact on each other.

Non-health care factors include the social determinants of health, such as employment and economic security, economic mobility, housing, and education.

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?

Telehealth/Telemonitoring: Virtual care has multiple use cases and can reach rural patients in different settings, including increasing access to specialists and improving behavioral health. For example, virtual visits funded by Centene were used to assess rural crisis situations in minutes versus hours, benefitting not only people in crisis, but also first responders. Experience with telehealth elsewhere can also help to inform rural initiatives; Centene uses telehealth technology in various areas, with approximately 3,000 avoided ER visits for individual market members as of November 2019. Elsewhere, the Telepsychology-Service Delivery for Depressed Elderly Veterans program found a 50% in reduction in symptom severity for most participants and the Bridges to Care Transitions program found remote patient monitoring (RPM) correlated with decreased admissions.

Partnerships addressing health and housing: In a medically- underserved rural county with triple the state incarceration average, Centene funded an advocate to help individuals with mental illness exiting incarceration secure transitional housing and community supports, resulting in a recidivism rate around half the state average.

Health disparity models identifying social and cultural barriers to health: Centene helped to successfully address postpartum care disparities at a rural clinic serving primarily Hispanic members, using formative research, barrier analysis, member focus groups and intervention development, provider interviews and engagement, and community partnerships.

Agricultural and nutrition education for youth and families: Centene supported a garden lab/greenhouse for students to learn food-growing skills and nutritional education. Combined with a weekly farmers market and healthy food vouchers, this resulted in increased fruit/vegetable intake for students and their families.

Produce Plus/Veggie Rx: A Centene partnership brings fresh fruits/vegetables to low-income members in rural medical clinics, community centers, schools and other public sites, resulting in improved weight for members at risk of developing diabetes.

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

Lack of patient volume is a significant issue for many rural facilities. It can make it difficult to gain the economies of scale needed to offer certain services, such as obstetrics or physical therapy, and puts financial pressures on many rural hospitals given that many costs are fixed even if beds are empty. It can also affect the amount of practice clinicians engage in for certain services, potentially impacting the quality of care for rural Americans. Lower amounts of patients also mean fewer providers are attracted to locate in rural areas. Greater flexibility on network adequacy, particularly with the use of virtual care, may help to mitigate this concern and may attract more health plans to provide coverage in rural areas. The resulting competition could also help to improve affordability of coverage.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

   a. Patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?
   b. There is broader investment in primary care or public health?

c. The cause is related to a lack of flexibility in health care delivery or payment?

There is increasing recognition that care could be delivered in alternative locations. For hospitals in rural areas, it is critical to have the operational excellence and flexibility in place to adapt to changing circumstances, such as the decline in demand for in-patient services. Hospitals that have adapted have targeted the right mix of services appropriate for the particular community and have sought out external partnerships to bolster scale.

Increased access to primary care may lead to decreased ED visits at hospitals, often due to decreases in preventable visits. However, many hospitals have recognized that they can play a role in preventative care along with outpatient clinics. It is critical for hospitals to adapt their operations and expertise, potentially in partnership with external organizations, to address population health more broadly.

The lack of flexibility in delivery and payment is especially significant for critical access hospitals (CAH), Emergency Medical Services (EMS) and many uses of virtual care. For example, some communities need inpatient beds at the local facility, while others may not. There are restrictions on acute care patients at CAHs staying longer than 96 hours before a transfer. Depending on the specific needs, for some communities a free-standing ED may be appropriate, but there are prohibitions in some states. For hospitals to continue to be successful, they need to be able to tailor services towards the local community and engage in innovative initiatives, including virtual care delivery and participation in value-based arrangements.

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?

To increase access, many states have created extensive national and local telehealth networks, including Arizona, Arkansas, California, Colorado, Delaware, Hawaii, and Illinois. California in particular made headlines back in 2010, launching what would become the nation's largest telehealth network, in partnership with the California Emerging Technology Fund and other private and public entities. Some health systems are also developing networks, to serve those in remote areas, ease the burden on overcrowded emergency rooms and improve mental health treatment.

Amongst many successes, these networks of care also faced a number of challenges that continue to serve as roadblocks. Historically, a lack of substantial capital coupled with limited reimbursement has deterred significant investment in telehealth. Furthermore, the law prevented Medicare payment for certain modalities and geographic areas.

However, there have been shifts in CMS 'approach towards telehealth coverage with its 2019 rule removing Medicare telehealth service restrictions on modality, patient location and care site, and adding new CPT codes for telemedicine. Laws have started to broaden Medicaid and commercial telehealth coverage as well. While policy makers have started to embrace telehealth, further challenges persist, such as the cost of supporting technology, lack of funding, and adequate broadband access.

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

Extending Full Scope of Practice: in areas with inadequate physician coverage, advanced practice providers, such as nurse practitioners, may be able to assist in extending the workforce, in partnership with other efforts to attract and retain physicians.

Community Health Workers ("Promotores"): Volunteers assist members in rural communities in navigating the health system and accessing local resources

Expanding Community-Based Service Options and Enhanced Workforce Capacity: Rural residents with disabilities typically rely more heavily on higher-cost institutional services, such as nursing homes, and enter them with lower levels of disability, than their urban counterparts, in part because many rural areas lack an adequate and sustainable home and community-based service (HCBS) and workforce infrastructure; nursing homes are often the only long-term services and supports (LTSS) option.

   a. Although states have made progress in rebalancing LTSS spending toward HCBS, much of this has been focused on urban areas. Financing incentives could be offered to States toward enhancing rural HCBS.
   b. Competition for health personnel, including Personal Attendants (PA), exists between rural and urban areas. Incentives can be made available to PAs who work in rural areas, including allowing for payment of time required for travel, orientation, training, and job shadowing; and reimbursement of gas, mileage, and auto expenses.
   c. Currently, savings in reductions in hospitalizations and Emergency Department visits typically accrue to Medicare (since most LTSS beneficiaries are dually eligible). CMS could explore demonstrations enabling savings from appropriate use of home care to be shared with States with some of that increasing wages for rural PAs.

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

The CDC has noted a higher opioid prescribing rate in rural areas. Patients at risk for opioid use disorder (OUD) benefit from medication assisted therapy (MAT) to improve health outcomes. MAT takes multiple forms, including utilization of methadone or buprenorphine. While methadone has a documented history of improving complications for OUD and reducing opioid misuse, its administration requires access, often daily, to methadone clinics, which is a major limitation given the lack of locations in rural areas.

Utilization of buprenorphine instead can overcome this because of the increased ease of access to office-based treatment or other modalities that may be more accessible in rural areas. Centene has worked with our health plans and other partners to increase the proportion of buprenorphine-trained providers to broaden exposure of MAT to patients, including in rural areas in collaboration with American Society of Addition Medicine (ASAM)-led training. Our seminars to date have trained 188 providers, excluding two upcoming trainings. Moving forward,

rethinking the regulatory requirements for buprenorphine prescribing could further enhance care in rural areas.

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?

Address Employment and Social Participation/Isolation: A 2019 Research and Training Center on Disability in Rural Communities study found rural people with disabilities experience lower levels of employment and access to transportation, with higher rates of isolation than urban counterparts.

Transportation Partnerships: States should consider partnering with managed care organizations on covering non-emergency transportation in rural areas, such as through including volunteer driver programs.

Rural Hospital Discharge and Transition Support: Most rural residents have to travel to hospitals in distant cities, where discharge planners are often unfamiliar with resources a patient could use to recover closer to home, frequently referring instead to follow-up services far from home. Combined with few transportation options, this results in low levels of follow-up care compliance and poor health outcomes.

From 2013-2017, the Montana ROADMAP project created and tested an enhanced discharge/ transition program facilitating patients' transitions from in-patient hospitalization back home to small towns or rural communities, saving an estimated $2 billion annually.

Flexible Reimbursement Rates: The Association of Programs for Rural Independent Living (APRIL) recommends that reimbursement rates are flexible enough to take into account facilities critical to rural health that have higher costs.

Tele-homecare: States can provide start-up cost assistance for telehealth; vital sign monitoring paired with specially-adapted video/audio technology can deliver basic health monitoring services in remote or rural areas at low costs.

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?

Definitions: even the definition of rural area can vary significantly, leading to confusion or difficulty making direct comparisons (HRSA, proximity to a critical access hospital or CAH, etc.). Having more consistent definitions can allow for better comparisons of data from different sources.

Standard Social Determinants of Health (SDoH) Screening Questions: This could better capture social needs in rural populations, which are often a significant driver of health

disparities. SDoH include social and demographic factors such as poverty, education status, race and ethnicity, gender, insurance status, and other factors that influence (1) development of illness, (2) ability to obtain and utilize healthcare, and (3) health and healthcare outcomes. Multiple socioeconomic factors contribute to health disparities, including income, education, residential segregation, stress, social and physical environment, employment, and others.

- **Data elements to consider:** population-specific differences in the presence of disease, health outcomes and access to healthcare by race, ethnicity and socio-economic groups

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?

To summarize some of the models above, we recommend:

1. Efforts to address provider shortages, including:
    a. Training and allocation of providers to rural communities
    b. Nurse Practitioners have demonstrated high quality for patients in primary care; in conjunction with other efforts, giving states the flexibility to allow full scope of practice in areas where there is an inadequate physician workforce could improve care.
    c. Transportation and virtual care solutions to support rural patients' access to relevant and quality care
2. Food security initiatives that focus not only on making food accessible and affordable, but also ensure good nutritional and quality options
3. Community support specialists/advocates that act as a source of knowledge and information on resources and social supports available, can forge partnerships and foster trust with nearby communities when supports are not available in the immediate vicinity, and can help patients navigate their benefits and the various support systems available