



November 29, 2019

Ways and Means Rural and Underserved Health Task Force
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Via e-mail: Rural_urban@mail.house.gov

RE: Rural and Underserved Communities Health Task Force Request for Information

Dear Rural and Underserved Communities Health Task Force Co-Chairs,

Envision Healthcare is a national physician-led organization of clinical professionals who work alongside hospitals, health systems and insurance companies in our pursuit of creating healthier communities and the delivery of high-quality clinical care. We are a leading provider of physician services, ambulatory surgery center (ASC) management, and post-acute care. Envision's physician services encompass more than 25,000 physicians, CRNAs, and advanced practice professionals (APPs), including nurse practitioners and physician assistants, at over 900 hospitals in 47 states in the specialties of emergency medicine, anesthesiology, radiology, hospitalist medicine, acute general and trauma surgery, and women's and children's services, as well as office-based practices. Our ASC services include over 260 facilities across the country focusing on gastroenterology, ophthalmology, and multispecialty centers. The scope of our services, which includes multiple physician specialties practicing in rural and underserved clinical settings, as well as the depth of experience operating outpatient ambulatory surgery centers brings a unique perspective across a broad continuum of facility-based care provision nationwide.

Specifically, our rural hospital division constitutes more than 100 emergency medicine hospital contracts. The average annual emergency encounters at these hospitals is approximately 10,250 per year per hospital. This equates to approximately 28 patient encounters per day and just over one visit per hour. Our experience in these settings helps frame the responses below.

On behalf of our dedicated clinicians, we appreciate the Rural and Underserved Communities Health Task Force ("Task Force") for the opportunity to comment on this Request for Information ("RFI").

Responses to RFI questions follow:

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?*

Patient outcomes are directly attributable to patient access to care. Access to care must be provided through primary care physicians but also hospitals that are adequately staffed with qualified providers (physicians, nurses, etc.) and have enough resources and equipment to provide care for the common injuries and illnesses requiring hospitalization in the communities they serve. Access, transfer agreements, and sufficient transportation options to the closest larger facilities capable of providing higher levels of care and access to additional specialty physicians and services are necessary. Network adequacy and network transparency becomes critical to improving patient outcomes so that patients understand the services their insurance product provides and so that services do not become cost prohibitive due to steadily increasing patient cost-sharing. Population education about healthy lifestyles, including management of chronic illnesses such as high blood pressure, obesity, and diabetes, as well as increasing resources to provide virtual or in-person follow-up for patients who have recently been discharged from hospitals are all opportunities to improve patient outcomes.

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?*

The key factor that addresses each of the initiatives listed is appropriate access to care whether that is through in person visits with their physicians or through the use of virtual health tools. In order to have appropriate access to care there must be reasonable reimbursement for services provided. For example, utilizing virtual health in rural and underserved settings will be instrumental in addressing many of the health problems that are seen in these communities; however, until reimbursement is established and sufficient to incentivize the development of these networks, growth will remain stagnant. Ensuring this level of reimbursement can be established in multiple ways, particularly in medically underserved and rural communities, either through increased focus on and incentives to improve network adequacy, and/or increasing levels of reimbursement for government-funded insurance such as Medicare and Medicaid. Rural and underserved hospitals generally have a higher percentage of patients who are either uninsured or receive Medicare or Medicaid, and as a result lack the financial resources to develop and deliver education and outreach programs. Additionally, programs that incentivize physicians and APPs to live and serve in underserved areas such as tuition reimbursement or loan forgiveness may prove beneficial in ensuring that there is sufficient primary care, often preventative, which reduces the need for more expensive acute hospital care, and facility-based clinicians in hospitals that provide the care in emergency settings which serve as our nation's safety net.

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

Envision believes that patient volume adequacy has multiple factors. Patient volume is important, as is the acuity of the care being provided as well as the payor mix of the patients that present to

receive care. The volume itself cannot be looked at in isolation but must be considered with all three pieces. From a clinical standpoint, sufficient volume helps to ensure that providers and staff remain actively engaged with patients in the community as well as providing the revenue sources for hospitals to continue operating, and potentially expanding their services, and facility-based providers to be adequately and fairly compensated for their professional services. Because of fee schedules, lower volumes, and unfavorable payer mix factors in rural areas, revenue streams for provider services do not cover the costs of their practices, including provider compensation, medical malpractice insurance, billing, and other administrative operational expenses, thus necessitating hospitals having to subsidize their practices.

The designation of hospitals as Critical Access Hospitals (CAH) should include a review, and potential increase of reimbursement in excess of their costs, as well as the criteria and formula for Critical Access designation. The latter would ensure there are not too many hospitals in rural areas trying to survive, and thus competing with each other, in a given service area based on the population within a defined radius of each CAH, as well as the distance of the CAH from more populated areas with hospitals of greater capability. Additionally, state regulations and provider reimbursement must be changed to allow for different care delivery models, such as APPs supported by telemedicine, to ensure that care can continue to be delivered in a cost effective and resource responsible manner, especially given the current and growing shortage of physicians in hospital-based practices, primary care, and other specialties.

Patient volume adequacy is necessary for the success of hospitals, whether designated as a CAH or not, serving a rural area defined by geography and population density; thus, utilizing something similar to the critical access formula is a viable solution in order to ensure the appropriate access to care for patients.

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?

Generally, Envision does not see frequent occurrences of transitioning to alternative care sites especially in emergent or urgent settings. Oftentimes a service line reduction or elimination in a rural or safety net hospital is directly due to revenue reduction, based on volume, payer mix, and payment reductions or delays by payers, leading to cost cutting mechanisms intended only to remain financially viable and keep their doors open.

b. there is broader investment in primary care or public health?

The relationship between the hospital setting and primary care are important for patients access to care available in a given community. Greater investment in primary care or public health would likely improve the overall health of patients; however, the hospital setting is still necessary to provide care as the communities' safety net. Rural and underserved communities generally have a higher percentage of patients with chronic diseases than many of their metropolitan counterparts; thus, increasing awareness and treatment options as preventive services may eventually reduce the

number of patients requiring care in an emergency or urgent care setting – thus improving overall health of the community and reducing the aggregate cost of care. Maintaining access, adequacy, and competency of emergency care will remain paramount for the greater good of the community.

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

The lack of payment flexibility is a driving factor in the closures of rural hospitals that have been seen across the country. As previously mentioned, rural and underserved areas have a higher percentage of uninsured or Medicare and Medicaid recipients. Reimbursement for the care of patients within this generally largest segment of the population does not provide hospitals or providers with sufficient revenue to cover the cost of their care; thus, reliance on the levels of commercial reimbursement for commercially insured patients is essential to offset the cost of care to the uninsured or underinsured. With commercial reimbursement continuing to be ratcheted downward, and high deductible plans shifting a greater portion of the cost to the patients, rural and safety net hospitals in particular are facing increasing financial difficulties with threat of service reduction and closure as seen over the past several years. Creating greater flexibility in payment or reimbursing rural and medically underserved hospitals at higher rates would help ensure their continued operations. Doing so also allows for greater reinvestment into additional programs, especially those focused on primary and preventive care, in these communities as well as opportunities for an increase in virtual health utilization. These are just some of the interventions that will ultimately bend the overall cost curve lower and reduce the growth of healthcare expenditures.

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?

Partly due to the regulatory barriers and limited reimbursement models in some states, Envision's experience in the formation of and participation in regional networks of care is limited in rural communities, particularly in terms of telehealth support. Hospitals and systems located in larger metropolitan and urban communities have branched out to form referral relationships, part-time service delivery of subspecialty care, and outright purchase of some hospitals in outlying areas. These models have demonstrated some success in improving patient access and quality of care; however, preserving the viability of the outlying hospitals in the rural and medically underserved areas will still require investment in their survival by improvements in facility and provider reimbursement, regulatory and financial support for alternative staffing models, such as APP care supported by physicians through telehealth, and expansion of primary care services.

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

Workforce shortages in rural and underserved areas is a primary cause for concern in providing access to care for patients. Many previously mentioned financial models developed to incentivize physicians and clinicians to move to rural areas include tuition reimbursement or loan forgiveness. These models are often effectively deployed for primary care providers. They would also be effective for attracting more highly qualified facility-based providers as well. For example, most

residency-trained, board-certified emergency medicine physician remain in urban and metropolitan practices following completion of their residency training programs and throughout most of their careers due to the higher compensation for their services which is directly related to higher volumes and better payer mixes in the populations they serve. In general, while the quality of emergency care in rural communities is very good, the majority of emergency care in rural communities is provided by experienced family medicine and internal medicine physicians practicing full time or part time in hospital emergency departments, as opposed to the most highly trained residency trained emergency physicians, because of lower compensation for their services. Incentives and training of emergency medicine physicians during their residencies for practice in rural areas would be a huge advance for rural emergency care delivery. Additionally, developing and implementing new care models focused on virtual health would help address the physician workforce shortages and allow for greater, more cost-effective access for more patients. The key to virtual health success is addressing reimbursement concerns ranging from low or absent reimbursement and elimination of barriers that prevent delivery and/or reimbursement for virtual health providers that reside across state lines.

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?

We agree that substance abuse and mental health issues are prevalent and inadequately addressed in rural and medically underserved communities. To our knowledge, efforts to provide access to these services have not been widely implemented but are currently being considered by legislators, community leaders, and the provider community. The most promising results, although not codified in the medical literature to a great extent, are anecdotally based on the expansion of access through telehealth, and affording physicians not formally trained in the chronic care of substance abuse the training and authority to provide acute substance abuse care, for example, with suboxone for opioid addiction.

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?

The concerns of access to post-acute care and long-term services in rural and underserved areas are more examples of the critical reasons that the hospitals that serve as the communities' safety net are able to continue to operate and ultimately have the ability to expand their services into the community. Envision is participating in initiatives to provide post-discharge care and monitoring for patients who have been hospitalized, assuring the continuity of care, reducing the possibility of readmission, and ultimately improving outcomes while simultaneously reducing costs. We are seeing positive results in this effort. Funding that will expand the ability of rural hospitals to invest in and develop similar programs is likewise essential to improving population health through post-discharge and long-term care to address chronic conditions. Identifying and supporting additional care delivery models, through paramedical professionals, such as advanced practice practitioners (APPs) as well as paramedics and nurses, supported by telehealth and other virtual health services will enable the rural and community hospitals to serve as care hubs and ensure these types of

patients are able to receive care locally, efficiently and effectively through innovative delivery of post-acute care and long-term services – and increasing the likelihood of access to care and patient compliance, both critical to overall population health.

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?

Hospitals in rural and medically underserved areas often lack the ability to access and assure the integrity of data that is necessary to evaluate the causes and propose solutions to the health disparities in the communities they serve. This is simply due, in many cases, to the insufficiency of their electronic medical record capabilities, due to their inability to invest in the more robust yet much more expensive systems in use by hospitals with more resources. Rural and medically underserved community hospitals may lack electronic medical record systems altogether or utilize “barebones” systems that are inexpensive due to their poor design, lack of analytical capability, and insufficient maintenance and updates. Additionally, analogous to the shortage of provider resources, there are areas of the country where the availability of the more highly qualified on-site I.T. professionals is too costly for the hospital. The data that would better identify the causes of health disparities for these populations would be available if the aforementioned challenges were addressed and solved. The data is similar to the data available for more metropolitan populations and could be retrieved, analyzed, and compared in order to better understand the causes, effects, and ultimately the costs of these disparities.

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?

The overarching concerns related to providing care to rural and underserved populations continues to be access. Efforts that focus on increasing access for patients in these areas will hopefully drive higher quality of care and improved patient outcomes. Increasing the ability of access to virtual health by ensuring adequate reimbursement in both government-funded insurance programs and commercial insurance would greatly benefit these communities. Increasing virtual health access helps solve wide ranging care concerns from substance abuse disorders, primary care and access to specialty care that patients are currently and/or would otherwise be unable to receive. It would also allow additional avenues for patient education which would help address chronic care issues such as proper diabetes treatment, smoking cessation, mental health disorders, and substance abuse. Lastly, increasing the number of primary care providers available in these communities is important to ensure access to ongoing preventive care services.

As a multispecialty organization with a footprint throughout the country in rural and underserved areas Envision welcomes the opportunity to work with the Task Force to address the disparities that exist. Additionally, on behalf of Envision Healthcare's clinicians, we thank you for the opportunity to comment on this RFI. We welcome the opportunity to discuss any of the topics covered in this letter further and to work collaboratively on delivering the best possible care to patients. Should you have any questions, please contact me at bob.kneeley@envisionhealth.com.

Sincerely,

A handwritten signature in blue ink, appearing to read "Bob Kneeley".

Bob Kneeley
Senior Vice President, Government Affairs