



November 29, 2019

Representative Danny Davis  
Rural and Underserved Communities Health Task Force Co-Chair  
2159 Rayburn House Office Building  
Washington, DC 20515

Representative Terri Sewell  
Rural and Underserved Communities Health Task Force Co-Chair  
2201 Rayburn House Office Building  
Washington, DC 20515

Representative Brad Wenstrup  
Rural and Underserved Communities Health Task Force Co-Chair  
2419 Rayburn House Office Building  
Washington, DC 20515

Representative Jodey Arrington  
Rural and Underserved Communities Health Task Force Co-Chair  
1029 Longworth House Office Building  
Washington, DC 20515

**Re: Request for Information**

Dear Representatives Davis, Sewell, Wenstrup, Arrington, and Members of the Rural and Underserved Communities Health Task Force:

On behalf of Gundersen Health System, we appreciate the opportunity to provide comment on the questions posed in the House Ways and Means Rural and Underserved Communities Health Task Force Request for Information. We will specifically be commenting on the challenges we face in rural communities regarding continuity of care, access, and services provided, specifically telemedicine. In addition, we will also make notes on access to care, primary care, and transportation.

Gundersen Health System is an integrated healthcare delivery system providing services throughout nineteen counties in western Wisconsin, southeastern Minnesota and northeastern Iowa. Our system includes a primary hospital in La Crosse, four critical access hospitals and over 50 clinics throughout the region. With over 7,000 employees, we are the largest employer in the Coulee region. We are committed to supporting public policy that helps to enrich every life through improved community health, outstanding experience of care, and decreased cost burden.

Our continued goal is to work with policymakers to improve quality, lower cost, and reduce regulatory and legislative burdens. At Gundersen, we work to distinguish ourselves through excellence in patient care, education, research, and improved health in the communities we serve. We believe value-based payment policies can drive better quality, lower the cost of care, and reduce overall spending in the Medicare program, and we strongly support continued implementation of payment systems that reward value. Set forth in the following sections, we are pleased to provide comments on the questions posed in the RFI.

### **Gundersen Response to Information Requests**

#### **1. What are the main healthcare-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 in rural areas are greatly impacted by access to services. In our rural Critical Access Hospitals (CAH) we have seen a greater need for transportation access for patients to attend follow up visits or transportation to pharmaceutical sites to continue care. Lack of regular follow-up visits can exacerbate patient health problems if they are not consistently addressed. This ends up with more health issues for patients' long-term and increased costs for treatment. Other health-care factors include pharmaceutical drug and device costs and needed advocacy to assist in patient navigation of the healthcare system.

Additional factors outside of the healthcare system that influences patient outcomes are the following:

- Transportation;
- Workforce availability;
- Food availability for food deserts;
- Safe and affordable housing; and
- Access to reliable childcare.

- 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?**

While there are many successful models to impact health outcomes, not every model will work for every community. Rural communities, while facing similar issues, often have unique challenges where a broad reform or initiative may not be suitable. We have seen success with different models for the different areas and states we have locations in. Currently, we are in the process of collecting data on the Social Determinants of Health in our communities to better identify what areas we can assist and what initiatives would be the most impactful.

Two ways we have seen success in increasing health outcomes are to incorporate Community Health Workers and the use of Telemedicine Services. Community health workers help promote health, prevention, and rehabilitative care in the community and assist community members in following prescribed care. They also assist community members and patients received needed services. Secondly, we have seen the increased usage of telemedicine and remote patient monitoring as having a positive effect on health outcomes. Telemedicine has expanded patient and community access to care which improves health and may help reduce exacerbations of chronic illness such as Congestive Heart Failure, Diabetes, and COPD. We strongly advocate for the expansion of broadband in rural communities as this would assist in furthering access to services for patients who live miles away from access to care. The expansion of broadband capabilities is essential for furthering the use and access of telemedicine for our rural communities.

- 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?**

To address 4.b, while primary care and public health are essential for the well-being of communities, primary care is not public health. Although the two can be a support for the community, public health initiatives do not supplement the need for primary care and

regular health visits. We do not recommend increasing public health dollars as a way to replace or supplement primary care. We do recommend further incentive for Medicare patients to follow up on appointments are care plans, as this will assist in decreasing the overall cost of care if conditions continue to be managed properly. For example, a public health initiative of promoting healthy food choices is a great way to engage the community to eat a more balanced diet. However, it will not help a diabetic who needs specialized diet instruction for a professional.

Additionally, when discussing the lack of flexibility in healthcare payment, there have been many issues with reimbursement for services and cost-based reimbursement, leading to address 4.c. Cost-based reimbursement creates incentives to treat as many patients as possible and often do not address health outcomes. However, in the past few years, regulatory agencies and legislation have moved towards value-based reimbursement which does incentivize positive health outcomes for patients. A major cause of the reduction of services or healthcare providers closing is the lack of adequate reimbursement for services. Currently, Medicare reimbursement rates do not adequately cover the cost of care provided, leaving providers and organizations at a loss. This has been a major factor in the closure of healthcare sites across rural America.

**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?**

At Gundersen, we do offer Telehealth options in many different specialties, however as mentioned above, reimbursement rates remain low. This does not incentivize other organizations to further implement telemedicine services and thus is at the detriment of rural patients. A major challenge we have seen regarding leveraging telemedicine are the restrictions on types of credential of providers. One example of this is a Speech Therapist who may be a part of a comprehensive care team for a patient with cancer or post-stroke. While the physicians can see the patient via telemedicine, these much-needed Therapists are excluded from the list of approved providers.

We have seen success in Minnesota as they have expanded the use of technology to improve access to care. They have broadened the number of providers on the approved list in addition to passing the Telemedicine Parity Law, which requires reimbursement for both Private Payers and Medicaid. Additionally, Wisconsin recently signed into law Telemedicine legislation that would remove the credentialing requirements for providers and add CPT codes that would allow providers to bill for telemedicine services.

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

We have identified needs and solutions to increase the healthcare workforce. We have seen that providing transportation, onsite training, and childcare has the potential to attract workers in rural areas. However, these issues are greater than healthcare organizations alone can impact, and public-private partnerships are necessary for success.

**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?**

Behavioral and addiction services are some of the most in-demand health services today. While we do implement telemedicine services to treat patients, we have a number of supplemental strategies that have been successful to address the lack of services in rural areas. These include outreach activities, including behavioral health assessments during primary care visits, partnerships with Federally Qualified Health Centers, and the use of private dollars and donations to support local activity such as 2-1-1 crisis line, suicide prevention, and Narcan training. We consistently partner with local and national community organizations to bring awareness and services to rural communities. As previously stated, we have seen success with public-private partnerships and collaboration.

**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?**

Communities have utilized a number of different resources to care for chronic and disabling conditions. A few examples include the Faith community, Community Health Workers, and volunteers who are involved in at-home care visits. AARP is also active in rural communities working to address social isolation through environmental challenges and partnership development.

Areas of concern regard the federal funding to states. This funding should funnel towards long term care, however, it is not being released to facilities. Additionally, we have consistently seen low reimbursement rates to long-term care facilities for direct care services at the state and federal level. Overall, this will drastically impact services and staff retention and have resulted in the closure of many rural long-term care facilities.

## **Conclusion**

With the opportunity to transform the healthcare system towards value-based care, we appreciate the opportunity to comment on this proposed rule. We urge legislators to work together with hospitals and physician groups to ensure programs are working to achieve the goals of better quality and lower cost. We look forward to continuing to provide feedback on the implementation of the new programs and initiatives for rural healthcare.

If you have any questions or need clarification, please feel free to contact us at any time.

Sincerely,

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