



November 27, 2019

The Honorable Richard Neal  
Chair  
Ways and Means Committee  
1102 Longworth House Office Building  
Washington, DC 20510

The Honorable Kevin Brady  
Ranking Member  
Ways and Means Committee  
1102 Longworth House Office Building  
Washington, DC 20510

Dear Chairman Neal and Ranking Member Brady:

The Movement is Life Caucus is pleased to have this opportunity to respond to your request for information (RFI) on behalf of the Rural and Underserved Communities Health Task Force. We believe this Task Force is an important place for addressing the serious issues we are confronting in terms of improving access to care in urban and rural underserved areas.

The Movement if Life Caucus is a multi-stakeholder organization dedicated to the elimination of health disparities based on race, ethnicity, gender and geography, particularly as they related to musculoskeletal health.

For the past 20 months, MiL has been working with Congressman John Lewis (D-GA) on legislation aimed at addressing health disparities as part of the process for developing, evaluating and implementing Alternative Payment Models for Medicare and Medicaid. We highly recommend members of the Task Force review the Equality in Medicare and Medicaid Treatment Act (EMMT) to see how these issues are identified and addressed.

Improving access to care and addressing health disparities is a topic that has historically enjoyed bi-partisan support and we commend you and members of the Task Force for working together to solve this problem.

If you or members of the Task Force have any questions about our responses or possible solutions, please do not hesitate to contact us.

Sincerely

Dr. Mary O'Connor, MD  
Chair, [Movement is Life](#)  
Director, Center for Musculoskeletal Care at Yale School of Medicine  
Professor of Orthopedic and Rehabilitation, Yale School of Medicine

**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?**

There are two main factors influencing outcomes of health care in rural and urban underserved areas: availability of healthcare providers (clinicians and/or hospitals) and social determinants of health.

Rural and Urban underserved areas are chronically short on the availability of healthcare whether that is physician/clinician availability or hospital inpatient availability.

The availability of care in rural and urban underserved areas is driven by the payment methodologies we use to compensate these providers.

Due to factors outside of the healthcare industry (i.e. social determinants of health) patients in these communities are often sicker, more likely to suffer from multiple chronic conditions, have substandard housing, inadequate (or non-existent) transportation<sup>1</sup>.

Individuals residing in underserved urban or rural areas are also far more likely to be on Medicare and/or Medicaid. Historically, payments from these programs have been less than the cost of providing care or, in the case of new quality or “value-based” payments, fail to take into consideration factors that affect outcomes that are beyond the ability of the clinician or hospital to control.

“Poverty, disability, housing instability, residence in a disadvantaged neighborhood, and hospital population from a disadvantaged neighborhood were associated with higher readmission rates. Adding social factors to risk adjustment cut these differences in half.”<sup>2</sup>

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<sup>1</sup> [Characteristics of Communities Served by Rural Hospitals Predicted to be at High Risk of Financial Distress in 2019](#)

<sup>2</sup> [Adjusting for social risk factors impacts performance and penalties in the hospital readmissions reduction program](#)

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/tele-monitoring?**

All of the examples described in the question have had a positive impact in communities in which these initiatives have been undertaken.

Unfortunately, the clinical success of these models is often overshadowed by a short-sighted actuarial analysis of some of these initiatives (transportation, and telehealth) that suggests that they increase spending because of greater access to care.

Telehealth and tele-monitoring hold great promise as a means of improving access and reducing long-term costs, particularly for services that have historically been difficult to access in underserved communities, such as behavioral health. Data indicates that via telehealth and tele-monitoring, we can better manage patients in a post-acute situation and/or patients with chronic conditions such that we can avoid unnecessary ER visits and unnecessary hospitalizations.

In addition, telehealth and tele-monitoring should not be viewed as a substitute for having an actual healthcare provider within reasonable proximity to where individuals live and work. Telehealth and tele-monitoring are important tools but they are not the complete answer.

We highly recommend you review the following as part of your analysis:

**[How does Rural America differ from the nation as a whole, regarding the social determinants of health?](#)** (Rural Health Information HUB)

**[Essential Data: Our Hospitals, Our Patients](#)** (Americas Essential Hospitals)

**[Adjusting for social risk factors impacts performance and penalties in the hospital readmissions reduction program](#)** (Health Services Research)

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

The Task Force should consider some form of payment unrelated to occupancy or utilization that is sufficient to cover the cost of operating a clinic or hospital. As noted in the previous question, efforts to reduce hospitalization, reduce ER visits and move to telehealth, while clinically appropriate, will have the effect of reducing revenue to hospitals and physician offices.

When the Congress talks about “saving” money, you must recognize that the savings realized by the federal government is money that is not going to a provider of care. Providers in safety net hospitals and clinics have a long history of cross-subsidizing services (i.e. the “profit” on one service is used to subsidize the delivery of another service that is unprofitable).

Often necessary services are deemed “unprofitable” because of low volume.

Low-volume can lead to high per service costs which then attracts the attention of a payer (whether commercial or government). Sometimes, the drive for having care delivered at the “most efficient” provider will have a downstream effect on the availability of services in rural/urban underserved areas leading to the unintended consequence of reduced access to care.

We must recognize that it is important to maintain infrastructure in rural and urban underserved areas that may not be optimally efficient. Some form of subsidy or alternative payment methodology that is related to cost rather than volume has proven to be a successful payment model for these low-volume service areas (rural or urban).

- 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?**

First, there is an interconnectedness between service line reductions and the overall availability of healthcare in a community.

An example of a service line reduction is when CMS removes a surgical procedure from the “in-patient only” list. This can have a dire impact on safety net hospitals. These procedures tend to be “profitable”, when performed on patients who are otherwise relatively healthy. Allowing these procedures to be performed in the outpatient/ASC environment means hospitals will simply be places where surgical procedures are performed on more complicated patients making these procedures unprofitable, further threatening the economic viability of the safety net hospital.

If this policy of removing procedures from the inpatient only list is continued, then it is imperative that there be a revaluation of the DRG payments for those procedures when performed on inpatients because hospitals will now only be doing these procedures on the more complex patients. And, it should be noted that outpatient facilities are typically not located in rural areas or underserved urban areas and will often restrict or limit patient access based upon payer.<sup>3</sup>

Finally, safety net hospitals, whether urban or rural, are often more costly because inadequate housing, transportation, long-distance travel and lack of appropriate post-acute care services may cause higher hospital readmission rates and/or longer lengths of stay making these hospitals less attractive to payers focused solely on securing low-cost facilities and patients.

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<sup>3</sup> [Musculoskeletal urgent care centers in Connecticut restrict Medicaid patients based on policy and location](#)

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?

NO RESPONSE

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

The National Health Service Corps Scholarship and Loan Repayment programs have a long-established track record of successful placement of physicians, PA, NPs and nurses in rural and urban underserved areas.

The long-term workforce issue is retention of the rural/urban underserved workforce. We know how to “get them there”. What we don’t have a strong track record on is how do we keep them there?

Adequate compensation for providers is a start.

Next, under value-based programs, we should not hold physicians/hospitals accountable for factors affecting outcomes that are beyond the ability of the physician/hospital to control. Payment models must have some form of risk adjustment for social determinants of health.

While hospitals cannot “move” as easily as a physician practice, continuing to hold hospitals accountable for things beyond their control will result in the closure of a hospital or medical practice because they have little reason to believe a new facility or provider can effectively replace the lost entity.

We highly recommend you review these articles:

[Adjusting Medicaid Payments for Social Determinants to Boost Care](#) (Journal of the American Medical Association, October, 2019\_

[Financial Incentives and Vulnerable Populations — Will Alternative Payment Models Help or Hurt?](#) (New England Journal of Medicine, March 2018)

Successful models should adequately compensate providers for care, however, when you overlay quality/value measures onto those payment models, you should not penalize providers for factors beyond their ability to control or properly risk adjust to take those factors into account.

- 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?**

**NO RESPONSE**

- 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?**

**NO RESPONSE**



**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?**

The problem is not the availability or integrity of data. There is ample reliable data available from a variety of reliable sources (CDC, Social Security Administration, Medicaid enrollment data, Census Bureau, etc.).

Data measures based upon the location of the provider (i.e. high need areas) or data collected and reported by the provider can be used to make payment adjustments or payment supplements to acknowledge SDOH. Many providers (hospitals, clinics and some physician offices) already collect patient income data in order to determine if a patient qualifies for free or reduced cost healthcare. In addition, when determining whether an area qualifies, for Health Professional Shortage Area or Medically Underserved Area or Medically Underserved Population designations, a range of socio-economic, demographic and health status data is collected and used to make those determinations. The government deems that data reliable for shortage designation purposes but it is suddenly unreliable when it comes to adjusting payments to reflect those social determinants of health?

Instead of continuing to suggest that the inability to adjust for Social Determinants of Health is due to “data availability” or “data integrity” we should use the data federal and state governments use for other programs to adjust payments to account for SDOH.

This is particularly true as payers move aggressively to hold physicians and hospitals financially accountable for poor outcomes or above average readmissions or ER visits.

The Ways and Means Committee should use its oversight authority to ask CMS what data it does have available.

**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?**

NO RESPONSE