November 26, 2019

Sent via email: ***Rural_Urban@mail.house.gov***

Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, District of Columbia 20515

Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, District of Columbia 20515

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

Dear Chairman Neal and Ranking Member Brady:

Thank you for the opportunity to share our insights and experience regarding health status and outcomes within rural communities. We commend the co-chairs of the Committee on Ways and Means' *Rural and Underserved Communities Health Task Force* (Task Force), Representatives Danny Davis, Terri Sewell, Brad Wenstrup, and Jodey Arrington, for seeking workable solutions to improving health outcomes in these communities.

Signify Health uses advanced technology to deploy the nation's largest mobile clinical network to support payers and health systems as they make the transition to value-based care. We further support this effort by building local networks of community organizations to address social issues before they become healthcare problems and expenses. Our technology unites payers, providers and patients to fully understand each patient's episodic or long-term needs and ensure they receive the right care at the right time in the right place. We serve over one million and a half Americans each year, in their homes and communities, reaching every county in the nation.

It is from this perspective that we are pleased to offer comments to five of the ten questions in response to the Task Force's inquiry.

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?

Rural and non-metropolitan communities often encounter barriers to healthcare in terms of affordability, proximity, and quality. Many of these extraneous factors have to do with social determinants of health that can disproportionately affect rural residents' ability to access healthcare services. In our experience, these include: inadequate financial means to pay for services; lack of transportation to reach services that may be distantly

located; lack of confidence to speak with their providers if English is not their primary language or they have low health literacy; stigma around issues such as mental health and substance abuse; and trust that their personal health information will be handled confidentially and compliantly. Each of these non-medical issues affects that quality and quantity of healthcare services that rural residents access, and can have downstream effects on their outcomes.

Since 2011, we have served over 3 million people and facilitated the delivery of over 25 million social determinant-related activities on their behalf. In order for healthcare and social service providers to operate as a virtual team to address an individual's complex and interrelated social needs, patient/client data must flow securely between HIPAA protected and non-HIPAA protected entities.

In this way, health and community partners can safely share information, coordinate services, and most importantly, document all clinical and social information into a combined longitudinal record. These records can stay with patients over time, across care settings, and can be connected back to quality, satisfaction, and financial 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?

In addition to the comments above related to social determinants of health, we believe episodes of care models are an innovative value-based care solution that improves patient outcomes by holding providers accountable for all services provided in a set time frame. As a result of the recent merger of Remedy with Signify Health, we are now the largest and most experienced coordinator of episodes of care in Medicare's voluntary demonstration models. As a Convener in Medicare's most prominent demonstration model, we position providers with tools and resources that can address issues such as access to care and health literacy throughout each episode.

Participants working with Signify Health (previously Remedy) in the Bundled Payments for Care Improvement Advanced (BPCI-A) Initiative have managed nearly 20,000 Medicare patients in rural communities and have run programs in over 70 rural hospitals since October 2018. A key area of focus in bundled payments is care coordination, which includes discharging patients to appropriate settings after a hospital stay, engaging patients in discharge planning, and tracking patients throughout each episode. Americans in vulnerable communities often rely on their hospital as their primary source of care, and providers involved in bundled payments are incented to ensure patients are educated about their care and are receiving the appropriate services at each step of

recovery. This coordination is shown to decrease readmissions during each 90-day episode by 10.1% and the number of days spent in skilled nursing facilities by 13%.

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

We strongly believe that in-home care, from evaluative services to palliative/hospice services, is a cost effective approach to ensuring access to health care services, and provides vital support to rural physicians and their patients. As an example of this effectiveness, CMS' Independence At Home model saved an average of $1,431 per beneficiary in its third performance year[1], primarily by reducing unplanned hospital use, and improved quality of care on a number of measures.

Studies have found that nine out of 10 Americans 65 years and older want to stay at home for as long as possible.[2] In-home health care can help aging individuals maintain healthy and active lifestyles and provides an important supplement to existing primary and specialty care services.

Services provided in the home have a strong clinical value; providers visiting a patient's home are able to gather hundreds of different data points about a patient's health condition, preferences, and habits, creating a full picture of the patient's overall health and health care needs. Signify Health clinicians spend an hour with a patient in their home. By visiting patients where ever they live, we are able to develop a holistic assessment of an individual's health and quality of life, and transmit this data in real time to an individual's primary care physician.

By integrating in-home services with specialty patient assistance programs we can also help patients access and adhere to complex therapies, including clinical trials, lowering costs for both patient and the health care system.

Further, studies have found that in-home health care can help to prevent falls and other common injuries, reduce hospital admissions and extra doctor visits, and can help to keep seniors healthy by ensuring medication adherence and adequate nutrition[3].

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?

[1] https://innovation.cms.gov/Files/reports/iah-rtc.pdf.

[2] https://assets.aarp.org/rgcenter/ppi/liv-com/ib190.pdf

[3] www.jointcommission.org; *Home – The Best Place for Health Care* 2011

Value-based models for substance use disorders, such as the Addiction Recovery Medical Home - Alternative Payment Model[4] (ARMH-APM), supported by the Alliance for Addiction Payment Reform (The Alliance) of which we are an active member, help providers facilitate patient recovery by establishing comprehensive solutions and holistic, long-term care management.

Critical to models such as the ARMH-APM is the establishment of a network that connects necessary clinical resources with broader community resources to support a patient throughout their recovery. The integration of these resources through common information systems facilitate clinical information sharing, resulting in better discharge and transition management.

Importantly, such models ensure the availability of a care coordination team that includes peer recovery specialists, behavioral health specialists, licensed counselors and primary care physicians.

The ARMH-APM calls for establishing an appropriate care management fee for the clinicians managing the patient. Underserved communities would therefore have access to additional funding through this model to more adequately pay for necessary care.

The model rewards localized care, preventing the substantial loss of delivery system revenue that occurs when a patient is transferred out of the area. While building local capacity will take time, transitioning to the ARMH can help reverse this loss of revenue and support capacity building.

The ARMH-APM is currently being piloted in five states and Washington, D.C.[5] Results from these demonstration pilots and others will inform the transformation of care delivery for the treatment of substance use disorder in urban and rural communities across the nation.

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?

Further expansion of rural and urban underserved focused value-based programs stands to drive significant improvements in patient safety and care quality. These models should move away from pure fee for service (FFS) reimbursement and focus on quality, global budgets, and patient safety.

[4] https://docs.wixstatic.com/ugd/4b8a91_6170bf6cc8304c348fc8ec67cc33b133.pdf

[5] https://www.incentivizerecovery.org/2019-press-release

To maximize chances for success, bundled payment programs and other value-based arrangements focusing on rural environments must pay heed to the unique challenges providers in these settings face, as documented by the GAO[6].

Health systems supporting rural and underserved populations need access to low-cost capital in order to fund the many upfront investments required to succeed in value-based arrangements. The Rural Health Care Program could serve as a model for such financing.

Value-based models for rural and underserved environments should permit and encourage health systems to develop relationships with conveners and other third-party entities in order to assist in underwriting the risk of participation, to help address administrative duties, and to manage compliance with multiple participation requirements. Successful models and/or those we can learn from (e.g., Pennsylvania Rural Health Model, Rural Community Hospital Demonstration, Frontier Community Health Integration Project Demonstration) should be replicated and expanded.
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Thank you again for the opportunity to provide feedback to the Task Force. We look forward to working with you on this important issue. Please do not hesitate to reach out to Kim Holland, Senior Vice President of Government Affairs, at kholland@signifyhealth.com if we can be a resource to you on this or any other issue.

Sincerely,

Joseph Jasser, MD
Chief Medical Officer

[6] https://www.gao.gov/assets/690/681541.pdf; Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices, 2016