UnityPoint Health

Government & External Affairs
1776 West Lakes Parkway, Suite 400
West Des Moines, IA 50266
www.unitypoint.org

November 27, 2019

Chairman Richard E. Neal and Ranking Member Kevin Brady
Ways & Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

RE: Rural and Underserved Communities Health Task Force Request for Information
Submitted electronically via Rural_Urban@mail.house.gov

Dear Honorable Chairman Neal and Ranking Member Brady:

UnityPoint Health (UPH) appreciates the opportunity to respond to this RFI on priority topics that affect health status and outcomes impacting optimal health for rural and underserved communities for consideration by the Task Force. **Attached are our responses to the RFI**.

UPH is one of the nation's most integrated healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. UnityPoint Health Accountable Care (UAC) is the ACO affiliated with UPH and has value-based contracts with multiple payers, including Medicare. UAC is a current Next Generation ACO, and it contains providers that have participated in the Medicare Shared Savings Program as well as providers from the Pioneer ACO Model.

We appreciate the opportunity to provide comment on this RFI on health status and outcomes in rural areas. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs

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?

RESPONSE: Patient outcomes in rural areas are particularly pertinent to Iowa as more than forty percent of Iowans — or 2 in 5 — live in rural communities and depend on small rural hospitals and clinics for their healthcare needs. According to the National Rural Health Association, rural residents tend to be older, experience higher rates of chronic illness and are more likely to be under- or uninsured. The CDC attributes a higher percentage of potentially preventable deaths to rural residents than their urban counterparts. While these factors often drive increased healthcare needs, actual outcomes frequently depend on access to healthcare services in a timely, right-sized and coordinated fashion.

While the demographics of the rural population itself would suggest heightened demand for services, the geographic spread of this population creates challenges to healthcare access. Access directly impacts patient outcomes. Perhaps the largest challenge to rural access is workforce shortages, including recruitment and retention. Ongoing shortages of physicians, nurses and other professionals in rural communities make it harder and more expensive to attract skilled healthcare professionals to remote rural communities. Iowa ranks 46th nationally in the number of physicians per 100,000 patients — of 99 Iowa counties, 61 are designated (in whole or in part) as health professional shortage areas (HPSAs) for primary care, and 86 are designated as HPSAs for mental health. OB/GYNs represent 4 percent of Iowa physicians and are located in 38 counties, leaving 60 rural counties without an OB/GYN physician presence.

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?

RESPONSE: Regional healthcare delivery systems can positively impact health outcomes via two-sided risk, provider-driven ACOs and capitated population health models that target enhanced patient engagement and shared decision making. To allow population health models to be sustainable in rural areas, the adage "all care is local" must be expanded to regions, include integrated care across settings and leveraging community partners. In addition, financial modeling must not penalize the fixed costs of access in rural areas.

That said, while preventive in-place community and ambulatory care are preferred, timely access

to acute care services and their associated networks are the backbone of positive health outcomes and overall rural community vitality. In rural communities, more than 100 hospitals have closed since 2010 and another 430 are at risk of closing – 17 within Iowa (Navigant, 2019). Rural hospital closures have been associated with a 5.9 percent increase in mortality rates (National Bureau of Economic Research, 2019). Hallmarks of successful models for rural health access are still the specialized designations and funding for essential medical services, namely critical access hospitals and sole community hospitals. There is also considerable potential for telehealth to overcome provider shortages, promote workforce efficiency and improve patient experience (see RFI question 5); however, telehealth has been overly regulated and underfunded and will not be fully realized without coverage expansion and payment parity.

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

RESPONSE: Rural communities need options to right size their healthcare access points to meet community needs and prioritize safety. The term rural hospital is not a one-size-fits-all proposition, as demonstrated by the various Medicare reimbursement designations related to inpatient size (rural referral centers, sole community hospitals, critical access hospitals (CAHs) and even "tweeners"). As Iowa's population base has further migrated to urban centers, rural populations have become more sparse and inpatient volumes in rural hospitals have plummeted. Certain patient volumes dictate closure of service lines due to safety concerns and staff proficiency. Reimbursement structures also impact fiscal sustainability related to low volume admissions and procedures, and Medicare policy (such as CAH status) has used a snapshot eligibility approach that leaves some communities without options but to close doors.

To promote flexibility for low-volume hospitals,

- Establish Rural Emergency Hospital (REH) Designation
    - Services: Transition from inpatient care to 24/7 emergency room services along with outpatient diagnostic services and therapeutic care
    - Transportation: Maintain protocols for timely transfer of patients to higher acuity facilities as needed
    - Telehealth: Qualify as originating site for telehealth, like CAHs
    - Network Agreement: Establish agreement with a larger, non-REH hospital for referrals and other support
    - Quality Standards: Mandated standards with financial penalties
- Modify CAH Program
    - Conversion Window: 18-month timeframe to convert rural hospitals to CAH status

  - Reimbursement: Enhanced reimbursement for home health care and emergency medical services
  - Co-Location of Services: Central facility to house Rural Health Clinics and provider-based and specialty physicians

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?

RESPONSE: UnityPoint Accountable Care (UAC) participates in the Next Generation ACO model with more than 100,000 attributed beneficiaries, including a significant rural geography. The Next Generation ACO has a telehealth waiver that eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and for the use of asynchronous telehealth services in certain specialties. UAC has been the most prolific user of this telehealth waiver. Our telehealth waiver use is 8- to 10-fold the average Next Generation ACO user each quarter, and we have targeted mental health services (particularly in Iowa's HPSA counties) and telemedicine in our emergency departments. Also of interest, our wavier beneficiaries are overwhelming classified as disabled as opposed to aged.

Although the waiver has allowed much needed service flexibilities, there are two telehealth opportunities where added flexibility would reap immediate rewards in terms of increasing access to care and improving patient outcomes and experience. These opportunities are:

- Including a beneficiary's home in rural areas as an originating site for telehealth services.
- Permitting health systems to donate telehealth infrastructure, including software and/or equipment, without running afoul of Stark or Anti-Kickback Statute (AKS) requirements. This donation arrangement would be similar to the proposed Stark exceptions and the AKS safe harbors for certain arrangements involving the donation of interoperable electronic health record (EHR) software or information technology and training services as well as the donation of cybersecurity technology and related services to protect the EHR.

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

RESPONSE: To strengthen the rural workforce, we urge a multi-faceted approach:

- Rural healthcare entities must be stable and sustainable. Given the rate of rural hospital

closures and over 400 more at risk (*see* RFI #2), rural geographies do not portray workplace stability, which hampers recruitment and retention efforts. Special funding to assure healthcare access (e.g. CAHs or REHs; *see* RFI #3) is crucial. Also important is enabling rural facilities to be efficient through administrative flexibilities, such as allowing one-stop healthcare hubs with co-located services and staff sharing arrangements. We were disappointed that recent CMS guidance failed to lift restrictions on CAHs.

- Regional lens should guide rural health delivery. Recruitment and retention efforts are aided when healthcare professionals have a connection to larger health systems and their resources through telehealth and co-management agreements.
- Top of licensure practice as set forth in state licensure laws should be recognized in federal law. In Iowa, advanced practice providers are filling physician gaps in primary care and emergency rooms in rural areas.
- Healthcare education should thoughtfully target individuals with an affinity for rural practice. Rural practice entails a lifestyle choice, and recruitment should start early. Career pathways and job shadowing opportunities would ideally begin prior to college coursework and concentrate on “growing your own” or youth residing in rural areas. Outreach should also include rural healthcare employees who may want to advance their careers, such as RNs becoming APRNs. As for medical and healthcare education curriculum, clinical rotations and residencies should prioritize rural practice.

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?

RESPONSE: Every rural county in Iowa is designated a HPSA for mental health. To facilitate behavioral health access, UPH has engaged in the following:

- Use telehealth to provide efficient access to psychiatrists and psychologists. While used in various ambulatory settings, it has been invaluable to conduct timely consults and evaluations for patients presenting at emergency rooms and admitted inpatient.
- Integrate behavioral health and primary care services. Since upwards of 80% of patients with mental illness seek care in medical settings (JAMA, 2018), we have initiatives to embed behavioral health consultants into primary care clinics. This is occurring in UnityPoint Clinic (UPC) sites and with Federally Qualified Health Centers. Also, in the reverse, we are operating a UPC primary care clinic within a Community Mental Health Center (CMHC) in Fort Dodge, Iowa.
- Leverage CMHC resources. To enhance integration efforts, UPH has established formal arrangements with 6 CMHCs. Each CMHC has a telehealth program to expand services

beyond its four walls. In addition, they also have various programming to provide services in client's homes. Particularly impactful for individuals with serious mental illness have been the Assertive Community Treatment (ACT) and the Integrated Health Homes (IHH) programs.

- Encourage advanced practice degrees. Allen College – UnityPoint Health recognized this need early and has been offering a behavioral health Master of Science in Nursing (MSN) track - Psychiatric Mental Health Nurse Practitioner (PMHNP) - for more than 10 years. Historically, interest has been high with PMHNP enrollment second only to the MSN family practice track.

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?

RESPONSE: Post-acute care (PAC) can be challenging in rural areas, and again, we urge solutions that offer options to allow rural communities to determine what best fits their community needs. We would encourage options that include:

- Co-Location of PAC Services within Rural Hospitals: For rural hospitals that choose to eliminate inpatient beds altogether and convert to REH status (*see* RFI #3), REHs should be allowed to maintain skilled nursing facilities (SNF) and receive specialized reimbursement for these PAC services. Currently, CAHs are permitted to co-locate SNF services, and this has been a valued service in certain rural communities.
- Expansion of Rural Program of All-Inclusive Care for the Elderly (PACE) Opportunities: PACE provides comprehensive medical and social services to certain frail, elderly people (participants) still living in the community. As an alternative to residential care, this integrated Medicare and Medicaid financing model was offered as a rural demonstration in 2006. Siouxland PACE in Sioux City, Iowa, was one of the 14 rural pilot sites. We would urge CMS to release future funding opportunities to enable more PACE Organizations to serve rural residents.
- Promotion of Value-Based PAC Networks: Through the Next Generation ACO, UAC participates in the SNF three-day waiver. Incorporated in this waiver are quality standards. As a result, UAC has partnered with its SNF network on quality initiatives. In March 2018, UAC received the 2017 Doyle Award from MCG Health for developing a high-performing post-acute care SNF network that reduced patient length of stay without any increase in rehospitalization.

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?

RESPONSE: The most impactful efforts involve sustaining access to essential services without jeopardizing safety or quality in rural areas. Where you live should not dictate if you live or your quality of life. We offer the following efforts as next steps to strengthen rural access to health care:

- Permit rural hospitals to right size their footprint and provide essential services, by voluntarily reducing their inpatient beds to reflect local needs. Rural hospitals reducing inpatient volume should have the option to be designated as a CAH or REH (*see* RFI #3).
- Allow health systems to donate telehealth infrastructure, including software and/or equipment, without running afoul of Stark or AKS requirements (*see* RFI #5).
- Expand provider-based Medicare Advantage (MA) offerings in rural areas, by establishing alternative mechanisms to meet MA network adequacy requirements. Alternative mechanisms to achieve network adequacy would promote enhanced healthcare access and increase the adoption of MA plans in rural areas, giving rural citizens more healthcare choices. The quantitative time and distance standards could be supplemented through access sources that include innovations in care delivery, such as telehealth and Centers of Excellence or regional arrangements. Both alternatives are common practices for service delivery within ACOs and could increase healthcare options to beneficiaries in areas previously unserved or underserved by MA plans. For instance, 30% of Next Generation ACO beneficiaries attributed to UAC reside in counties that do not meet network adequacy standards, yet it would be a mischaracterization to say that these FFS beneficiaries lack access to healthcare services.