

November 29, 2019

The Honorable Richard Neal  
Chairman  
House Ways and Means Committee  
1102 Longworth House Office Building  
Washington D.C. 20515

The Honorable Kevin Brady  
Ranking Member  
House Ways and Means Committee  
1139 Longworth House Office Building  
Washington D.C. 20515

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

Dear Chairman Neal and Ranking Member Brady:

Vizient, Inc. appreciates the opportunity to respond to the Ways and Means Committee's Rural and Underserved Communities Health Task Force request for information. Vizient appreciates your leadership in seeking to identify and advance impactful solutions to help support rural and underserved communities and their essential health care needs.

**Background**

[Vizient, Inc.](#) provides solutions and services that improve the delivery of high-value care by aligning cost, quality and market performance for more than 50% of the nation's acute care providers, which includes 95% of the nation's academic medical centers, and more than 20% of ambulatory providers.

Vizient also serves a diverse membership of hospitals and other non-acute health care service providers in rural America, including a significant number of independent community hospitals, critical access hospitals, rural health clinics and other non-acute providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than \$100 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Vizient strongly believes that it is essential for our country to support a vibrant and high quality health care system that ensures access to care for patients in rural and underserved areas. We believe that this goal could be meaningfully accomplished through: 1) adequate reimbursement to ensure hospitals and other providers in rural and underserved areas have the means to serve their communities and provide access to appropriate and high-quality care; 2) incentives to ensure that

rural and underserved communities have the ability to recruit and retain the highly-skilled workforce needed to provide care; 3) regulatory modifications to ease unnecessary restrictions and provide new flexibility for providers to implement alternate payment and care delivery models to better serve their communities; and, 4) expanded access to broadband and necessary funding to support adoption and scaling of telemedicine services to ensure access to both primary care services and specialists who may otherwise be unavailable in rural and underserved communities.

In our response, we will offer feedback to some of the specific questions raised by the Task Force. We thank you for the opportunity to share our views to help support the important work being done by the Task Force.

**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?**

- A [CDC study](#) concluded that Americans living in rural areas are more likely to die from five leading causes of death than those in metropolitan areas. Four of the five leading causes of death are chronic diseases which require significant coordination and intervention to manage. Access to basic primary care needed to screen for these chronic conditions, manage chronic patients, and coordinate the complicated health care system is significantly deficient in rural areas. An April, 2019 [article in the Journal of the American Medical Association](#) studied the utilization of emergency departments (EDs) in urban and rural markets and found the rate of use in urban markets has been flat for 10 years while the rate in rural markets has risen more than 50%. At the same time, the patients seen in rural EDs presented with less severe conditions while urban EDs saw no change. This demonstrates that patients in rural areas lack access to more affordable and appropriate sites of care for their primary care needs. This lack of access leads to less chronic care management, which is likely a factor in the higher death rate of rural patients with chronic diseases.
- There are also factors outside of health care that impact the health of rural patients, but these factors vary greatly by geography, size of the market, and demographic mix. Many organizations have tailored their approach to unique market-level needs and worked collaboratively with local stakeholders to prioritize the health improvement goals for the community. A health care system serving rural areas in Illinois is working to innovate for the most vulnerable people in their broad market by bringing community leaders to the table and establishing shared goals. In these small, dispersed farming communities older patients wanted an easy way to stay connected with their providers without logging-in to a cumbersome electronic medical record. Thus, the health system determined that in communities like this, with limited broadband access, a text message-based solution would need to be developed to provide patients with the connectivity they desired. By combining the expertise and resources of the health system with the input and

direction from the community, an innovative solution was tailored to meet the top patient priorities.

- Although solutions need to be tailored to fit the needs of specific populations and communities, [research shows](#) some commonalities regarding the impact that social determinants of health have on individuals in rural areas:
  1. While not a problem exclusive to rural America, poverty and unemployment impacts certain rural communities profoundly. In the Southeast, Louisiana, Mississippi, Alabama, and Georgia all have more than one quarter of their rural population in poverty. While poverty [has been shown](#) to correlate with negative health outcomes, in rural areas poverty can be an even bigger challenge as it often means a lack of family support and/ or social isolation, insufficient transportation options, and lack of access to employment opportunities, particularly those that offer health insurance benefits.
  2. In other rural parts of the country where the population is so dispersed, (the plains and western states) rural populations struggle with access to healthy food (defined as a grocery store within 10 miles). Seventy five percent of the rural population in South Dakota is more than 10 miles from a grocery store. Food insecurity, or lack of access to healthy food in particular, can contribute to poorer health overall and/or a higher incidence of certain diseases such as [diabetes](#) in adults and [anxiety and depression](#) in children.

**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?**

- Managing chronic conditions is particularly challenging in rural markets with limited health care infrastructure and access to providers. Deploying community health workers has [been effective](#) and made a positive impact in rural markets. In many rural areas, it does not require advanced analytics to identify frequent utilizers of the ED who need help managing their chronic conditions. According to many rural ED physicians and nurses with whom Vizient has been engaged, they can identify, by name, the individuals who use the ED too frequently. Upper Peninsula Medical Center on the eastern shore of Maryland has deployed four community health workers from a Lower Shores Clinic each to work with 25 frequent utilizers of the ED. By helping them with medication reconciliation and connecting them to a primary care provider, 75% of the patients had zero readmissions to the hospital within a year. These kinds of high touch programs can be particularly impactful in rural markets where even the small scale nature of the intervention can yield an impact on dozens of patients and their families.

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

- Since 2010 there have been [119 rural hospital closures](#). To explore the cause of the financial distress that led the hospitals to close, [Sg2](#), a subsidiary of Vizient, studied the inpatient market performance of rural hospitals across six states and discovered that hospitals in small markets (< 9,000 population which represents 33% of our sample of 215 hospitals) almost never performed in the top quartile. At the same time, a majority of the hospitals that have closed were in very small markets which were unable to generate sufficient volume to support the hospital. Even in a cost-based reimbursement system the hospital still needs to reach a volume threshold to cover fixed costs. With that in mind, an alternative approach to rigid regulatory requirements for Critical Access Hospitals may be appropriate as the smallest markets could be offered more flexible bed numbers and inpatient stay requirements to maintain their cost-based reimbursement status. One example of this would be adopting legislation (S. 586/H.R. 1081) to relax the requirement for Critical Access Hospitals to certify that patients will be discharged or transferred within 96 hours.

**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?**

- A medical center in Iowa knew they needed to transition their critical access hospital to match the changing demographics of their community, which includes a large number of older patients with chronic conditions and fewer women having babies. They made the tough decision to not recruit a new obstetrician when the only provider in the market retired. Instead they pivoted to recruit more nurse practitioners to provide primary care and geriatrics. The trade-off they made with that decision was to act as the coordinating hub for the estimated 50 women in their market who gave birth annually instead of opting to provide deliveries at the hospital. Because of that change they were able to provide health care services locally, to a much larger patient population, for a wide variety of services including radiology, sleep studies, respiratory therapy, chemotherapy, and needed labs (all of these services saw volume increases). The key to their success was leveraging data (which can be challenging and costly to access and utilize for rural hospital administrative teams) to understand the diversity of community needs and make a decision to prioritize which services were most needed to support the most members of the community.

**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?**

- [Prairie Health Ventures in Nebraska](#) is a collaborative alliance with 52 member rural hospitals (some independent hospitals and some aligned with larger health systems). The alliance was formed to pool resources and share strategies. Its members work collaboratively to provide group purchasing, regulatory support, shared providers, shared IT services (recruiting health IT experts to rural markets is nearly as difficult as recruiting physicians), grant writing, ACO collaboration, and virtual health services. For example, one service they offer is recruiting specialists who will rotate throughout many of the rural hospitals to allow patients to be seen in their local hospital. To further support their collaborative approach, more federally-funded rural residency programs and enhanced loan forgiveness for providers working in rural markets would allow them to recruit the volume of providers needed to efficiently centralize care for this dispersed population. Congress is currently considering two pieces of legislation that could help mitigate these challenges. Specifically, S. 2406, the Rural America Health Corps Act, and S. 348 / H.R. 1763, the Resident Physician Shortage Reduction Act.

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

- There is a saying about provider recruitment and retention in rural markets: “if they didn’t grow up here, they won’t stay here.” Sadly, this is reflected in the [data](#) which shows that only 43% physicians that serve in health provider shortage areas stay in the market 5 years after their obligation is fulfilled for loan forgiveness. With that in mind, some innovative hospitals and health systems are working to cultivate high performing high school students by building education and exposure opportunities to encourage these students to pursue careers in medicine. In 2011 the [University of North Dakota established the Scrubs Academy](#) where a group of local rural hospitals can send 7<sup>th</sup> -9<sup>th</sup> graders from their communities to a four day training seminar with hands-on education about different careers in health care. The program has now been around long enough start to see a return, as early Scrubs students are now entering medical school with the goal of practicing in their rural communities. Unfortunately, programs like this are rare as they require significant investment and outreach to large rural areas to generate meaningful interest among partner hospitals as this is a long-term approach and rural communities have immediate needs.

**Legislative Options:**

There are numerous pieces of legislation that have been introduced in both the House and Senate during this Congress that should be considered for inclusion in any legislative package seeking to make improvements in care delivery in rural and underserved communities. While not a comprehensive solution, Vizient supports the following individual pieces of legislation:

Regulatory Relief		
<a href="#">H.R. 1041 / S. 586</a>	<b>Critical Access Hospital Relief Act</b>	Repeals the 96-Hour rule that requires Critical Access Hospitals to certify whether a patient will either be discharged or transferred within 96 hours
<a href="#">S. 895 / H.R. 3416</a>	<b>Rural Hospital Regulatory Relief Act</b>	Permanently extends enforcement moratorium on direct supervision requirements for outpatient therapeutic services.
Telemedicine		
<a href="#">S. 1037/H.R. 2788</a>	<b>Rural Health Clinic Modernization Act</b>	Allows advanced practice PAs/NPs to operate Rural Health Clinics; allows local RHCs to be “distant site” locations for telemedicine interactions; increases reimbursement amount for RHCs.
<a href="#">S. 2408 / H.R. 4900</a>	<b>Telehealth Across State Lines Act</b>	Provides for study to examine telemedicine across state lines, provides grants for expansion of telemedicine providers (20 million over 5 yrs.), and creates a CMMI demonstration expanding use of telehealth across state lines
<a href="#">S. 2741 / H.R. 4932</a>	<b>Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019</b>	Expands access to the use of telehealth and remote patient monitoring services in Medicare
Workforce		
<a href="#">S. 948 / H.R. 2895</a>	<b>Conrad State 30 and Physician Access Reauthorization Act</b>	Extends Conrad 30 J-1 Visa program through FY 2021 so that foreign physicians who are willing work in rural areas can remain in the U.S.
<a href="#">S. 2406</a>	<b>Rural America Health Corps Act</b>	Creates a loan repayment program for individuals who agree to complete their service obligation in a health professional shortage area that is rural.
<a href="#">S. 348 / H.R. 1763</a>	<b>The Resident Physician Shortage Reduction Act</b>	Increases the number Medicare-supported Graduate Medical Education Slots by 15,000 over a five-year period.
Payment and Delivery System Reform		
<a href="#">S. 2648 / H.R. 5212</a>	<b>Rural ACO Improvement Act</b>	Modifies formulas used to calculate benchmarks for rural accountable care organizations.

## **Conclusion**

Vizient appreciates the committee's ongoing commitment to finding meaningful options to help improve care in rural and underserved communities. We hope our feedback will be constructive as the Ways and Means Committee, the Task Force and Congress work to identify and implement meaningful solutions to improve our health care system and patient outcomes. In closing, on behalf of Vizient, I would like to thank the task force for providing us the opportunity to comment on this important RFI.

Please feel free to contact me at [shoshana.krilow@vizientinc.com](mailto:shoshana.krilow@vizientinc.com) or Steve Rixen at [steve.rixen@vizientinc.com](mailto:steve.rixen@vizientinc.com) or at (202) 354-2600 if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

A handwritten signature in black ink that reads "Shoshana Krilow". The signature is fluid and cursive, with the first name being more prominent.

Shoshana Krilow  
Vice President of Public Policy and Government Relations  
Vizient, Inc.

CC:  
Representative Jodey Arrington  
Representative Danny K. Davis  
Representative Terri Sewell  
Representative Brad Wenstrup