OCHIN

A driving force for health equity

Transmitted via electronic mail to WMSubmission@mail.house.gov

March 11, 2024

The Honorable Jason Smith
Chairman
Ways & Means Committee
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Ways & Means Committee
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Re: *Statement for the Record – Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities*

Dear Chairman Smith and Ranking Member Neal,

On behalf of OCHIN, we appreciate the opportunity to submit comments for the record in response to the U.S. House of Representatives' Committee on Ways & Means' *Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities*. OCHIN is a national nonprofit health information technology and research network that serves nearly 2,000 community health care sites with 25,000 providers in 40 states, reaching more than 8 million patients including Critical Access Hospitals, rural and frontier health clinics as well as federally qualified health centers and local public health agencies. We strongly support your focus on opportunities and challenges to enhance access to care in patients' homes and modernizing care in rural and underserved communities. In rural communities across the nation, the infrastructure, workforce, and sustainable funding needed to keep the doors open among Critical Access Hospitals and community clinics simply do not exist. In a recent analysis, half of rural hospitals could not cover their costs, up from 43% the previous year and 418 rural hospitals across the U.S. are "vulnerable to closure."[1] Innovative and fundamental investments are needed to revive rural America—communities that serve as the bedrock of America's independence and self-sufficiency.

OCHIN: DRIVING INNOVATION, ACCESS, AND SELF-SUFFICIENCY

For over two decades, OCHIN has advanced health care solutions by leveraging the strength of our network's unique data set and the practical experience of our members to drive technology innovation for patients and providers in rural and other underserved communities. OCHIN offers technology solutions, informatics, evidence-based research, and workforce development and training in addition to policy insights. OCHIN has the largest collection of community health data in the country and more than two decades of practice-based research and solutions expertise. We provide the clinical insights and tailored technologies needed to expand patient access and connect care teams, and improve the health of rural and medically underserved communities. With over 137 million clinical records exchanged last year, OCHIN puts "one patient, one record" at the heart of everything we do to connect and transform care delivery. We ensure all health records flow seamlessly between patients and their many providers, giving clinicians greater insight into their patients' health and helping to complete the circle of care in

[1] Operating in the Red: Half of Rural Hospitals Lose Money, as Many Cut Services, KPP Health News (March 7, 2024) (Accessed March 8, 2024).

rural communities. We also drive interoperability on a national scale through our growing health information network and automated electronic case reporting for public health. In addition, OCHIN maintains a broadband consortium network to support rural health care providers access Federal Communications Commission (FCC) subsidies.

THE CHALLENGE: PERSISTENT HISTORICAL DISPARITIES COMPOUNDED BY DIGITAL DIVIDE

Rural communities face unique and formidable challenges that threaten their resiliency and sustainability. Across the nation, rural providers have crumbling infrastructure, inadequate payment models, endemic staffing and clinician shortages, lack of broadband hampered by bureaucratic and overly complex subsidy programs, and patients who must drive long-distances to access care (when they do have transportation and sufficient time). Addressing worsening health outcomes in Rural America and building vibrant rural communities go together. Rural providers that can sustainably provide health care in prosperous and challenging times alike remain the backbone of rural communities as a significant employer. And just as healthcare providers play a central role in rural communities, the vitality of our nation is dependent on a thriving Rural America.

Rural providers must manage:

- Higher Disease Burden and Health Disparities. Patients in rural communities are older and have a higher prevalence of chronic disease, such as heart disease, diabetes, and obesity than their urban counterparts. Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts. Shortages of mental health and behavioral health clinicians in rural communities have amplified the deadly consequences of the mental health crisis. Farmers are 3.5 times more likely to die by suicide than the general population.[2] Social determinants of health, such as poverty, limited access to transportation, and inadequate housing, contribute to health disparities among rural seniors. The Centers for Disease Control and Prevention (CDC) notes that rural seniors are more likely to experience food insecurity and social isolation, which can negatively impact their health and well-being.
- Higher Per Patient Costs and Risk. Rural providers shoulder higher per patient costs due to the lower volume of patients served yet payment policies do not reflect this basic financial reality. Rural hospitals need volume to lower their marginal cost to improve sustainability. Covering existing costs without a margin and at a loss prevents them from modernizing infrastructure (including health IT), investing in workforce development, cybersecurity, and digital health innovations including AI. Further, with the focus on value-based payment (VBP), identifying high-risk patients and implementing population health management strategies are essential for success in such models. Yet, rural providers have smaller patient populations, making it challenging to achieve meaningful risk stratification and develop targeted interventions for improving outcomes and reducing costs.
- Endemic Clinical and Operational Staff Shortages. While clinician shortages are prevalent across the nation, rural communities face more persistent and deepening shortages of primary care, specialty services, and emergency care due to geographical isolation. HRSA reports over 65 million Americas live in primary care Health Professional Shortage Areas (HPSAs), with a majority located in rural areas. Clinician shortages only tell half of the story. Rural communities also face

[2] Farmers 3.5 times more likely to die by suicide, National Rural Health Association says, 10News, February 23, 2024 (Accessed 3/11/24)

shortages of health IT professionals including those needed to strengthen cybersecurity. As the unfilled jobs gap widens, the onus has been placed on other non-health IT staff to acquire an increasing array of IT skills and competencies.

- Inaccessible Health IT Workforce Training and Development Programs and Technical Assistance. Existing federal and state programs do not provide rural providers ready access to funding for health IT upskilling programs and community-based training initiatives that provide ready on-ramps to careers for individuals without college degrees. Further, rural providers do not receive resources to hire technical staff nor access technical assistance that would ensure they can optimize digital health technologies. Existing workforce development programs do not reflect the health IT needs of rural communities. And rural providers do not have the resources and technical expertise to collect, analyze, and report the necessary data for VBP initiatives nor resources to implement essential cybersecurity measures and training. Addressing workforce training needs including promoting digital literacy among healthcare professionals and operational staff is essential to transform health care delivery and ensure cyber hygiene.
- Antiquated Health IT System and Aged Infrastructure and Buildings Requiring Basic Yet Costly Maintenance and Replacement. Adoption rates of upgraded and modernized electronic health records (EHRs) in rural healthcare facilities are lower due to cost barriers, technical limitations, and workforce capacity constraints. Integrating EHR systems with existing workflows and ensuring interoperability with other healthcare systems is costly and complex, particularly for small, rural providers and they have not received funding or resources to implement such updates, in over a decade. Interoperability challenges and fragmented health information systems impede the exchange of patient data between healthcare providers, hospitals, and clinics in rural areas. This lack of seamless data sharing leads to gaps in care coordination, redundant tests, and inefficiencies in healthcare delivery. Because of systemic underfunding of rural communities, rural providers are not able to maintain buildings and infrastructure nor retrofit or replace essential infrastructure creating conditions that undermine the delivery of care, and in some cases compromising safety and impeding efforts to recruit and retain staff.
- Limited Broadband Access and Arcane, Punitive, and Complex Subsidy Programs**.** Rural areas often lack access to high-speed internet infrastructure, which is essential for health information exchange, EHR, and a host of virtual services including telehealth, eConsults, and remote physiological monitoring. Without reliable connectivity, rural healthcare providers cannot deliver a range of virtual services and access online resources. The existing FCC program for rural health care providers requires specialized expertise, is complex, legalistic and resource intensive with loss of funding for failing to meet exacting, voluminous and duplicative documentation requirements. The providers that need it the most lack the resources (staff) to provide the volumes of documentation and information required by the FCC.
- Restrictive and Uncertain Telehealth/Virtual Services Regulatory and Payment Policies. The changing sands of Medicare reimbursement, potential reduction in reimbursement due to AMA's CPT Editorial Panel telehealth coding changes,[3] and varied state Medicaid, managed care and commercial health insurer payment policies creates confusion, complexity, administrative burden and financial barriers for rural healthcare providers. It also creates significant risk where

[3] There is concern that recent changes to CPT coding for telehealth changes will result in lower payment for virtual services even though the cost of such services is equal to the cost for in-person. (This will also overnight nullify state parity laws by creating parallel, but different codes for the delivery of the same service but using a different delivery mode.) In the OCHIN network patients who lack transportation or do not have stable housing are more likely to use telehealth options. Lower reimbursement for telehealth will disproportionately impact providers in rural and underserved communities.

continuous changes heighten compliance challenges. There is an unprecedented level of evidence demonstrating the value of virtual services to patients and providers in rural and other underserved areas. Yet, Medicare and other payers continue to add new restrictions and documentation requirements. And the regulatory environment also continues to change (licensure and controlled substance prescribing). This comes at a time of shortages and record rates of clinician and operational staff burn-out. This drives complexity and cost which ultimately closes the door for rural patients and providers.

- Skyrocketing Cybersecurity Risks and Threats and Inadequate Resources to Implement New AI Systems. Rural healthcare facilities have limited resources to invest in essential cybersecurity measures and infrastructure upgrades, making them vulnerable to cyberattacks and data breaches. Protecting patient privacy and securing digital health systems against cyber threats requires foundational investments that have not been made in Rural America. And as the race to innovate in health care is fueled by AI breakthroughs among flagship health systems and large technology companies, rural and underserved providers and communities will only be left further behind without the necessary infrastructure, staffing, and essential guardrails needed to implement and innovate in this space. All of this requires significant investments targeted to onboard rural and underserved providers.

RECOMMENDATIONS

Many of the challenges outlined above require strategic and targeted funding and programmatic streamlining of existing federal programs to remedy. The solutions are interrelated and involve investments in people as well as technology in addition to traditional brick and mortar. We outline several recommendations below that are an important starting point:

- Modernized Health IT Systems. Rural providers, particularly Critical Access Hospitals, require funding to adopt new fully integrated, right sized systems that can meet their patient population needs and optimize their financial sustainability. Currently, rural providers utilize dated, fragmented technologies. Alternatively, they are dependent on incentives that compel them to use large systems' health IT systems that do not meet rural patient clinical needs nor their operational/financial needs. In these arrangements, the needs of rural providers are secondary to the priorities of large health systems. Congress can leverage existing programs by directing federal agencies such as the USDA to streamline and simplify its community grants program as this could be used to fund adoption of modernized health IT. Currently, the arcane requirements of this program prevent rural providers, who do not have grant writers, from applying to these programs. Further, Congress could direct some of the previously authorized and appropriated broadband funding to include modernized health IT systems and cybersecurity as these are prerequisites to closing the digital divide.
- Virtual Specialty Services Network Dedicated to Patients in Rural and Underserved Communities Integrated with Primary Care Providers. VBP models require enhanced care coordination and integration across healthcare settings, including primary care, specialty care, and post-acute care. Rural healthcare systems face challenges in developing and maintaining care networks, collaborating with external providers, and ensuring seamless transitions of care for patients. We urge Congress to invest in a demonstration to test a virtual specialty services network that integrates and coordinates with rural primary care providers and specialists, so patients get care when and where they need it. For those rural hospitals or clinics that want to hire specialists to participate in the virtual specialty network, it will enable these rural providers to expand their geographical reach and increase their patient volume—thereby increasing sustainability and access. As discussed below in greater detail, we urge the Committee to support the passage of H.R. 7149, Equal Access to Specialty Care Every Act

of 2024 (EASE Act). The EASE Act would require the Centers for Medicare and Medicaid Services (CMS) Innovation Center to test a delivery model designed to improve access to specialty health services. The demonstration would fund the development of a panel of specialists using virtual modalities targeted to rural primary care providers and those in other underserved areas for their patients who are covered under Medicare, Medicaid, and self-pay (sliding scale). It would include health IT integration with primary care providers and the specialist network.

- Parity for Telehealth Services (Audio-Only and Interactive Video) While Extending the COVID-19 Public Health Emergency (PHE) Regulatory and Payment Flexibilities. The evidence-base produced by the COVID-19 PHE flexibilities—both regulatory and payment—has been substantial and represents real world evidence generated from different sites of care, regions, health conditions, and patient populations at a scale rarely (if ever) provided in the testing of clinical interventions and modalities. In the OCHIN network, the data has established that these flexibilities have not increased inappropriate utilization, but instead have expanded access to care in lower cost sites of care (ambulatory settings) and have afforded patients facing structural barriers such as lack of transportation and housing insecurity access to care. In addition, OCHIN has tested the use of eConsults to reduce lengthy wait times for specialty care (dermatology) in a frontier community and found that it resulted in cost savings and reduced wait times for those patients that required in-person care. Rural health clinics and Critical Access Hospitals should receive the maximum level of flexibilities to use virtual modalities and the payment must reflect the higher per person cost reality of care delivery in rural communities.
- Invest in Health IT (including Cybersecurity) Workforce Development and Training programs for Rural Communities. The ongoing and deepening shortage of health IT professionals illustrates the need for improved health IT workforce development and training of all health staff—not just staff in the IT department—particularly as the role of technology in care delivery expands. We recommend that Congress streamline existing workforce programs (developed for the 20th Century) and implement new ones that provide a direct on-ramp for individuals with high school diplomas or GEDs in rural communities as part of career ladders. Such programs should include training individuals from rural and underserved communities in partnership with community health clinics, local public health agencies, and Critical Access Hospitals as bridges and ladders to additional opportunities in health care and/or technology. The pathways should include entry points as community health workers or medical biller/coders to data and clinical quality analysts or health information management specialist to and beyond. We urge Congress to invest in online learning options that are coupled to placement opportunities with local rural health care providers to optimize care delivery, establish local career opportunities, and strengthen rural communities.

CROSS-CUTTING SOLUTION – SPECIALTY CARE ACCESS AND SUSTAINABILITY

We recommend that the Committee advance a multi-prong set of recommendations while also urging immediate passage of key legislation, the EASE Act, to test a solution that could address several of the outlined challenges. The EASE Act of 2024 would provide funding for a demonstration to build and evaluate a virtual network of specialty providers dedicated to serving patients in rural and underserved communities covered under Medicaid or Medicare to facilitate transitions to value-based care. This bill would not only test a method to expand access to essential specialty care services to patients but would test if such a model could serve as an on ramp for interested rural hospitals and other rural providers to increase volume for their specialists to drive financial sustainability as part of the dedicated specialty panel.

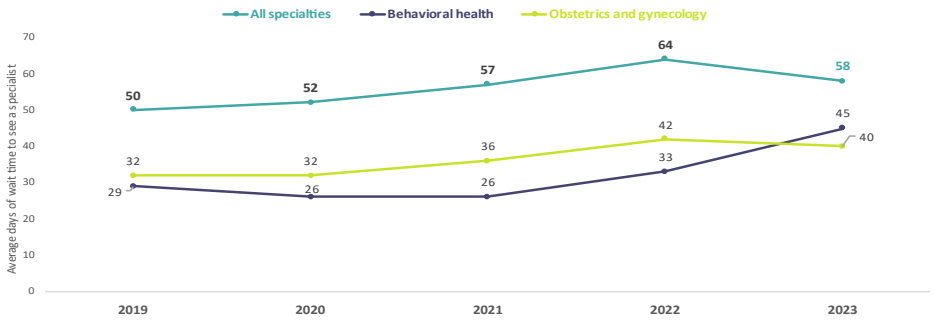
Lack of access to integrated specialty care for patients who live in rural and other underserved communities is a persistent challenge that will only deepen due to endemic clinician shortages and

demographic trends driving increased clinical need. Patients and primary care providers in rural communities need ready access to specialists to address chronic conditions like diabetes, heart disease, and mental health conditions. Left untreated, chronic conditions drive higher disease burden and costs to the health system while worsening health disparities.

OCHIN network data reflects local, regional, and national trends of limited access and lengthy wait times for specialty care, which drives health disparities in rural and other underserved communities. This reality was documented in the OCHIN network before the COVID-19 PHE and similar trends have continued despite the availability of extensive telehealth flexibilities during the COVID-19 PHE. The overall average wait time to see a specialist has increased to 58 days in 2023 from 50 days in 2019. The average wait time to see certain specialists is even more pronounced: neurologists (84 days), gastroenterologists (71 days), and ophthalmologists (66 days). Medicaid insurance is associated with a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance as found in a meta-analysis of studies evaluating access to care in Medicaid programs.

Average wait time to see a specialist increased from 50 days in 2019 to 58 days in 2023.

Average days of wait time to see a specialist by specialty type and year, 2019 to 2023*



*2023 data is for period 1/1/2023 to 8/31/2023

Source: Epic Clarity database accessed through Referrals DB, accessed 09/18/2023

OCHIN conducted a specialty demonstration to pair a rural provider with a dermatologist utilizing eConsults. The findings were clear that using virtual modalities drives access, improves the quality of care, and increases savings. This modality saved 59% of what would have otherwise been referrals to a dermatologist. Average time to care was reduced from 55 days to 10 days. Further, for patients who needed an in-person appointment with a dermatologist, they were prioritized based on need, and were typically seen more quickly than standard referrals.

Specialist shortages, geographic mismatches, lack of transportation, other structural impediments, and non-competitive Medicaid reimbursement rates compared to Medicare and commercial health insurers contribute to these delays. However, two powerful factors include the lack of: (1) specialist networks with requisite licensure and ready willingness to accept referrals from providers in rural and underserved communities; and (2) streamlined technological connections and technical assistance to support operational needs and coordination for specialists and primary care providers in rural and underserved communities.

It is critical to conduct the demonstration among providers with the most challenging mix of patients to ensure provider sustainability in rural and underserved communities. This model should be tested among providers that serve a significant number of Medicaid insured and under- and uninsured patients (who self-pay including on a sliding scale) along with those with Medicare coverage. In rural and underserved communities there are fewer Medicare and commercially insured patients relative to providers serving patients in more affluent communities.

While the recent CMMI Making Care Primary Model (MCP) demonstration contains many essential provisions to support sustainable transitions to value based payment, a key component that will undermine participant success remains the lack of dedicated specialty care clinician networks. The MCP model (which is limited to 8 states) provides a nod to specialty care access by providing a payment mechanism for services but does not address the lack of access that primary care providers and their patients have to clinician specialty networks that will accept the patient mix they serve. Such virtual specialty clinician networks do not exist.

The EASE Act demonstration would fund the technological infrastructure, technical assistance, and the creation of a dedicated virtual network of specialty clinicians that accept referrals from safety net providers. The virtual specialty network would utilize a range of virtual modalities (including clinical decision support, eConsults, and telehealth, for example) and coordinate care with primary care clinicians. The demonstration would test the impact on access, health outcomes, and the role of timely specialty care access that is coordinated with primary care on costs while also providing an assessment of the impact on sustainable transition to value-based payment for providers in rural and underserved communities.

CONCLUSION

Passage of the EASE Act along with the permanent extension of COVID-19 PHE telehealth regulatory and payment flexibilities along with improved parity of coverage of other virtual modalities in the Medicare and Medicaid programs for rural health clinics is a critical first start. Congress also can ensure already authorized and appropriated funding is used as ultimately intended—overcoming the digital divide faced by rural communities.

Thank you for your leadership. Please contact me at stollj@ochin.org if you would like additional data and information.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer