OCHIN

A driving force for health equity

Transmitted via electronic mail to Emma.Schultheis@mail.house.gov

June 12, 2024

The Honorable Cathy McMorris Rodgers
Chair
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn HOB
Washington, D.C. 20515

The Honorable Brett Guthrie
Chair
E&C Committee Health Subcommittee
U.S. House of Representatives
2434 Rayburn HOB
Washington, D.C. 20515

Re: *Statement for the Record – Hearing on "Checking-In on CMMI: Assessing the Transition to Value-Based Care"*

Dear Chairs McMorris Rodgers and Guthrie,

On behalf of OCHIN, we appreciate the opportunity to submit comments for the record in response to the U.S. House of Representatives' Energy and Commerce Committee's Subcommittee on Health *Hearing on Checking-In on CMMI: Assessing the Transition to Value-Based Care*. OCHIN is a national nonprofit health information technology and research network that serves over 2,000 community health care sites with 25,000 providers including Critical Access Hospitals (CAHs), rural and frontier health clinics as well as federally qualified health centers and local public health agencies in 43 states, reaching more than 6.1 million patients. The Centers for Medicare and Medicaid Innovation (CMMI) authority to test new models that can drive improved health outcomes and improve efficiencies is essential for rural providers that are facing a sustainability crisis. To date, few CMMI models have included rural providers (rural health clinics and CAHs, for example) and there remains an urgent need to test models to address the challenges Rural America faces including lack of access to specialty care. We support maintaining CMMI authority while urging increased focused on rural models and models to support underserved communities as there are significant opportunities to drive savings, improve operational efficiency, and improve outcomes in these areas. CMMI also has an opportunity to increase engagement with communities to learn more about their needs and improve transparency in the process utilized to develop new models.

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. We provide the clinical insights and tailored technologies needed to expand patient access, 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. In addition, OCHIN maintains a broadband consortium network to support rural health care providers access Federal Communications Commission (FCC) subsidies.

THE CHALLENGE: RURAL INNOVATION MODELS

We urge Congress and CMMI to focus on opportunities and challenges to the successful transition to value-based pay within rural and underserved communities including the need to break down barriers to care and provide and expanded access to integrated specialty care. In rural communities across the nation, the infrastructure, workforce, and sustainable funding needed to keep the doors open among CAHs 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, such as testing virtual specialty models as proposed in H.R. 7149/ S. 4078 Equal Access to Specialty Care Everywhere Act of 2024 (EASE Act of 2024), are needed to revive rural America—communities that serve as the bedrock of America's independence and self-sufficiency.

Rural communities face unique and formidable challenges that threaten their resiliency and sustainability. Across the nation among rural providers, the current payment and delivery models are not meeting patient needs and are de-stabilizing the viability of rural providers. CMMI is the only vehicle for testing new models in rural and underserved communities. Rural providers must manage:

- 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. There is an urgent need for CMMI to test new models and undertake additional demonstrations that identify sustainable delivery models in rural and underserved communities—this work is at a nascent stage.
- Restrictive and Uncertain Telehealth/Virtual Services Regulatory and Payment Policies. The change in Medicare reimbursement, potential reduction in reimbursement due to AMA's CPT Editorial Panel telehealth coding changes, and varied state Medicaid, managed care and commercial health insurer payment policies creates confusion, complexity, administrative burden, and financial barriers for rural healthcare providers and those in other underserved communities. It also creates significant risk where 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. CMMI can extend these flexibilities to test, for example, the delivery of specialty care through telehealth and other virtual modalities which is critical to evaluate the impact on outcomes and efficiencies created by providing care in lower cost sites of care earlier in the progression of disease.

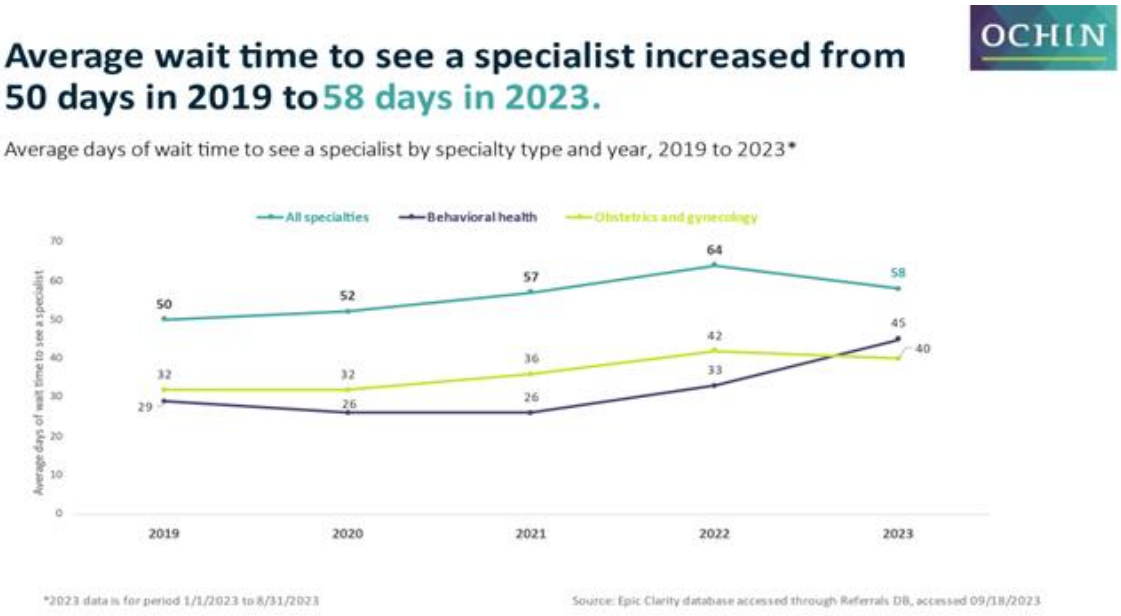
CMMI AUTHORITY AND THE EASE ACT DEMONSTRATION

An area where CMMI authority to test new models is best exemplified by HR 7149/ S 4078 EASE Act of 2024. This legislation enjoys bipartisan support and would require CMMI to undertake a virtual specialty network demonstration, which would offer integrated services in rural and other underserved communities to test the effectiveness of increasing access to specialty care through a range of virtual modalities. Furthermore, the EASE Act would test a dedicated network of specialists that is integrated into the primary care practices of federally qualified health centers, rural health clinics, other community health clinics and in partnership with other rural providers. Using technology to bridge the gap could help us deliver fully integrated care and bring us one step closer to high quality and high value care. This demonstration is an important assessment of a range of virtual care options including telehealth and eConsults (consultation between a primary care clinician and specialist concerning a specific patient) when delivered in coordination and collaboration with a patient's primary care clinician. In order to transition to new value-based models, timely access to specialty care services is an essential building block.

Representatives Michelle Steel and Susie Lee, and Senators Markwayne Mullin, Kyrsten Sinema and Thom Tillis introduced the EASE Act (HR 7149 / S.4078) to encourage CMMI to create a new payment model for rural and underserved communities to reduce long wait times many seniors and residents face in these communities when seeking care from a specialist. The bill was developed based on years of data OCHIN collected and reviewed to help community health centers and rural hospitals improve care integration and work with independent, large group physician practices across the country, as well as collecting data to create a new value-based payment model.

The case for CMMI's authority to test new models is crucial for rural communities—particularly in the area of specialty care access. 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 underserved 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 cost 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). OCHIN conducted a specialty demonstration to pair a rural provider with a dermatologist utilizing eConsults. This modality saved 59% of what would have otherwise been referrals to a dermatologist. The average time to obtain 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.

The wait time for patients and providers in the OCHIN network are not anomalies. Several recent publications underscore this is a challenge prevalent throughout the country. For example, in Pittsburgh, it is reported that wait times have continued to grow. Two major health systems in Pittsburgh, University of Pittsburgh Medical Center (UPMC) and Allegheny Health Network, were asked to provide their specialist wait times by a news outlet. Reportedly, both refused, but UPMC issued a statement that "[n]ationwide, there has been an influx of people seeking to catch up on specialty care they may have delayed during the pandemic and most U.S. health systems are facing challenges accommodating demand." Across the country in California there are reports that Medicare Advantage patients with chronic illnesses face geographical isolation as there is a lack of in-network providers for several hundred miles and require patients to travel far for care.[1] However, many patients may not be able to travel to far locations for care due to their chronic health conditions or lack of transportation. In Kansas, hundreds of rural hospitals are on the brink of closure and the threat of closure has only increased as they must contend with Medicare Advantage. Through Medicare Advantage, many patients do not have access to other benefits needed for their care, and as these small rural hospitals do not turn away patients, they bear the burden of sacrificing increased staffing and money to care for patients.[2]

[1] Tara Bannow, "Physicians Take Medicare Advantage to Task for Rural Patients' Care Gaps," STAT, June 2, 2024, https://www.statnews.com/2024/06/03/medicare-advantage-cms-comment-care-gap-provider-network/.
[2] Michael Mcaullif, "Rural Hospitals Facing Low Medicare Advantage Pay Risk Closing," Modern Healthcare, May 14, 2024, https://www.modernhealthcare.com/politics-policy/rural-hospitals-medicare-advantage-pay-closing.

Specialist shortages, geographic mismatches, lack of transportation and other structural impediments including in some cases lack of competitive rates to 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.

This is why CMMI authorities are critical to conduct demonstrations among providers with the most challenging mix of patients to ensure provider sustainability in rural and underserved communities. While the recent CMMI's 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 eight 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. It also does not include rural health clinics.

While Congress looks for ways to improve outcomes and reduce cost; and medical schools continue to look for ways to grow our physician workforce, one pathway that can fill the needs of communities (especially rural areas) and prevent costly hospital admission is the EASE Act which looks to utilize telehealth or e-consults to help our most vulnerable populations receive timely care.

CONCLUSION

The focus of both Congress and CMMI to address the payment needs of rural and underserved communities is crucial to ensuring the success of the transition to a value-based pay system. We also applaud efforts to increase transparency into the process for model selection and prioritization.

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