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Dec. 2, 2019

House Ways and Means Committee
Rural and Underserved Communities Health Task Force
1119E Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

The Association of State and Territorial Health Officials (ASTHO) is pleased to provide comments in response to the Rural and Underserved Communities Health Task Force's Request for Information. ASTHO is the national nonprofit organization representing the public health agencies of the United States, the U.S. territories and freely associated states, and the District of Columbia. ASTHO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to ensuring excellence in public health practice. Our comments below reflect these priorities and perspectives.

ASTHO appreciates that the committee aims to identify bipartisan policy options to improve care delivery and health outcomes within these communities. Our comments focus largely on rural areas, but many also apply to underserved regions and the U.S. territories. In many states and territories, there is a lack of access to care, particularly for mental health and substance abuse/misuse treatment, dental care, and HIV diagnosis and treatment. In remote areas, patients may have to drive many hours or even take medical flights to access services. In some instances, patients may forgo treatment until it is more serious and interferes with their daily lives, costing the healthcare system more than if the ailment was prevented in the first place.

The environments where people live, play, study, and work are critically important to improving the health and wellness of the population, and we are grateful that this committee is working on this issue. The committee's broad and influential jurisdiction is especially relevant to this issue, as the programs under your purview—from unemployment insurance to child support laws to family support for families—are places where elements of the safety net system connect to support those in our society who need it most. Each program can be an opportunity to lift someone up and improve his or her standing in life while supporting those factors that contribute to a healthy and balanced life. As we continue this discussion, we encourage the task force to think creatively about how we all can inject a vision of health and wellness into the programs that touch the people we serve.

Below are ASTHO's comments on the specific questions included in the request for information and included in our comments are hyperlinks to additional resources.

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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?

Results from a 2017 CDC *Morbidity and Mortality Weekly Report* research series [identified](#) higher rates of mortality among populations with certain health conditions and higher disease burdens, as well as lower life expectancies in rural areas compared to urban regions. According to the study, many 2014 deaths among rural Americans were potentially preventable, including 25,000 from heart disease, 19,000 from cancer, 12,000 from unintentional injuries, 11,000 from chronic lower respiratory disease and 4,000 from stroke. The study found that unintentional injury deaths in particular were approximately 50 percent higher in rural areas than in urban areas, partly due to a greater risk of death from motor vehicle crashes and opioid overdoses in those areas. Contributing to these problems, the distance to healthcare facilities and trauma centers and rapid access to specialized care can be more challenging for people injured in rural areas.

Individual access to care (and community economic vitality) can be strongly affected by hospital closures. As of February 2019, more than a [fifth](#) (21%) of rural hospitals were at a high risk of closure, and 277 (64%) of those were considered essential to their communities (measured in terms of trauma status, service to vulnerable populations, geographic isolation, and economic impact). ASTHO's blog post, "[The Impact of Rural Hospital Closures and State Responses](#)," provides additional information about this issue.

The additional systems or factors outside of the healthcare industry that influence health outcomes, called the social determinants of health, and include:

- **Reliable and affordable transportation options:** Reliable [transportation](#) allows residents to travel to work and maintain employment, access healthcare services, and purchase groceries—all of which directly correlate with improved health outcomes.
- **Access to broadband internet:** Broadband internet is critical to ensuring [capacity](#) to utilize technologies that expand access to health services, such as [telehealth](#) or access to electronic medical records. Broadband internet can also support healthy behaviors by connecting people to resources that can help them manage chronic health conditions. The high cost of broadband internet and broadband [connectivity gaps](#) can pose access to care barriers for rural populations.
- **Household income:** Rural communities have a [lower](#) average median household income and a higher percentage of children living in poverty compared to urban communities. According to a [study](#) published in the *Journal of the American Medical Association*,

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individuals with lower incomes are more likely to report unmet health needs and less likely to have health insurance.

- **Educational attainment:** Studies [indicate](#) that educational attainment is linked to healthier behaviors, better health outcomes, higher use of preventive services, and an increased life expectancy into adulthood. [Rural residents](#) are nearly three percentage points less likely to complete high school and nearly 14 percentage points less likely to obtain a college degree.

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?

Community health workers (CHWs) are an important workforce in rural areas with limited health services. CHWs come from the communities they serve, so they may speak the same language, share lived experiences, and have the same socioeconomic status as the clients they serve. Training community health workers may also boost community employment rates, should there be sustainable funding for CHWs. A factor that often restricts CHW employment is limited reimbursement for their services by most third-party payers (including Medicare and Medicaid), which means that financing CHWs often falls to grant-funded programs and small pilot programs.

Healthcare delivery systems' interest in CHWs has increased greatly in recent years, and systemic reviews of CHW interventions, such as those listed below, show consistent promise in mental health and chronic disease management among certain populations:

- **Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations:** This [study](#) shows that interventions by CHWs appear more effective when compared with alternatives and are cost effective.
- **Community Health Worker Interventions to Improve Glycemic Control in People with Diabetes:** [This](#) review of 13 randomized controlled trials involving CHW interventions showed a modest reduction in levels of hemoglobin A1c (a common indicator of diabetes) compared to usual care.
- **Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes:** In this [study](#), CHWs worked with low-socioeconomic status hospital patients to create individualized action plans for healing and recovery after release, providing tailored support for at least two weeks. Results included an increased likelihood that patients would

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obtain primary care, greater improvements in mental health, increased patient activation, and a lower likelihood of multiple 30-day readmissions (40% rate reduced to 15.2% in the control group).

- **Community Health Worker Support For Disadvantaged Patients With Multiple Chronic Diseases:** In this study, high-poverty, publicly insured patients with multiple chronic conditions worked with CHWs to achieve a disease management goal over six months. Results included improved mental health, increased support for disease self-management (63% compared to 38% in the control group), lower hospitalization rates (16% after six months compared to 17.8% for the control group, and 23% after one year compared to 32% for the control group).

Additionally, when expanding use of technology such as telehealth, it's important to build rural or underserved communities' capacity to identify their own healthcare access issues, set their own priorities, and connect their needs with appropriate resources to solve their own problems. Often, stakeholders present "solutions" to rural or underserved communities without their input and buy in. When communities are empowered to come up with their own solutions, the results are often more creative, appropriate, effective, and efficient. Some successful state models of these activities can be found in ASTHO's [telehealth resource guide](#).

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

In fee for service environments, it can be difficult for rural hospitals to achieve sufficient patient volume to remain financially stable. As a result, states are pursuing alternative payment models to improve access to care and rural hospital sustainability. Pennsylvania's [Rural Health Model](#) aims to improve health outcomes and access to care among rural residents through global budgets. Rural critical access and acute care hospitals participating in the model receive a fixed payment, set in advance, to cover inpatient and outpatient services. Participating hospitals must also create rural hospital transformation plans that offer a path for community feedback and engagement to help hospitals tailor their services to the local community's needs. The Pennsylvania Department of Health is working with CMS to advance this model. (Please see ASTHO's [blog](#) for additional information about this program.) Other state alternative payment examples include the following:

- Oregon's [Rural Health Reform Initiative](#) aims to transition rural hospitals away from cost-based reimbursement and toward value-based payments through coordinated care organizations. The initiative first investigated which hospitals would be unlikely to remain financially viable without cost-based reimbursement and measured hospitals' readiness to

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transition. In 2019, the Oregon Health Authority [recommended](#) 14 hospitals to transition to alternative payment methods, and non-contracted rates will be calculated for 2020.

- This year, Texas enacted a [bill](#) that adopts a prospective reimbursement methodology to pay rural hospitals that increases the state's authority to alter the reimbursement rate determination process. The bill sets forth a path to guarantee that rural hospitals are accurately reimbursed for the true costs incurred in providing care during a previous fiscal year.

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?

ASTHO encourages the committee to review our 2017 telehealth [resource guide](#), which thoroughly details telehealth state models, including the challenges they encountered. Moreover, the committee may want to review ASTHO's 2019 telehealth capacity survey [results](#), which revealed that nearly a quarter of the 39 responding state and territorial health agencies listed funding and reimbursement policies as their top challenge to advancing telehealth. The current telehealth reimbursement landscape varies across states and creates a confusing environment for individuals who use telehealth and health systems that provide care across multiple states. For example, the types of telehealth modalities that are covered under public and private payers vary from state to state: While all 50 states and Washington, D.C. provide reimbursement for some form of live video, only 21 state Medicaid programs reimburse for remote patient monitoring, and only 11 reimburse for store-and-forward telehealth services.

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

Healthcare workforce shortages can reinforce or contribute to health disparities. Rural communities tend to have [fewer physicians](#), nurses, specialists, and other healthcare workers, while also facing higher rates of chronic disease, mental illness, and obesity than their urban counterparts. Retaining adequate healthcare personnel in shortage areas is often a challenge, especially as healthcare personnel working in these areas often experience isolation from their peers and burnout from seeing a greater number of patients and working longer hours than those in non-shortage areas. To ensuring an adequate healthcare workforce, it's essential to improve the reach of provider recruitment programs, which can build a strong and diverse workforce that represents the population served.

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State and territorial health officials and their [primary care offices](#) are working with federal partners to provide training and tools for providers and residency students currently working in or looking to work in underserved areas, such as through the [J1 Visa Program](#), [National Health Service Corps](#), and [Nurse Corps](#). Primary care offices also collect data on local HRSA-designated health professional shortage areas (HPSAs).

In addition, state legislatures are attempting to reduce gaps in the available healthcare workforce through a variety of measures, including legislation that increases provider recruitment and retention programs and appropriating funding for healthcare workforce development programs. This year, states have introduced or enacted the following select legislation to increase access to healthcare by addressing healthcare workforce shortages.

Washington State

In April 2019, Washington state [enacted a law](#) to increase access to primary care by establishing the International Medical Graduate Workgroup, consisting of governor-appointed members that represent the department of health, health insurance carriers, and community and migrant health centers. This workgroup will study barriers to practice for international medical graduates and make recommendations for how the state can implement an international medical graduate assistance program by January 1, 2022. The legislation is intended to help integrate international medical graduates into the Washington state healthcare delivery system. In addition, in May 2019 the state [enacted a law](#) establishing the Washington Health Corps, a program that provides loan repayment and conditional scholarships to health professionals who complete a commitment to work in underserved areas of the state.

California

In May, the California Senate passed [Assembly Bill 1759](#), requiring the Office of Statewide Health Planning and Development to allocate appropriated funding for four programs that seek to increase the healthcare workforce in rural and underserved areas. Two of the funded programs focus on increasing opportunities for a diverse pool of students to pursue careers in healthcare. These programs aim to expand recruitment and training for students from areas of the state with a large disparity in patient-to-doctor ratios and students from other “underrepresented and low-income backgrounds.” The additional two programs focus on expanding loan repayment programs for primary care physicians and clinicians that agree to serve in HPSAs, as well as expanding the number of primary care physician and psychiatry residency positions in HPSAs.

Alaska

In May 2019, both chambers of the Alaska state legislature [passed a bill](#) that would provide student loan repayments and direct incentive payments to eligible healthcare professionals, as

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defined by a health care professional workforce enhancement program. This bill would also authorize the commissioner of health to appoint an advisory council to advise the department of health on the program. The advisory council would oversee and evaluate the program in areas that include identifying and monitoring underserved and professional shortage areas, eligible sites, and program data management.

Iowa

Lastly, Iowa [enacted a law](#) in May 2019 that will provide opportunities for residency students to participate in rural rotations for exposure to rural areas of the state. The University of Iowa will also conduct a physician workforce study on the state's workforce challenges related to recruiting and retaining primary care and specialty physicians. The study will examine current physician workforce data, projected physician workforce shortages by region of the state, and analysis of the availability of residency positions, with an emphasis on the need to recruit and retain physicians in rural Iowa. By providing financial incentives and collecting data on provider shortages, states can improve access to healthcare services in under-resourced communities and improve provider recruitment and retention.

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?

One way that states and territories may improve oral health and increase access to dental care is by utilizing mid-level providers to address the shortage of dental providers in underserved and rural areas. This can be challenging, as some dental provider groups oppose this move, but dental hygienists in school settings who are able to apply dental sealants in rural and underserved communities could potentially effect transformational oral health change in these areas. However, in order to realize this, reimbursements will need to be structured to make these arrangements financially favorable for rural dentists and their dental hygienists. This would increase access to dental services and move toward a sustainable solution for preventive oral health care in these communities. Incentivizing Medicaid programs to reimburse for dental care and incentivizing dentists in rural and underserved communities to take Medicaid patients would be another part of the solution to addressing access to oral care.

Another way to expand access to oral healthcare in rural and underserved communities is by [co-locating services and establishing bi-directional referrals](#). Strategies include improving the availability of clinical and preventive oral health services for children and adults, defining high-impact preventive services, establishing patient- and family-centered medical and dental homes, and screening for high blood pressure, diabetes, and prediabetes in dental offices. For example:

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- Colorado's [Cavity Free at Three](#) program trains medical and dental professionals to provide preventive services for children and pregnant women to reduce oral health disparities among at-risk populations. This program illustrates that beyond reclassifying oral health as primary care, it is important to establish bidirectional referral and collaboration with other primary care providers.
- North Carolina's Into the Mouths of Babes/Connecting the Docs [program](#) trains primary care physicians to deliver preventive oral health services for early childhood populations insured by the state Medicaid program. Through this initiative, Medicaid reimburses the provider for evaluation and risk assessment, parent and caregiver counseling, fluoride, and referral to a dental home for children from when teeth first come into the mouth to age 3 1/2. The program has contributed to a statewide decline in dental cavities since 2004 and has reduced disparities in early childhood tooth decay.

State and territorial health officials play a critical role in improving oral health and need to have the infrastructure and capacity to robustly plan, deliver, and evaluate dental public health activities and services. Strategies and promising practices for state and territorial health departments to consider include promoting the use of the Association of State and Territorial Dental Directors' [Guidelines for State and Territorial Oral Health Programs](#).

States and territories may also employ telehealth services to improve access to behavioral health services. Results from ASTHO's 2019 telehealth capacity survey, showed that 94 percent of states wished to expand behavioral health telehealth services in their jurisdictions, and 81 percent wished to expand chronic disease services through telehealth. These responses indicate a strong need for more behavioral health and chronic disease services delivered through telehealth.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

There is a need for standardizing of non-medical determinants of health measures, which is foundational to measuring health equity because currently, there is no clear consensus on the definition these determinants of health or standardized metrics. The lack of consistent methodology is a serious challenge to advancing population health level improvements and creating cost efficiencies. Standardization of metrics would enable states to identify best practices, scale up effective interventions, and replicate in other states. Standardization could also enhance the ability to share data across agencies and state lines and provide a national

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view of these non-medical determinants of health. State health agencies are creating their own indices and datasets to measure health equity, which can be a rich source of data for researchers ([Rhode Island Department of Health Statewide Health Equity Indicators](#), [Virginia Department of Health's Health Opportunity Index](#), [Vermont Social Vulnerability Index](#)).

Thank you for the opportunity to comment on the request for information. If you have any questions or require additional information please contact Carolyn McCoy, ASTHO's senior director of government affairs, at cmccoy@astho.org.

Sincerely,



Nathaniel Smith, MD, MPH
President, ASTHO
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