



UnityPoint Health

Oral Testimony

Prepared for the United States Senate Committee on Finance Hearing

Rural Health Care in America: Challenges and Opportunities

May 24, 2018

Submitted by:

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and

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Good Morning. My name is Sue Thompson, CEO of UnityPoint Health Accountable Care, serving the healthcare needs of thousands, in the states of Iowa, Illinois and Wisconsin. Thank you for this opportunity to address the committee on several of the challenges facing healthcare in rural America, and offer up some ideas for potential solutions. Now, I would be remiss, if I did not take this opportunity to publicly thank our Senator from Iowa. Senator Grassley has made access to quality healthcare in rural regions of our country a relentless priority. Thank you, Senator, for everything you do for Iowa and the country.

Before assuming my job at the corporate office of UnityPoint Health, I was the CEO of a small health system affiliated with UnityPoint in Fort Dodge, Iowa.

Trinity Regional Medical Center is a 49 bed hospital, including a group of physician clinics and home care services that over the years have held the designations of a 200 bed PPS hospital, sole community hospital, rural health clinic and most recently, a “Tweener”, as it participates in the Rural Demonstration Program.

Trinity has formal management arrangements with five critical access hospitals

and close referral relationships with sister UnityPoint metropolitan markets, including Des Moines.

But possibly, the most unique experience Trinity has participated in to date has been as a Medicare Accountable Care Organization (An ACO). Classified as a “Pioneer” ACO, Trinity took responsibility for improving the quality and lowering the total cost of care for approximately 10,000 Medicare beneficiaries attributed to them in this rural northwest Iowa community. They did this successfully, and continue to do so, as a Next Generation ACO. It is through this work the challenges facing rural health communities, hospitals and providers have become so palpably clear to us.

The first challenge to highlight is the dichotomy in the incentives that exist between those who operate under total cost of care programs like ACOs, Medicare Advantage plans, and bundled payments and their rural counterparts who operate under fee-for-service, cost-based reimbursement methods. While

the former looks to keep members healthy and out of the hospital, the latter is rewarded when hospital beds are full of Medicare patients. If the two groups worked in isolation from each other, this might work. But they do not. They are intrinsically woven together. The beneficiaries attributed to the Trinity Pioneer ACO move in and out of the rural facilities in the region. When regarding value-based payment models, the rural groups often ask, “where do we fit in?” To date, the answer to that question is, “you don’t.” The policy approach has been to exempt them from value-based payment policy altogether. We submit that this approach is not working and needs to change. Rural healthcare can fit into value-based payment models.

So, you wonder, “is UnityPoint Health advocating that cost-based reimbursement be deconstructed?” To that we answer, “no, we are requesting it be renovated.”

This brings me to the second challenge I must highlight, and this challenge is the greatest: Access to healthcare services in rural areas. Bringing quality care to

rural Americans comes at a cost. The cost is distinct from the actual provision of the medical service. These additional, unique costs relate to the time and distance from major service centers, lack of comprehensive community services, and healthcare workforce dead zones. We propose the renovation of healthcare delivery in rural areas include a value-based component tied to quality medical outcomes and expenditures, and that a separate and distinct payment structure is developed for the portion of cost-based reimbursement that pays for the costs associated with access in rural areas.

While our written testimony goes into detail around how such a system could be structured, I offer you some playful “do’s” and just one “don’t” as you design this type of system.

The Do’s

- Do encourage the CMS Innovation Center to develop pilots that test Medicare Advantage programs designed to work in rural markets like Iowa. We see great

potential for Medicare Advantage to bring the benefits of population health methods to rural areas.

- Do design ACO benchmarks to accommodate for the additional cost of bringing access to rural markets.
- Do support bills like the Rural Emergency Acute Care Hospital or “REACH” Act that allow rural hospitals to transition to new designations designed to meet modern needs.
- And do continue to allow telehealth practice to extend the reach of our in-person providers.

And with the upmost respect, one Don't:

- Don't embrace a policy that allows free standing ambulatory surgery centers to establish residence in rural markets and cherry pick patients by procedure – further straining the viability of community hospitals. I challenge you to find one for-profit, free standing, ASC that has an emergency room.

In closing, healthcare entities are the backbone of many of our rural communities.

They should remain the resource for healthcare emergencies, connecting to a

broader array of healthcare services, and wellness epi-centers. We need our rural

healthcare delivery systems to be viable and we need them to make the transition

to the rural health access centers we know they can become.

Thank you for the opportunity to share these views.



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Chairman Hatch, Ranking Member Wyden and Honorable Members of the Committee, On behalf of UnityPoint Health and UnityPoint Accountable Care, thank you for the opportunity to submit written testimony as a supplement to the oral testimony provided on May 24, 2018 at the *Rural Health Care in America: Challenges and Opportunities* hearing. By way of background, I am pleased to submit the following comments to further illustrate health care challenges experienced in rural Iowa, along with greater detail regarding potential solutions highlighted in my oral testimony.

Background

UNITYPOINT HEALTH

UnityPoint Health® is one of the nation's most integrated health systems. Through relationships with more than 280 physician clinics, 38 hospitals in metropolitan and rural communities and home care services throughout its 9 regions, UnityPoint Health provides care throughout Iowa, western Illinois and southern Wisconsin.

UnityPoint Health entities employ more than 30,000 physicians, providers, clinicians and staff. Each year, through more than 5.4 million patient visits, UnityPoint Health, UnityPoint Clinic and UnityPoint at Home provide a full range of coordinated care to patients and families. With projected annual revenues of \$4.08 billion, UnityPoint Health is the nation's 13th largest nonprofit health system and the fourth largest nondenominational health system in America.

UNITYPOINT ACCOUNTABLE CARE

Iowa Health Accountable Care, L.C., doing business as UnityPoint Accountable Care, L.C., is an Iowa limited liability company that brings together a diverse group of health care providers, including hospitals, physicians, and home health entities. As part of UnityPoint Health, UnityPoint Accountable Care is one of the largest Accountable Care Organizations (ACO) in the nation, with a growing network including 47 hospitals and more than 7,750 Iowa, Illinois, Wisconsin and Missouri physicians and providers and more than 85 skilled nursing facilities. In 2017, UnityPoint Accountable Care provider networks provided care for more than 200,000 lives in governmental and commercial insurance value-based arrangements. UnityPoint Accountable Care is one of the largest participants in the Centers for Medicare & Medicaid Services' (CMS) Next Generation ACO Model and is a leader in industry transformation.

In my oral testimony before the committee, I referenced the experiences of UnityPoint Health – Trinity Regional Medical Center (TRMC) in Fort Dodge, Iowa, and those of the five Critical Access Hospitals (CAH) it partners within the UnityPoint Health – Fort Dodge region – both in regard to designations under rural payment rules and TRMC’s participation as the Trinity Pioneer ACO – are responsible for the total cost of care of attributed Medicare beneficiaries.

UNITYPOINT HEALTH – FORT DODGE (TRINITY HEALTH SYSTEMS)

Trinity Health Systems, also known as the UnityPoint Health – Fort Dodge region, covers an eight-county area in North Central Iowa with a population of approximately 137,000. The region includes 27 primary and specialty care clinics, home care services, a Community Mental Health Center and its flagship hospital, TRMC. In addition, the region includes partnerships with five “affiliate” CAHs.

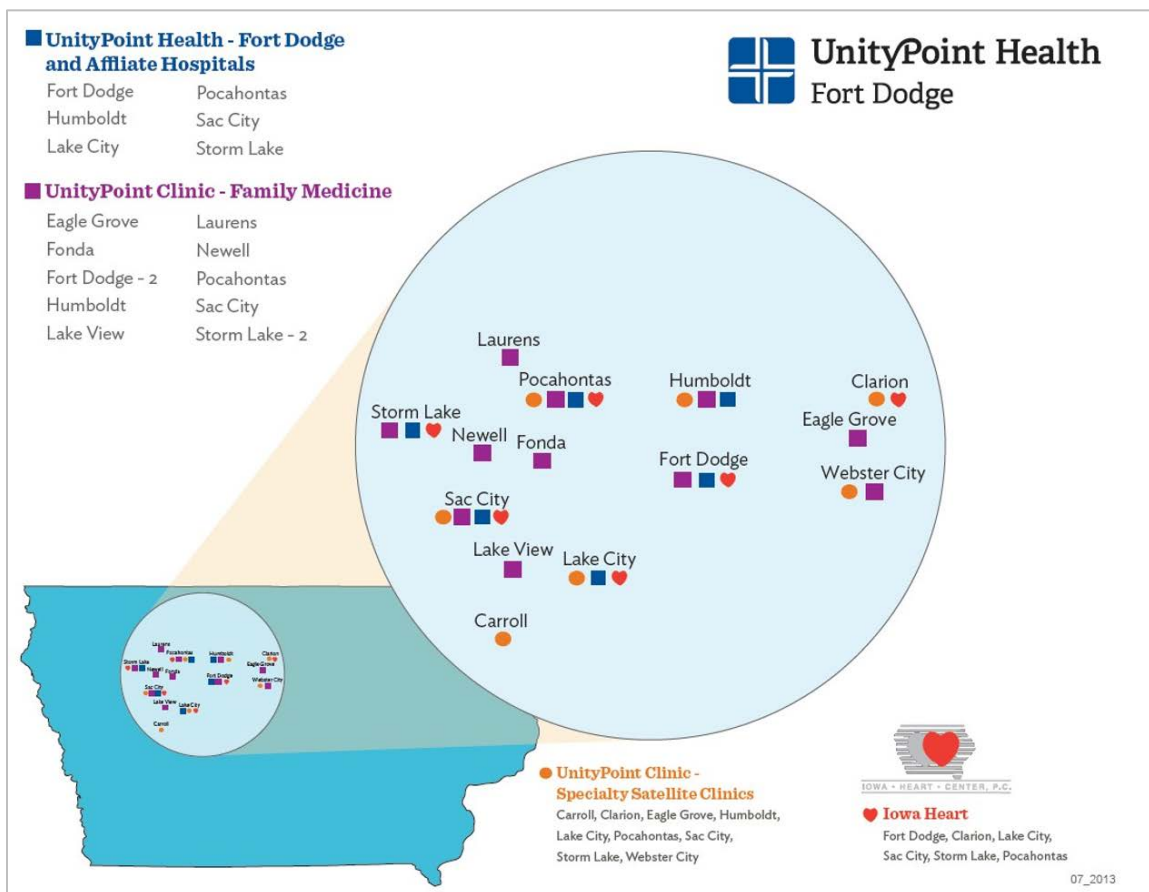


Figure 1: Map of the UnityPoint Health - Fort Dodge region and related entities and services.

UNITYPOINT HEALTH – TRINITY REGIONAL MEDICAL CENTER

TRMC, located in Fort Dodge, Iowa, is a licensed, non-profit hospital. In addition, TRMC is a safety-net hospital, designated by the CMS as a sole community hospital and a rural referral center. Most recently, TRMC converted from a Prospective Payment System (PPS) hospital to a “tweener” status hospital by reducing its inpatient beds to below 50. This conversion allowed TRMC to become eligible to participate in the CMS Rural Demonstration Program for the year 2018¹.

TRMC employs over 1,000 healthcare professionals, technicians and individuals with a medical staff of approximately 90 providers. In 2016, TRMC served 3,460 patients, with 51.9 percent having Medicare as a primary payor.

CRITICAL ACCESS HOSPITAL PARTNERS

As referenced above, TRMC provides management services to five CAHs in its eight-county service area. These hospitals include Buena Vista Regional Medical Center (Storm Lake, Iowa); Humboldt County Memorial Hospital (Humboldt, Iowa); Loring Hospital (Sac City, Iowa); Pocahontas Community Hospital (Pocahontas, Iowa); and Stewart Memorial Community Hospital (Lake City, Iowa). With a common electronic health record (EHR) platform shared between these entities, the CAHs serve as important extensions of the region’s care continuum.

TRINITY PIONEER ACO

In 2011, several healthcare entities, including TRMC and Trimark Physicians Group (now part of UnityPoint Clinic, the primary and specialty care arm of UnityPoint Health), came together to create the Trinity Pioneer ACO. Originally 1 of 32 planned organizations using the Center for Medicare & Medicaid Innovation Center’s (CMS Innovation Center) Pioneer ACO Model, its success took it to the final stages, positioning it as one of the final 19 Pioneer ACOs. **It is important to note that the five CAHs referenced in the previous section provide care to some of the Medicare beneficiaries attributed to the Trinity Pioneer ACO; however, the hospitals themselves were not participating entities in the ACO.**

Despite the small size of TRMC, the hospital and its region have been an early adopter of value-based service delivery. As a CMS Pioneer ACO Model participant, TRMC wholeheartedly embraced delivery system reform efforts to move from service volume

¹Centers for Medicare & Medicaid Services. (2017, April 17). Rural Community Hospital Demonstration [Press release]. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-17.html>

to population value. This entails a shift in investment away from inpatient care towards preventive and primary care with an emphasis on greater access to care in outpatient settings. The Trinity Pioneer ACO was able to produce two years of savings under the model while demonstrating strong performance in quality and patient experience^{2 3}, all of which earned national recognition from the U.S. Department of Health and Human Services (HHS), including an onsite visit from then HHS Secretary Sylvia Burwell, who commented that, “I’m here today to visit one of the great models of people accelerating change that the rest of the nation needs to do.”⁴

Due in part to its success in the Pioneer ACO Model, the Trinity Pioneer ACO has since migrated to the CMS Innovation Center’s Next Generation ACO Model under UnityPoint Accountable Care. Participation in this model makes many of the UnityPoint Health – Fort Dodge region’s physicians and providers eligible for Advanced Alternative Payment Model (AAPM) status under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

THE DICHOTOMY CREATED BY OPPOSITE INCENTIVES FOR PROVIDERS IN RURAL MARKETS IS A CHALLENGE

It is through this work that the challenges facing rural communities, hospitals and providers have become so palpably clear to us. While the success of the Trinity Pioneer ACO came by meeting quality metrics and lowering the total cost of care, its CAH partners were then and are still operating under a cost-based reimbursement model. The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to care by keeping services in rural communities. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services. Through this model, CMS reimburses CAHs for their “allowable” costs; that is, costs that CMS deems core to the business of operating a hospital⁵. This cost-based reimbursement model creates a different and often contradictory incentive to that which is in place under value-based models, including the Pioneer ACO and Next Generation ACO Models, among others.

² Pioneer ACO Model Performance Year 3 (2014) Quality and Financial Results. <https://innovation.cms.gov/Files/x/pioneeraco-fncl-py3.pdf>

³ *Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Evaluation Findings from Performance Years One and Two March 10, 2015.* (2015, March 10). <https://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>

⁴ Burwell touts UnityPoint Health ACO (2016, July 15), *The Messenger*. <http://www.messengernews.net/news/local-news/2016/07/burwell-touts-unitypoint-health-aco/>

⁵ *Critical Access Hospitals Payment System.* (2017, October). http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_cah_final09a311adfa9c665e80adff00009edf9c.pdf?sfvrsn=0

This dichotomy that exists between those who operate under total cost of care programs like ACOs, Medicare Advantage (MA) plans and bundled payments, and their rural CAH counterparts, who operate under a cost-based reimbursement model is not optimal. The population health movement, and more generally the movement to managed care in both the Medicare and Medicaid programs, and further encouraged by the construct of MACRA have left rural providers behind. Policy must be adjusted to encourage our rural partners to engage more deeply in value-based models, of which are outlined in the sections below.

Access to Healthcare Services Continues to be a Significant Challenge for Rural Communities

The second challenge highlighted in my oral testimony is the most daunting: access to healthcare services in rural areas. Bringing quality care to rural Americans comes at a cost. The cost is distinct from the actual provision of the medical service. These additional, unique costs relate to the time and distance from major service centers, lack of comprehensive community services, and healthcare workforce dead zones.

POTENTIAL SOLUTIONS FOR THE CHALLENGES IDENTIFIED

I. Redesign Rural Reimbursement in a Manner Which Divides the Medical Spend from the Cost of Providing Access

We propose payment for healthcare delivery services in rural areas include a value-based component tied to quality medical outcomes and expenditures, and that a separate and distinct payment structure is developed for the portion of cost-based reimbursement that pays for the costs associated with access in rural areas.

In Iowa, 82 of our 117 hospitals are identified as CAH⁶. Given the geographic density of these rural healthcare entities, there is potential to develop and implement a new rural healthcare delivery model that evaluates a cluster of hospitals in a defined geographic area of the state (for example, CAHs in a 30-mile area or a defined number of counties) that focus on select areas of care. Or, if these hospitals, in order to retain their cost-based structure, develop local integrated delivery systems that would then be aligned to an AAPM. These local delivery systems would be required to include either a minimum percentage or a

⁶ Rural health for Iowa Introduction - Rural Health Information Hub. <https://www.ruralhealthinfo.org/states/iowa>

defined number of aligned lives of the AAPM. As part of the local integrated delivery system, the CAHs would be required to offer a defined set of services, such as extended hours for primary care and mental health services (either face-to-face or through telehealth), 24/7 emergency department care and immediate connections to community-based social services that can address the needs of patients such as transportation, housing or food insecurity, among others. If these minimum criteria are met, the participating CAHs in the local integrated delivery system would keep their cost-based reimbursement. If CAHs unable to demonstrate success in the model, policy for modifying the cost-based reimbursement might be considered.

Policy Recommendations:

1. Design ACO benchmarks to accommodate for the additional cost of bringing access to rural markets.
2. Access to care payments should be left out of ACO benchmark calculations.
3. While access to care payments between rural and urban centers need to differ, rural providers need to be held to the same quality of care standards as urban providers for areas within their scope of expertise.

II. Create Rural Designations that are Meaningful to Modern Day Rural America

Policy Recommendation: Congress should create new designations for Rural Emergency Rooms and Rural Access Centers. Specifically:

- **Rural hospitals should be redefined in to specified categories based on average daily census.** An example categorization could define the hospitals as: (1) Small Rural (average daily census of five or fewer patients); (2) Rural (average daily census of six to 25 patients); and (3) “Tweener” (average daily census of 26 to 49 patients).
 - **“Small Rural” hospitals** would receive cost-based reimbursement for outpatient services in exchange for discontinuing acute inpatient services while maintaining 24/7 emergency department services.
 - **“Rural” hospitals** would continue to receive cost-based reimbursement if they are participating in an ACO, MA plan or

other value-based model that includes a component of downside risk.

- **“Tweener” hospitals** would receive “permanent”, ongoing cost-based reimbursement for inpatient services if they are participating in an ACO, MA plan or other value-based model that includes downside risk. In turn, these tweener hospitals should become a rural health “aggregator”, serving as a convener by which the populations served by the tweener and local “Small Rural” and “Rural” hospitals patient populations could form a rural ACO or other value-based arrangement.

Support bills like the Rural Emergency Acute Care Hospital (REACH) Act⁷ that allow rural hospitals to transition to new designations designed to meet modern needs. The Act would allow CAHs and PPS hospitals with 50 or fewer beds to convert to Rural Emergency Hospitals and continue providing necessary emergency and observation services. Rural Emergency Hospitals would receive enhanced reimbursement rates of 110 percent of reasonable costs, and enhanced reimbursement for the transportation of patients to acute care hospitals in neighboring communities.

III. Adjust the Medicare Advantage Program to Tie Rural Health Regions into Population Health Resources

Policy Recommendation: Encourage the CMS Innovation Center to develop pilots that test MA programs designed to work in rural markets like Iowa. We see great potential for MA to bring the benefits of population health methods to rural areas.

An MA/ACO Hybrid Model could leverage the successes of and lessons learned from high-performing, two-sided risk Medicare ACOs to shift from volume-based payments to a model designed to promote the delivery of higher quality care to rural Medicare beneficiaries. The underlying shared savings model for ACOs is not sustainable and ACO reimbursement still relies on a Fee-For-Service foundation. Although the MA Model has been increasing its national market penetration, regional market penetration varies significantly and rural states

⁷Rural Emergency Acute Care Act, S. 1130, 115th Cong. (2017-2018). <https://www.congress.gov/bill/115th-congress/senate-bill/1130/text?q=%7B%22search%22%3A%5B%22%5C%22Rural+Emergency+Acute+Care+Hospital+Act%5C%22%22%5D%7D&r=1>

have been slow adopters due in part to stringent network adequacy rules and Medigap plans that perpetuate Traditional Medicare.

Models submitted to the CMS Innovation Center that facilitate rural enrollment into MA Organizations (with integrated provider partners) and give regulatory flexibility to integrate clinically-nuanced ACO approaches into their benefit design, should be tested. It may be upon the chassis of MA plans that rural markets have the ability to tap into additional workforce, population health resource and connection to specialty care.

IV. Fully Utilize Telehealth as an Extender of In-Person Visits

Policy Recommendation: Congress has recently dramatically increased the telehealth services that are available through the Medicare program. We are appreciative of this movement, and encourage Congress to continue the loosening of restrictions surrounding when telehealth services are covered by the program.

V. Freestanding Ambulatory Surgery Centers are Threatening Rural Healthcare

Medicare covers surgical procedures provided in freestanding or hospital-operated ambulatory surgical centers (ASC). ASCs are distinct facilities that furnish ambulatory surgery; the most common procedures in 2015 were cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures. According to preliminary estimates from the CMS, Medicare payments to ASCs were \$4.4 billion in 2016, including both program spending and beneficiary cost sharing.

With recent reports that routine surgeries performed outside of hospitals in ASCs have led to 260 deaths since 2013, continued concerns about the lack of connection between ASCs and hospitals exist. As part of a national study on ASCs, Kaiser Health News and USA Today found that, while Medicare requires ASCs to have processes in place with local hospitals in the event that emergencies arise, the geographic location between a rural ASC and the nearest hospital can have fatal impact on patients in need of emergent post-surgical care provided in the rural ASC setting⁸.

⁸ Jewett, C., Alesia, M., & USA TODAY Network. (2018, April 24). As Surgery Centers Boom, Patients Are Paying With Their Lives. <https://khn.org/news/medicare-certified-surgery-centers-are-expanding-but-deaths-question-safety/https://khn.org/news/medicare-certified-surgery-centers-are-expanding-but-deaths-question-safety/>

In January 2008, Medicare began paying for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a new payment system that is primarily linked to the Hospital Outpatient Prospective Payment System (OPPS). Under the OPPS, Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule. Like the OPPS, the ASC payment system sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. Beneficiaries are responsible for paying 20 percent of the ASC payment rate.

Policy Recommendation: Prohibit freestanding ASCs from establishing residence in rural markets.

In Closing

Healthcare entities are the backbone of our many of our rural communities. They care for their residents from birth to death and should remain the resource for healthcare emergencies, connection to a broader array of healthcare services, and wellness epicenters. We need our rural healthcare delivery systems to be viable and we need them to make the transition to the rural health access centers we know they can become.

Thank you for the opportunity to share these views.