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Testimony to the House Committee on Ways and Means, Subcommittee on Health

June 26, 2024

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Chairman Buchanan,Ranking Member Doggett, and distinguished members of the Subcommittee, thank you for the invitation to participate in this hearing. My name is Sarah Chouinard, MD. I am a family physician and currently serve as the Chief Medical Officer for Main Street Health. I am a past co-chair for the Centers of Medicaid & Medicare Services' (CMS) Transforming Clinical Practice Initiative and past president of the West Virginia state chapter of the American Academy of Family Physicians. I grew up in Huntington, WV, where I attended medical school and completed my rural health track residency. For the 18 years after graduating medical school, I was Chief Medical Officer and a frontline physician at Community Care of West Virginia (CCWV), a Federally Qualified Health Center serving 48,000 rural patients annually. Today, I am Chief Medical Officer for Main Street Health, a rural value-based care company partnering with more than 3,800 rural primary care providers in 26 states and caring for over 650,000 rural seniors across America. I took this position to help address some of the toughest problems in healthcare, focusing on rural health equity. My intent in this testimony is to offer insights from my career by describing four lessons I have learned and offering three thoughts for future care delivery models serving rural patients.

I have seen firsthand how the current fee-for-service payment model leaves patients feeling overwhelmed by its complexity and doctors feeling overextended and unsupported.[1] Even in a sophisticated, outcomes-driven community health center like CCWV, a typical day in the life demands charting, filling out health plan forms, population health management phone calls, conferring with specialists, office management, data gathering, and community involvement. Burnout in fee-for-service medicine is real.[2] Compounding these problems, expenditure on primary care in the U.S. has diminished over the past decade, from 6.2% in 2013 to 4.6% in 2020 across all insurance types.[3] Medicare, which insures 1 in 3 rural adults, spends only an estimated 4.2% of its total spending on primary care.[4,5] Primary care providers need assistance, and the problems are exacerbated in rural settings.

Rural patients are older, sicker, and have higher rates of chronic diseases than urban and suburban Americans.[6] With over 60 million people living in rural areas, we can significantly impact the health of our country by focusing on rural health.[7] These circumstances warrant federal attention aimed at new models of care delivery. This opportunity for positive change is the reason I left my job of 18 years to join Main Street Health three years ago.

Main Street Health's mission is to bring value-based care to rural communities across the United States. Even though we launched only three years ago, we are already the nation's largest provider of value-based care focused exclusively on serving rural America. We believe in the old ways of medicine when healthcare was simpler. By partnering with local rural providers, we reinforce the importance of trust and relationship-driven care in rural communities. We have found that rural providers need more resources to ensure patients have access to the right care at the right time. That's why we provide our partner clinics with a community health worker (which we call a Health Navigator), data, and tools to succeed in a value-based care delivery model.

From my experience as a frontline primary care provider and as Chief Medical Officer at multiple rural healthcare organizations, here are four lessons I have learned that may be informative as you build future rural healthcare policies:

1. **Rural healthcare must be seen as one of the most – if not the most – important dimensions of improving healthcare inequities.**
   A health disparity, as defined by the U.S. Department of Health and Human Services, is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.[2] They adversely affect groups of people who have systematically experienced greater obstacles to health, like rural Americans. People living in rural areas often face significant barriers to healthcare access, including geographic isolation, limited

transportation options, and a shortage of healthcare providers. While 20% of the U.S. population resides in rural areas, only 10% of physicians practice there.[8] This discrepancy results in less access to primary care, creating inefficiencies that increase reliance on emergency care and leading to higher costs for the healthcare system.[9] The five leading causes of death (heart disease, cancer, unintentional injuries, chronic lung disease, and stroke) are significantly higher in rural areas compared to urban areas.[10] Simply applying models and workflows that have been successful in urban settings to rural communities is insufficient. Rurality is its own unique health disparity and new models must be built in consideration of these differences.

2. **Rural healthcare solutions need to build on the unique relationships that exist between patients and providers in rural communities.**
   Rural communities are built on trust, and new ideas are best received when they deeply involve the community itself.[11] At CCWV, we had 17 outpatient clinics scattered across small West Virginia towns. Each geography had its uniquely challenging characteristics, but what was consistent was that providers wore multiple hats as community leaders. Our patients were our neighbors. Doctors served as Little League coaches, attended church with their patients, and cared for generations in each family. The old ways of medicine where doctors visit patients in their homes, stay after hours to see sick kids, and meet worried patients in the office on the weekends to assuage concerns is still alive and well across rural America. We should make sure not to forget this, as there is incredible power in these relationships that can be used to significantly improve care in rural America.

3. **Rural clinicians need more resources to succeed in transforming care, but these resources must be focused on driving outcomes that matter to patients vs. just supporting the current delivery system.**
   At CCWV, we served as a hub in the community and as a safety net for patients. Being remote, access to comprehensive services was a challenge. For example, dental care was often not available in our communities, even though regular dental care is associated with 23% lower rates of ischemic stroke.[12] We routinely received federal grants to enhance our scope of services, like providing dental care, that would extend our ability to care for patients. However, once the grant lapsed, the care ended. The problem with grant funding is that grant dollars are not a sustainable source of funding. Grants are also often complicated in their requirements and the money is restrictive. Resources need to be focused on long-term programs that are connected to improving outcomes for patients. While no model is perfect, models like Medicare Advantage and the Medicare Shared Savings Program (MSSP) that have clear and transparent quality metrics, the potential to offer additional resources and payment to providers, and proven sustainability are the types of models that have the potential to transform rural healthcare over time.

4. **Addressing non-medical needs is important if you want to improve healthcare in rural America**.
   More than genetic factors or access to healthcare services, non-medical needs, often referred to as social determinants of health, have a greater influence on health.[13] In the fee-for-service model, addressing these non-medical needs – such as coordinating transportation, educating patients on their insurance, and solving for food or housing insecurity – is not incentivized. When I was in practice, understaffed care teams in a fee-for-service model did not have the time to focus on resource coordination. However, through the type of value-based care programs we participate in at Main Street Health, we have been able to embed Health Navigators in each of our partner clinics, and these individuals have been able to focus on caring for patients' non-medical needs. For example, we had a patient, who we will call Roger, who went to the emergency room three times in one month for respiratory complaints. Roger's Health Navigator leaned in and discovered that Roger was unable to pay his electric bill due to a short-term personal problem.

Without electricity, he could not use his electric nebulizer machine at home and sought emergency care for shortness of breath. Roger's Health Navigator helped him apply for a long-standing program offered by the local electric company that covers a specific dollar amount of monthly bill payment. With power restored, Roger ceased going to the emergency room and regained control of his chronic condition. Focusing on these type of non-medical needs is essential to improving health outcomes in rural areas.

In light of these lessons learned, there are three thoughts I would consider if I was designing policies focused on improving healthcare in rural America.

1. **New value-based care models in rural communities must be simple and easy to both understand and implement; these models should not require rural providers to change their technology tools and should not require significant upfront investments from rural providers.**
Rural health providers are often solo practitioners or small practices who lack administrative support.[14] It is unrealistic that overstretched primary care providers in small town America can stay abreast of policy updates, nuanced quality measure changes, and program opportunities while practicing in geographically and economically isolated communities.[15] On average, the primary care practices Main Street partners with have fewer than three providers in each clinic. These practices do not have quality improvement teams or in-house IT departments to track quality or payment metrics. If rural practices are to participate in value-based care models, the models must be simple and easy to understand and implement.

In our experience, it is important that new models do not require rural practices to change the technology they use. Over the past three years, Main Street has partnered with primary care practices that use 87 different Electronic Medical Records (EMRs), ranging from very simple software applications that are hosted on-site to more robust, cloud-based platforms. Had we asked these practices to change their EMR system or use new technology, they would not have partnered with us. Instead, we have learned how to build integrations with practices' existing EMR systems to provide clinicians the data and information they need in the EMR that they are used to working in every day.

CMS has made some progress on simplifying a subset of its value-based care programs. For example, the Medicare Shared Savings Program (MSSP) has gone from 10 quality measures in prior years to three quality metrics this year. However, it is unclear exactly how the implementation of these three measures will work in many rural practices, as the current CMS requirement is that these three measures be submitted through new electronic integrations that many rural practices and their EMRs may or may not be capable of. While Main Street has been able to help rural practices meet this new requirement through our integrations with practices' existing EMRs, many rural practices may not be able to meet this requirement on their own.[16]

Making upfront financial investment in new payment models is also unrealistic for most small rural primary care clinicians. Part of our success at Main Street is due to providing upfront, reliable revenue to providers rather than making them wait on shared savings payments. CMS has made some strides in this area, including launching the Advance Investment Payments (AIP) model, which offers eligible ACOs in rural and underserved areas an upfront payment of $250,000 and two years of quarterly payments if they enter the MSSP program.[17] CMS should continue to invest in similar easy-to-understand payment models.

To the extent that CMS models remain complex and hard to understand, it is likely that there will need to be groups like Main Street Health, regional rural hospital associations, statewide

Federally Qualified Health Clinic associations, and others who step in to partner with small rural primary care practices to help them participate in CMS's value-based care models. While this may be an okay outcome from a policy perspective, having CMS models be simple enough for practices to participate on their own would likely be ideal and lead to more rapid adoption of value-based care models across rural America.

2. **Rural care delivery needs to leverage every clinician (and non-clinician) at the top of his or her license.**
   To be able to deliver care in rural environments successfully, every member of a rural care team needs to work at the top of his or her license, and we need to learn how to leverage non-clinical staff like community health workers. At the core of Main Street's model is the Health Navigator, a non-clinical community health worker that we place in each clinic.[18] Health Navigators work directly with patients and offer assistance to seniors and clinicians to do all the things the clinic's current staff typically doesn't have time for: calling a patient after a hospitalization to ensure they come back to the primary care office for a visit, helping close quality gaps, and ensuring a patient's non-medical needs are met. We have seen first-hand that our Health Navigators make a tremendous difference in the lives of our patients and providers; they have helped close well over 100,000 HEDIS quality gaps for our clinic partners.

   Clinicians must also be able to work at the top of their license, and rural value-based care models need to be able to support this. For example, today there are 28 states where nurse practitioners have full-practice authority and can open their own practice.[19] Inconsistent with this policy, however, nurse practitioners cannot serve as qualifying providers for attribution to an accountable care organization (ACO) in the Medicare Share Savings Program (MSSP). Currently, the program requires beneficiaries to have 1 or more visits with a qualifying physician to be attributed to an ACO. Allowing primary care nurse practitioners to serve as qualifying providers for the sake of attribution (at least in rural practices where they are the most senior clinician) could be an effective way to expand access to this value-based program while simultaneously recognizing the importance of every provider working at the top of his or her license in rural communities.[35]

3. **Virtual care creates an emerging opportunity to increase access to specialty care in rural America.**
   Limited access to specialty care in rural communities has been shown over and over again to negatively impact the health and survival of rural patients.[20, 21] However, virtual care is creating significant new opportunities for specialty care delivery in rural America. For example, in many rural communities, patients with stroke symptoms can often experience a delay in care or stroke diagnosis due to the distance they need to travel to access specialized neurological services. However, this can, and in many cases is, now being addressed by the availability of virtual telestroke consultations that allow rapid consultation with a specialized neurological teams for diagnosis and treatment of patients who present in a rural hospital with stroke symptoms. These models have been shown to improve timely diagnosis and treatment for patients exhibiting stroke symptoms across rural America.[22] Telecardiology models are also showing promise for bridging the gap in rural specialty care. For example, in rural areas with a limited access to cardiologists and their associated procedures (e.g., ECG, echocardiography), patients too often are transferred immediately to the large metro hospital for a workup. Research has shown routine availability of electrocardiograms (ECGs) at the primary care level that are then read by a virtual cardiologist can facilitate early referrals to secondary care, reduce unnecessary referrals where appropriate, and improve both short-term and long-term mortality.[23, 24]

   Policy needs to support these types of virtual specialty care delivery models in rural areas. For example, today, some of these virtual specialty models involve a specialist conducting a virtual

visit with a patient and then prescribing a drug that can be infused for treatment on site at a patient's local hospital. However, these infusions are only sustainable in many case if the local hospital is eligible for 340B. Approximately 75% of hospitals in rural America are Critical Access Hospitals.[25] While the 340B program is arguably too large and being taken advantage of by many organizations, the fact that Critical Access Hospitals in rural America cannot access the 340B program for some of the most important specialty drugs seems inequitable and is a significant hindrance to expanding these virtual models into many rural communities (as background, excluding Critical Access Hospitals from access to certain 340B-eligible specialty drugs was a policy compromise made by Congress during the negotiations around the Affordable Care Act).[26, 27]

As demonstrated by the above, I am an optimist on the possibility of improving care in rural America. I am seeing the progress that can be made every day at Main Street Health, as we partner with over 1,200 clinics and 3,800 rural providers across the country. If we continue to leverage the unique relationships that rural primary care providers have with their patients, create more simple value-based care models like Medicare Advantage and MSSP, leverage clinicians and non-clinicians at the top of their ability, and implement new virtual specialty delivery models, there is a true opportunity to improve the delivery of care in rural America and to decrease the rural health disparity that exists today across our country. Thank you for inviting me to testify and share my experiences.

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