

Rural Health Roundtable with Congressman Ron Kind, 2/23/11

I - CMS/Medicare INTERPRETATIONS

CAHs not being able to contract for any “direct services.”

1. Outdated rules based on tying the RPCH (Rural Primary Care Hospital) criteria to RHC criteria at the outset of the RPCH demonstration program have led to this problem. The rule carried over in the hasty start up of the CAH program in 1997. **There is no basis for continuing this requirement for CAHs in 2011, considering all of the other current conditions of participation applicable to CAHs, and the point to which the CAH program has evolved.**

Provider taxes are not a reportable CAH cost

1. Support a reintroduction and passage of the Rural Hospital Protection Act (111th-HR 6346) that directs the Secretary of HHS, in determining reasonable costs for reimbursements to critical access hospitals (CAHs) after January 1, 2004, to include certain health care related taxes as allowable costs. Prohibits any offset, in computing such costs, against tax assessments paid by such a hospital of amounts the hospital receives from a state.

II - CMS/Medicare REGULATIONS

CAH Bed Cap

1. Seek legislation to eliminate the hard cap of 25 beds for CAHs and replace with an average daily census requirement. Flexibility will allow for CAHs to respond to public health or other emergencies with more effective and efficient care.

Health Care Reform

- *Concerns do you have about the implementation of ACA on rural hospitals and beneficiaries*
 1. According to RUPRI reports: (1) rural uninsured rates are higher than urban uninsured rates, (2) rural incomes are lower, and a (3) greater proportion of rural employed by small business. Consequently, **backing away from a national commitment to insure all Americans and creating health insurance exchanges for individual and small employer markets will hit rural America harder.**
 2. From RWHC Editorial “Rural Health Equals Rural Jobs”: Our country needs rural hospitals, doctors and other caregivers to do more, to do better and do it for less. This is a reality driven by an aging population and the need to be competitive globally. **But for rural America, it also matters where our state, federal and private sector health care dollars are spent. We who care about rural health must be heard—that the total impact of rural health is as much to keep and grow rural jobs, as it is to provide critically important health care locally.**

3. **We believe ACOs must recognize the uniqueness of health care in rural communities.** Unlike most urban communities, there are usually not enough providers to support multiple ACOs having closed provider networks. But many rural communities are located in areas that will have the potential for overlapping ACOs from multiple urban-based networks. To retain local access, rural communities will need local providers to be able to offer their services to multiple ACOs. CMS needs to develop criteria that support this approach by allowing both affiliated and independent local rural providers to participate in multiple ACOs and requiring ACOs to meet strong access standards.
 4. **The enforcement of current Community Access Standards is absolutely critical to prevent steering of Medicare beneficiaries and inordinate leverage by Medicare ACO plans against rural providers.** The current Medicare Advantage program statutes and regulations have required CMS to ensure that plan enrollees have reasonable local access to covered services. How CMS and ACOs will interpret what is “reasonable” is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. As stated in the CMS Medicare Managed Care Manual: “Plans must...ensure that services are geographically accessible and consistent with local community patterns of care.” It is critical that CMS be clear and transparent about how it intends to apply this principle to Medicare’s initial and subsequent generation of ACOs.
 5. **It must be recognized that ACOs have the potential to destabilize the existing rural safety net.** Once we are beyond the initial gain-sharing pilots, it is not known whether or not ACOs will be required to honor existing Medicare rural add-on payments for safety net providers such as Critical Access Hospitals and Rural Health Clinics.
 6. We must further strengthen the country’s primary care workforce and **make sure that primary care workforce, including general surgery, is adequately stocked in rural America.”**
 7. **Health insurance exchanges will create a bias against rural providers if their risk adjustment mechanisms do not consider access as a system goal or variable that effects payment.** I.e. the exchanges methodology for an “adjusted ‘cost’ basis” needs to take into account payments made for plans to meet network adequacy standards.
 8. Providers with Medicare and/or Medicaid “reasonable cost contracts” will be particularly vulnerable to under payment due to health insurance exchange risk adjustment mechanisms. PPS providers are financially incented to code as high of severity as allowable. Cost based providers have not invested at the same rate coding staff education and computer assisted decision aides. **CAHs and RHCs are much more likely to under-code co-morbidities and consequently lose reimbursements from insurers who face risk base adjustments to their premium dollars.**
- *Resources and information needed in order to implement the reform provisions*
 1. **Rural relevant metrics, data and best practices** to improve the transparency, quality and efficiency health care.
 2. **Sufficient healthcare workforce** willing and able to work in rural settings.
 3. **Capital and technical assistance for HIT**, particularly inpatient, to help finance the lengthy upcoming transitions.
 4. **Health insurance exchanges designed to promote local access.**
 5. **Health information exchanges designed to avoid anti-rural biases.**

III - CMS/Medicare RULES

CY 2011 Outpatient Prospective Payment System (OPPS)

- *Primary concerns with the final CY2011 OPPS rule*

1. It is a positive that CMS extends for an additional year—through CY 2011—its decision not to enforce the direct supervision policy for therapeutic services provided in CAHs and small and rural hospitals with 100 or fewer beds. **But the 2011 OPPS rule's requirement for physician "direct supervision" of certain hospital outpatient therapies, even with the changes from the original 2010 OPPS rule, will have an extreme and disparate impact on rural hospitals.**
2. **As hospitals have set protocols to address safety and quality, as required by Conditions of Participation (CoP), we do not believe that CMS needs to impose direct supervision on all Observation or drug administration services.** Direct supervision is not a requirement for inpatient services—to impose direct supervision for outpatient services is not clinically sensible. To suggest that the CoPs and payment regulations are unique to each other and to contrast their purpose is an extreme viewpoint. The inference that the payment regulations are primary and have precedence over CoPs is not in any beneficiaries interest.

- *Primary concerns with the physician supervision criteria*

1. Following “clarifications” in the 2009 & 2010 OPPS rules, CMS proposes in the 2011 OPPS rule, a set of 16 outpatient therapeutic services which require only direct supervision for the initiation of the service, followed by general supervision for the remainder of the service. All other services would continue to require direct supervision. **The burden of this revised policy change is of continued concern to rural hospitals and communities in which the shortage of physicians is especially severe, let alone that some of the services, such as Hydration (96360/96361) in and of themselves do not require significant monitoring and can be performed by many different levels of health professionals.**
2. **Minimally invasive procedures included in the current list requiring direct supervision by an MD/DO require no more than RN supervision in other Medicare-certified health care settings,** like nursing homes and home health settings. In fact, an intramuscular injection, such as a flu vaccine, can be administered in a grocery store, pharmacy, or casino. Is CMS implying that these low-risk procedures are more likely to have complications requiring physician intervention when provided in hospitals?
3. **What may be most problematic is that CMS apparently believes that small rural hospitals and Critical Access Hospitals (CAHs) operate in a world devoid of staffing and resource constraints.**

- *Primary concerns with the changes to the GME provisions*

1. CMS enumerated some positive developments from the Affordable Care Act (ACA), in particular the redistribution of unused residency slots. As mandated by the ACA, CMS will redistribute unused medical residency slots that have been vacant during a prior cost reporting period to other hospitals. **We continue to be very concerned that there will be too few residency slots available for a much needed expansion of rural primary care and rural general surgery residency slots.**

CY 2011 Medicare Physician Fee Schedule (MPFS)

- *Primary concerns with the final CY2011 MFPS rule*
 1. Congress again extended the rule that implements will ridiculously unmanageable reduction to Medicare physician payments beginning January 1, 2012. **Congress needs to fix the flawed physician payment formula and stop the dysfunctional brinksmanship.**
- *Concerns regarding the 60% primary care services threshold for the 10% incentive payment*
 1. It is a positive that the rule implements a 10 percent primary care incentive payment (PCIP) for primary care services delivered by a primary care practitioner for five years, as required by the ACA, beginning January 1. But **applying the same 60% threshold to rural and urban practices disadvantages rural communities (even though rural communities face greater shortages).** According to a May 2009 study by The Robert Graham Center, AAFP Center for Policy Studies, “The 60% threshold would capture nearly 60% of family physicians but a lower proportion of rural physicians, likely due to their naturally broader scope of practice.”
- *A positive regarding the CY2011 Physician Fee Schedule*
 1. **Not a concern but something we are glad about: along with the onetime “Welcome to Medicare” comprehensive physical exam, the rule adopts the ACA policy providing Medicare beneficiaries with annual wellness visits, including “personalized prevention plan services,” with zero cost-sharing, effective January 1.** Apart from the direct benefit to beneficiaries, it will also strengthen the physician-patient relationship in advance of acute medical care episodes.

CY2011 Home Health PPS

- *Primary concerns with the final CY2011 Home Health PPS regulation*
 1. **We are concerned that the accumulative effect of the following will cause access to access to rural home health services to decline:** reimbursement reductions, new requirements for face to face encounters by physicians, and changes being made in the therapy tiers. In addition we are concerned that there may insufficient coders with the expertise ICD10 available in many rural settings.
- *Reductions in reimbursement affect access to home health services*
 1. An insufficient revenue base, due to the reductions or the face to face encounters not made, can negatively impact home health agencies including potential closure of many rural agencies.

IV - HIT and Rural Hospitals

From Louis Wenzlow's Blog "Rural Health IT" (sponsored by WORH and RWHC)

- *Issues rural hospitals are facing in the adoption and implementation of HIT*
 1. **"The jury is still out as to whether CMS and ONC have any intention to do what it will take to ensure that the majority of rural providers are not practically excluded from the HIT incentive program:**
 - a. Will the legislation and the subsequent rulemaking help or hurt rural providers and the communities they serve?
 - b. Are policymakers honestly intent, as they have said, on working to address the issues of the digital divide between rural/small and urban/large providers?
 - c. What can decision makers be doing to make this program a success for all providers, including those who are starting at early stages of adoption and need the most help?"
 2. **"The meaningful use bar remains an extraordinary challenge for the majority of rural hospitals:** The final rule added some flexibility but also included new challenges, such as EHR implementation in the ED. It is still an open question whether most small rural hospitals will be able to attain meaningful use as it is currently defined. **The idea that the same meaningful use bar can be fairly used to measure achievement for providers at both advanced and early EHR stages remains problematic."**
 3. **"Traditional cost based reimbursement won't fix the problem:** Some have argued that traditional cost-based reimbursement should address these problems for CAHs. CAHs can just spend more, hire more people, etc. and they will be reimbursed at cost, the argument goes. If this were really the case, then why is there a disparity to begin with? The reason traditional cost-based reimbursement does not address these problems is that on average Medicare cost-based reimbursement covers only about 40% of a CAH's capital and operating costs. If there is no additional financial ROI for the HIT system (which there often isn't) and if the CAH is operating at near break-even (which many are), then the HIT investment can easily drive them into the red."
 4. **"The definition of CAH eligible expense should be clarified:** It's unlikely the HIT incentive program will even begin to address the digital divide between CAHs and larger hospitals and systems unless CMS both (1) provides clarity and (2) rules in a way that truly covers the array of costs **necessary** to implement advanced EHR environments... Given the vast array of depreciable costs that are **necessary to administer** and are **associated** with certified EHR technology, there is a real potential that the CAH bonus could actually make a difference. But until CMS validates that specific costs meet these requirements, the potential will go largely unrealized."
- *Resources needed in order for rural hospitals to fully participate in the HIT incentive payments and HIT adoption*
 1. **Limitations seen to date:** The Federal incentive program has been designed with a focus on advanced EHR users (which rural hospitals generally are not); and the Regional Extension Center technical assistance program has been designed with a nearly complete focus on the needs of primary care providers (i.e. Eligible Professionals) rather than hospitals.

2. **Access to capital:** “How will rural providers get the capital they need for the front end investment in EHRs, when they won’t be getting their incentive for years after they make the investment (since achieving meaningful use is a multi-year process)? ARRA allowed for the creation of a loan program to address this problem, but ONC elected not to pursue such a program. ONC should reexamine this decision.”
3. **Technical assistance:** “The ONC Regional Extension Center program was created to provide technical assistance. However, ONC has prioritized only a small fraction of available funds to help CAHs and other small rural hospitals. Many RECs will be utilizing the “rural hospital” funds to help rural hospital affiliated physician clinics rather than the hospitals themselves. So rural hospitals should not count on inpatient system technical assistance unless the REC in their region is making a concerted effort to provide it.”

MedPAC Rural Report

1. **A field trip to rural American by MedPAC staff, however well intentioned, does not create meaningful data.**
2. **In particular, MedPAC staff reported at the November MedPAC meeting that during their field work, rural Medicare beneficiaries did not report having problems accessing primary care.** To say the least, this is inconsistent with much experience and research over a long period of time. (Staff may have come to the conclusion that access was an issue by misinterpreting focus group participants who were reported as saying “they generally had a usual source of primary care.”)
3. In any event, data about current access barriers and current rural health professional vacancies is practically meaningless. **With access and workforce data, we must “skate to where the puck is going to be.”** The future impact on Medicare beneficiaries and the healthcare system of the upcoming baby boomer retirements leveling off of workforce supply and exponential increase in demand must be MedPAC’s focus.
4. **When comparing “rural” to “urban” it is important to disaggregate urban data:** (1) differences between rural and more adjacent suburban/small city locations can more clearly be seen as well as (2) similarities between rural and inner city challenges can more clearly be seen.
5. **It is critical that both Medicare and all-payer net margins be determined in any analysis.**
6. **DHHS Secretary Berwick’s Triple Aim* to improve health, improve care and reduce cost is as relevant to rural America as anywhere else. But this vision must be applied in a manner sensitive to the rural context of both the population served and providers locally available.**

(* The Triple Aim as developed by IHI is to (1) Improve the health of the population; (2) enhance the patient experience of care (including quality, access, and reliability) and (3) reduce, or at least control, the per capita cost of care.)
7. **MedPAC needs to support the development of rural relevant objectives when they discuss (1) best clinical and prevention practices, (2) quality metrics and (3) cost targets.**

8. Assuming that MedPAC will again stress the use of telemedicine, MedPAC must understand **that telemedicine is an opportunity to bring more services to rural beneficiaries as opposed to primarily being used to replace face to face services currently available.**
9. **Rural Medicare beneficiaries don't live in a vacuum.** The viability of a community's providers depends upon the insurance available to the rest of the community. As noted above, according to RUPRI reports: (1) rural uninsured rates are higher than urban uninsured rates, (2) rural incomes are lower, and a (3) greater proportion of rural employed by small business.
10. **"Rural health care means more rural jobs which in turn means healthier communities and more robust rural health care for the entire community, including Medicare beneficiaries.** Our country needs rural hospitals, doctors and other caregivers to do more, to do it better and do it for less. This is a reality driven by an aging population and the need to be competitive globally. **But for rural America, it also matters where our state, federal and private sector health care dollars are spent. The total impact of rural health is as much to keep and grow rural jobs, as it is to provide critically important health care locally.**
11. **MedPAC has a duty to challenge (and not perpetuate) myths about rural America** that have made their way into previous federal reports when drafted with minimum to no rural input:
 - a. Rural residents don't want to get care locally.
 - b. Rural folks are naturally healthy, need less.
 - c. Rural health care costs are less than urban care.
 - d. Rural health care is inordinately expensive.
 - e. Rural quality is lower; urban is better.
 - f. Rural hospitals are just band-aide stations.
 - g. Rural hospitals are poorly managed/governed.