

Western Wisconsin Rural Health Roundtable with Congressman Ron Kind & Centers for Medicare & Medicaid Services (CMS) Administrator Don Berwick at Jackson County Courthouse in Black River Falls on August 18, 2011

Suggested Talking Points and Questions for Dr. Berwick are in Bold Italics.

Followed by background commentary in normal font.

Final as of 8/11/11—the following items are in alphabetical order with no priorities implied.

1. Access Standards for Federally Funded Provider Networks

We believe that CMS must assure that Accountable Care Organizations (ACOs) and Medicare Advantage Plans meet reasonable access standards for health care in rural communities. How does CMS define and enforce such standards?

We support access standards that retain and hopefully improve access to care in rural communities. Wisconsin Statute 609.22. requires health plans (with closed provider networks) to respect “...normal practices and standards in the geographic area,” and Wisconsin Insurance Code 934 (2) (a) requires, with respect to managed care plans, “geographical availability shall reflect the usual medical travel times within the community.” Traditionally, CMS has had similar language for Medicare Advantage plans.

Enforcement of current Community Access Standards for the ACO model is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by Medicare ACO plans against rural providers. While the first generation of Medicare ACOs proposes to use a retrospective attribution model, it is reasonable to expect CMS to evolve the model over time to a prospective attribution model, requiring closed provider networks.

To that end, it is important that the first generation of ACOs meet strong access standards. 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 CMS has previously stated: “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.

2. ACO Proposal for Medicare Beneficiaries in Rural Communities

The current CMS ACO proposal does not recognize the uniqueness of health care in rural communities. For the proposed Medicare ACO attribution model to work for rural communities, rural physicians must be allowed to participate in more than one ACO. Is CMS willing to make that change?

Unlike in most urban communities, there are usually not enough providers in rural communities to support multiple ACOs having closed primary care provider networks competing with each other. Many rural communities are located in areas that will have the potential for overlapping ACOs with multiple urban-based networks. To retain local access over the long run, rural communities will need local providers to be able to offer their services to these 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.

How do we promote collaboration between urban and rural while respecting the competitive model inherent in regional ACO development? CMS needs to develop a rural model in addition to the current urban centric model. The current lack of a rural ACO vision is like when CMS introduced the wage index and every MSA got its own index and the rest of the state was thrown into one pot of leftovers.

CMS should develop a two-step attribution model for costs to ACOs. First, as now proposed, costs would be assigned based on use of primary care physicians. Then a second step would be added to attribute costs among ACOs depending on which specialists predominated with a primary care physician's patients. This would require specialists to declare a principle ACO affiliation as primary care physicians are asked to do. CMS would also need primary care physicians to declare a primary ACO affiliation for patients where no specialty care was provided.

3. ACO Potential Impact on Rural Safety Net

Once CMS goes beyond the initial ACO models, 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 (CAHs) and Rural Health Clinics (RHCs). What does CMS anticipate proposing?

Without rural add-on payments, the existing rural safety net will quickly unravel. The development of the CAH program was due to the fact that rural hospitals were shutting their doors and leaving rural residents without reasonable health care access.

4. CAH Bed Cap

In order to better meet the local variation in need of inpatient services, is CMS willing to support legislation to eliminate the hard cap of 25 beds for CAHs and replace it with an average daily census requirement?

This was proposed under the Critical Access Hospital Flexibility Act (111th-HR 668), which Congressman Kind also co-authored. Flexibility will allow for CAHs to respond to public health or other emergencies with more effective and efficient care. It would also not require CAHs to contact CMS regarding a variance when unforeseen events occur, potentially reducing subjective interpretations by CMS. A case could be made that CMS has previously moved towards flexibility when they imposed average length of stay rules rather than a hard cap.

Further, if Congress and CMS decide that an average daily census is a wiser requirement, we request that CMS would allow a window for those Small PPS rural hospitals that would have qualified for CAH status under the Governor's designation to reconsider if a change to average daily census is made. This would allow for appropriate community determination and secure long-term local access.

5. Chronic Disease Prevention

What steps is CMS taking to support the wellness of rural communities and help high-risk populations that are disproportionately located in rural and underserved areas?

We support the one-time "Welcome to Medicare" comprehensive physical exam; the rule adopts the PPACA 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.

Rural populations must be targeted in health education, chronic disease prevention, and healthy lifestyle modification before any initiative in rural health improvement can be effective. Existing programs that are based on proven evidence-based research should gain more financial backing, exploring and implementing payment reform that promotes preventive care and enhances chronic disease management.

Access to local prevention programming should be improved for rural populations. To provide enhanced access, we support and encourage: a) targeted and directed prevention initiatives to those populations outlined as high risk for chronic illness; b) working with rural communities to link with effective national, state, or county prevention programs and making them available to more people; c) supporting utilization of locations that are easily accessible, such as schools, churches, workplaces, community centers, and various healthcare facilities, and d) support of programs that recognize the influence of friends and family as participants in an individual's behavior change.

6. Commercial Insurance Inequities in Rural Communities

How is CMS working with national health reform to address the commercial insurance disparities that face rural America?

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. Rural America: (1) rural uninsured rates are higher than urban uninsured rates, (2) rural incomes are lower, and (3) a greater proportion of rural America is employed by small business.

7. Drug Pricing Program (340B)

Does CMS support the further expansion of the 340B drug pricing program to include orphan drugs?

CAHs should be made eligible for the full 340B Drug Pricing Program without the exclusion of orphan drugs. In addition, the 340B Drug Pricing Program should be expanded to include inpatient

drugs. This could be a huge cost saver for rural hospitals. When rural hospital costs are lowered, reimbursement from the government payers is lower, and therefore mutually beneficial.

8. Economic Development in Rural Communities

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. What is CMS' role in supporting rural economic development?

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.

9. Emergency Medical Services (EMS)

EMS services are quickly becoming unsustainable in rural Wisconsin. How can CMS support EMS services in rural areas?

We support the elimination of the 35-mile standard currently required for cost-based reimbursement for CAH ambulance services. This elimination is needed by rural Medicare beneficiaries to maintain services.

10. Federal Commissions

What is CMS' view on representation on federal boards and commissions, in particular MedPAC and the Independent Payment Advisory Board?

We support proportional rural representation on all federal healthcare-related commissions, task forces and advisory groups. Federal commissions should seek input and consultation from the Secretary of Health and Human Service's National Advisory Committee on Rural Health and Human Services. Additionally, such federal commissions should adequately address the impact of their considerations and recommendations on the rural health care delivery system.

11. GME

Congress is expected to be cutting GME at the very time rural communities desperately need to expand Rural Training Tracks and Rural Rotations. What can CMS do to help redistribute existing dollars more equitably between rural and urban sites?

CMS enumerated some positive developments from PPACA, in particular the redistribution of unused residency slots. As mandated by the PPACA, 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. Data has shown that where a physician trains is where they'll likely practice.

Rural ambulatory sites eligible for graduate medical education reimbursement through Medicare should be broadly defined. Urban or other teaching hospitals sponsoring rural training tracks should be allowed to recover costs through Medicare whenever they bear all or substantially all of the costs of resident education, including when residents are located at hospital sites that do not claim direct and/or indirect costs through Medicare.

12. Healthcare Workforce

What are CMS' top priorities to address current and forecast workforce shortages disproportionately affecting rural communities?

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. Congressman Kind helped secure \$400 million in PPACA to provide a bonus payment in fee-for-service payments to primary care physicians. CMS should look to work with groups on how to better incentivize and reward primary care providers.

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 the focus.

When comparing "rural" to "urban", it is important to disaggregate urban data so that: (1) differences between rural and more adjacent suburban/small city locations can more clearly be seen, and (2) similarities between rural and inner city which face similar challenges can be better compared.

13. Health Information Technology (HIT)

How can CMS and the Office of the National Coordinator for Health Information Technology (ONCHIT) better assist rural America in their efforts securing HIT?

Congress should require vendors of information systems used in rural communities to incorporate national standards for HIT into their systems. This includes systems used in all care settings to assure interoperability with both a larger network and within rural facilities.

Regional networks provide benefit to rural health care systems in providing economies of scale in the implementation of HIT. Federal and state government should assure the infrastructure and policy framework is in place to allow these networks to form.

Federal anti-kickback statutes and the Stark laws often limit adoption of HIT by limiting the ability of rural hospitals which are many times in the strongest position to invest in HIT to provide support to other providers. Stark and other applicable laws should be liberalized to allow rural hospitals to serve as the convener or hub for rural networks.

Rural health facilities need assistance in planning for, purchasing, and supporting HIT. ARRA/HITECH funding for rural hospitals and eligible professionals should be enhanced to address the unique challenges faced by rural providers and patients. Therefore, existing funding mechanisms need to be enhanced and new ones specifically focused on rural America should be created.

To facilitate the seamless exchange of information among rural health care providers, incentive payments for implementing EHR should be expanded to include payments to Home Health Agencies, Hospices, Skilled Nursing Facilities, Emergency Medical Services, and any other providers eligible for Medicare and/or Medicaid payments.

The importance of integrating broadband access and health IT should be a priority for any federal HIT program or effort. Factors unique to rural America such as long distances between health care providers and broadband network hubs, should be addressed with special consideration. Additionally, the importance of wireless broadband access to rural health providers, such as EMS who cannot utilize wired connections, should be included in federal broadband efforts.

14. Home Health under the Prospective Payment System (PPS)

How will CMS support the continued availability of home health services in rural America?

We are concerned that the accumulative effect of the following will cause 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. Additionally, we are concerned that there may be insufficient coders with expertise on ICD10 working in many rural settings. 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.

15. Hospice

How will CMS support the continued availability of hospice services in rural America?

Hospice services have historically been under-utilized in rural areas but it is the culminating step in the continuity of care for patients. We are concerned that pressures to cap costs will lead to reduced access in rural areas and only lead to less cost-effective and desired care of the patient. Further consideration should be used to determine if reimbursement is adequate and if capping per Medicare beneficiary is the best model to ensure rural services will be financially viable to continue.

16. Hospital Readmissions

Does CMS believe that there can be a hospital readmissions program that recognizes rural health care realities? If so, how?

We support a readmissions program that recognizes that rural healthcare facilities serve as a “one-stop” shop for rural residents. CMS is proposing to use the three currently reported 30-day readmission measures for heart attack, heart failure and pneumonia as part of readmissions reductions program that begins in FY 2013. Congress has directed CMS to exclude from the measures readmissions that are unrelated to the prior discharge such as planned readmissions and transfers; however, the measures exclude only a very limited set of planned readmissions. Rural hospitals tend to be the only point of care for a large geographical area and there is a larger probability that rural hospitals will see a larger percentage of readmissions so a stronger clarification on unrelated and planned readmissions is needed. We believe this would be better following the intent of Congress.

17. Hospital Services Furnished “Under Arrangement”

What is CMS’ view of services being furnished under arrangements at rural health care facilities?

CMS has suggested some providers have incorrectly interpreted which inpatient services a hospital may provide under arrangements and in turn wants to make a clarification to the Provider Reimbursement Manual (PRM), specifically nurses are not allowed to be contracted in the ED and outpatient departments because this regulation only applies to the inpatient side. We do not believe that Wisconsin rural hospitals have misinterpreted the PRM for service reimbursement. However, we tend to become concerned when CMS makes clarifications in proposed rules without a broader explanation or data to support. To this end, we would like to have CMS provide more information to make sure any changes wouldn’t negatively affect care coordination and service delivery models currently in place that have been able to reduce costs that are subsequently passed on to consumers.

Outdated rules based on tying the RPOCH (Rural Primary Care Hospital) criteria to RHC criteria at the outset of the RPOCH 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. It appears that CMS is further refining their position in the proposed CY2012 OPSS rule. We hope CMS will decide to earn some rural goodwill and impose a system that offers flexibility and coverage for rural health care providers.

18. Hospital Wage Index

The Institutes of Medicine (IOM) released their first phase report studying Medicare’s Geographic Adjustment Factors in early June. What is CMS’ view on these studies and some of their initial findings, especially in regards to the hospital wage index?

These recommendations provide an important first step in addressing the geographic disparities that have been hurting health care providers in Wisconsin for decades. In particular, the recommendation to collect new data on office rents and use data on the full range of occupations employed by doctors and hospitals are improvements over current policy. We would support IOM’s recommendation on the smoothing of boundaries for hospital wage indices between MSA and non-MSAs. However, we are very concerned about IOM’s proposal to again put rural physicians in single statewide non-MSA grouping.

The hospital wage index should be changed to reflect only legitimate differences in area wage rates, not average per employee expenditures that are biased toward urban areas. Use of the hospital wage index should be limited to hospital inpatient services. The currently mandated use for outpatient services, home health care, long-term care and Medicare Advantage payments should be modified to reflect only wage rates relevant to those specific services.

Further, CMS needs to take steps to address an obscure change tucked into PPACA that will net Massachusetts hospitals \$275 million more a year at the expense of nearly every other state, including Wisconsin, which will lose \$7 million per year in Medicare payments. The change requires that the money for Medicare hospital wage reimbursements be a fixed amount nationally, rather than a fixed amount for each state, meaning that any increase for Massachusetts requires a decrease for other states.

19. Medicaid Flexibility/Medicaid Maintenance of Effort (MOE) Waiver

What is CMS' inclination towards granting maintenance of effort waivers? What would be a strong argument for a waiver in CMS' view?

In order to address unsustainable spending levels in the Medicaid program for states like Wisconsin with high Medicaid enrollment, reasonable changes to eligibility and enrollment policies and procedures should be considered as an alternative to a significant reduction in the Medicaid eligibility income limit. Flexibility in granting waivers from the MOE requirements is needed to avoid across-the-board eligibility reductions. Our last State biennial budget called for \$466 million in Medicaid efficiencies left to be found, a waiver in the State's MOE will help achieve the savings while lessening the effects to the beneficiaries.

20. Meaningful Use

How can CMS best help rural hospitals reach meaningful use?

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.

21. Off-campus Provider-Based Services

The ability of CAHs to open off-campus provider-based locations is unduly restricted by existing provider-based regulations. To prevent abuse in a few situations, current regulations create a barrier for rural providers becoming more effective. Is CMS willing to support reopening this issue?

As primary care and other preventative and therapeutic services are able to move to an outpatient setting, it is important that CMS encourage and not impede the more effective provision of care to rural patients. This will also allow for hospitals to focus on acute care needs and rehabilitative services that require more advance or centralized medical equipment.

22. Medicare Advantage Plans

Does CMS have any plans to implement the recommendations that the State Insurance Commissioners proposed or other mechanisms to strengthen oversight of Medicare Advantage plans?

Over 30% of Medicare beneficiaries in Wisconsin receive their benefits through a Medicare Advantage plan. While CMS has safeguards in place to protect beneficiaries, there does not seem to be a mechanism for providers to seek a remedy if a plan is not abiding by Medicare regulations. Former Wisconsin Commissioner of Insurance, Sean Dilweg, served as Chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners and that organization proposed that CMS adopt rules to provide state insurance commissioners with additional oversight of Medicare Advantage plans.

Would CMS support requiring Medicare Advantage plans to go through the cost settlement process with CAHs like standard Medicare?

Currently, only some Medicare Advantage plans provide for a retrospective cost settlement, but that is a matter of contract negotiation. Absent contract language regarding a cost settlement, the plans pay a CAH based on the “interim rates” established by Medicare. These rates are an estimate of what the costs will actually turn out to be, but in the aggregate they may be more or less than what the cost report will determine. Medicare Advantage plans need to be required to reimburse CAHs at our cost-based reimbursement and perform a cost settlement process with CAHs like Medicare FFS.

23. Medicare Physician Fee Schedule (MPFS)

How will CMS handle any gap in Geographic Price Cost Indices (GPCI) payments to physicians between current law and PPACA?

There seems to be a potential regulatory gap in provisions dealing with the Medicare physician fee schedule work floor and the Practice Expense (PE) increases in the GPCI formula that were in PPACA. Providers throughout the country (including Wisconsin), have benefited from the physician work floor which has been in place since MMA 2003, and the PE increases made possible by PPACA are subject to some uncertainty regarding 2012 payments because PPACA Section 3102 required and funded changes for 2010 and 2011 and called upon the Secretary to implement changes on a budget neutral basis by January 1, 2012.

While there are changes recommended in PPACA governing PE for 2012, there are no provisions extending the physician work floor for 2012. Statutory provisions in PPACA Section 3102 call for a CMS analysis of medical office rents, and employee wages only. Without the physician work floor in place, organizations in low payment states may see the physician work component drop to their pre-2003 rates. For example, Wisconsin could face as much as a 4% PE cut and a 1.8% reduction off the work floor, which nets out to about a 3% cut, unless some continuity provisions are made.

24. Nursing Homes

A recent CMS rule will implement an average of an 11.1% cut in reimbursement for all skilled nursing facilities (SNF). Is CMS concerned that such severe cuts will disproportionately affect rural, hospital-based, SNFs potentially leading to closure which would lead to lack of access for rural populations?

CMS released the SNF PPS final rule for FY2012 on July 29; it contained a cut in Medicare reimbursement that, based on case-mix and on geographic location, may be larger or smaller than 11.1%. These reductions go beyond what is necessary for budget neutrality and a need claw-back from bad actors abusing the previously set rules on group therapy. This will threaten the ability to provide quality care to rural seniors. The changes in group therapy definitions that limit group therapy to exactly 4 patients is dictating a universal standard for service patterns without flexibility, and coupled with the reimbursement reductions, will be especially challenging for skilled nursing facilities to manage. The cuts may force many hospital-based non-profit nursing homes out of business and open the door for the major for profit entities that may provide a less desirable service for rural vulnerable populations.

25. Physician Supervision

Direct physician supervision should be required only when indicated by clear clinical evidence. Small rural hospitals and CAHs often operate under significant staffing and resource constraints. How can CMS implement responsible flexibility in their requirements for physician supervision at rural health care facilities?

Federal laws and regulations should take a common sense approach to physician supervision requirements in small, rural hospitals (PPS and CAH).

Following “clarifications” in the 2009 and 2010 OPPI rules, CMS proposed in the 2011 OPPI 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. In the final 2011 OPPI rule, CMS made allowance for non-physician supervision of therapeutic services, tightened up language on “immediate availability,” and promulgated a notice of non-enforcement through CY 2011 on hospitals with 100 or fewer beds and CAHs.

Moving forward, we would hope CMS would revisit the burden of such a policy change on rural hospitals and communities in which the shortage of physicians is especially severe, let alone that some of the services, in and of themselves do not require significant monitoring and can be performed by many different levels of health professionals. Furthermore, minimally invasive procedures included in the list required 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, i.e. a flu vaccine, can be administered in a grocery store, pharmacy, or casino.

We were disappointed that CMS chose not to match OPPI rules to the Conditions of Participation (CoP) to maximize flexibility in supervision standards. As hospitals have set protocols to address safety and quality, as required by CoPs, 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.

If any federal panel or entity, such as the Ambulatory Payment Classification (APC) Panel, is to determine physician supervision levels by procedure, then representation on such panel or entity should be expanded to include physicians that practice primarily in small, rural hospitals. It appears that CMS is addressing representation in the proposed CY2012 OPPI rule.

26. Provider Taxes

We believe provider taxes are an appropriate mechanism to support State Medicaid programs and should, like any other tax, be reimbursed as part of a cost report. What will CMS allow and not allow?

Provider taxes that CMS has approved for Medicaid Federal Financial Participation (matching) are Medicare allowable costs and Medicaid payments should not be used to reduce the amount of such allowable costs. We support the passage of the Rural Hospital Protection Act (HR 1398), which Congressman Kind is co-author, 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. The introduction was in reaction to the FY2011 IPPS proposed rule that sought a clarification in the Provider Reimbursement Manual for determining allowable

reasonable costs under Medicare and had the potential to interject a subjective process in determining allowable cost on a case by case basis.

The bill prohibits any offset, in computing such costs, against tax assessments paid by such a hospital of amounts the hospital receives from a state. Medicaid costs continue to increase and Wisconsin, like many states, has turned to assessments on hospitals to raise or not reduce Medicaid rates. Wisconsin is well under the allowable percentages in their hospital assessments under federal law, but it is important that these assessments—which are imposed “(f)or the privilege of doing business in this state”—are allowed to be included in a cost report. CMS decided to not enforce any clarification that the proposed 2011 IPPS rule was considering, but this has left great uncertainty for states that have provider taxes. Any change in current practice would erroneously characterize legitimate and much needed Medicaid payments for services provided to Medicaid patients as tax “refunds.” This change would drastically reduce rural health services by negatively affecting those hospitals with a disproportionately higher share of government reimbursed patients.

27. Relocation of CAHs

We agree that it is reasonable that a relocating CAH continue to meet the same criteria that led to its original state designation, serve at least 75% of the same service area, offer 75% of the same services, and utilize at least 75% of the same staff in its new location. In Wisconsin, it appears at the end of the day this has not been a problem. Have there been problems elsewhere that we should be aware of?

We support allowing CAHs to relocate and retain their CAH status without further review from CMS when the CAH moves within five miles of its existing location. CMS should revisit regulations and interpretative guidelines governing relocation of CAHs, which require a CAH to meet the necessary provider criteria under which it was originally certified and which defines new facility construction as relocation. While there have been some issues in the past with Wisconsin CAHs and relocation hurdles put up by the Region V office, we were thankful that the national office and Secretary of HHS were helpful in reaching a resolution, so that in determining relocation a CAH could meet their original designation criteria.

Hospitals like educational facilities have a limited lifespan, whether it may be a result of lack of space to expand a building footprint or need to update the facility’s technology or usable space to better serve patients. It is sometimes easier and more cost-effective to relocate and start anew as opposed to addition after addition. CMS plays the pinnacle role in the relocation of a facility and they need to provide certainty and timely communication in their determinations.

28. Risk Adjustment in Health Insurance Exchanges

What steps will CMS take to make sure that the risk adjustment mechanisms used by health insurance exchanges (and the wider individual and small group market) do not create a competitive disadvantage for rural health care providers?

Health insurance exchanges have the potential to 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.

methodology for an “adjusted ‘cost’ basis” needs to take into account payments made for plans to meet network adequacy standards. Health insurance exchanges need to be designed and approved to promote local access.

29. Rural Floor Budget Neutrality Adjustments

The current proposed rule does not fully explain the methodology or data variables that CMS used to calculate the effect of the budget-neutrality error made in prior years. What process is planned to address this issue?

We appreciate the restoration CMS is proposing in applying a +1.1 percent adjustment to IPPS standardized rates in recognition of a decision in the case, *Cape Cod Hospital vs. Sebelius*. In the attempt to provide better transparency, CMS should provide clarification to hospitals on precisely how CMS performed those calculation as well as the data sources it used.

30. Small Volume Data Reports

How can CMS work better with partners to better analyze small volume data from rural hospitals and the appropriately help and make sure the rural hospitals aren't disproportionately affected?

CMS proposes adding two new domains -outcomes and efficiency- to improve the Hospital Value-based Program (HVBP) to better patient outcomes and lower costs. We hope that CMS will acknowledge that low patient volume and/or the eligibility of those patients to be included in the proposed metrics, will affect the hospitals' performance in HVBP. This is true whether measuring their baseline, achievement or sustained rates. Small volume PPS hospitals have fewer cases; they will see more fluctuations in their measured scores and potentially go from 100% to 90% (or lower) with one case.

The HVBP includes both HCAHPS scores and core measures. HCAHPS will make up 30% of the VBP score. Patients discharged to swing bed programs and nursing homes are excluded as of July 1, 2011, discharges. This can be a significant portion of discharges for a rural hospital. So the smaller volume can greatly affect their measured scores in this area, just as with core measures.

Need development of rural relevant objectives when they discuss (1) best clinical and prevention practices, (2) quality metrics and (3) cost targets.

31. Telemedicine

What is CMS' vision for the use of telemedicine in rural facilities?

Use of 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.

32. “Upcoding”

Rural hospitals oppose the cuts under the past two proposed Inpatient Prospective Payment System (IPPS) rule that seem to be based on poorly isolated and unsubstantiated claims of “upcoding”, which CMS claims coding or classification changes that do not reflect real changes in case-mix. Given the evidence that small rural PPS hospitals case indices have not risen nearly as quickly as other PPS hospitals, why should they receive the same adjustment?

These cuts are especially tough in light of the \$2.6 billion in market-basket and productivity cuts to Wisconsin hospitals that are to be implemented over the next 10 years under PPACA. This prompted Wisconsin hospitals to ask and receive six of our Congressional Representatives (including Cong. Kind) to sign on to a “Dear Colleague” letter opposing these cuts. Further cuts on top of the \$2.6 billion in PPACA are unsustainable and will undermine the ability for rural Wisconsin hospitals to continue to provide care for our patients. This cut would also have a large negative effect on hospitals as they look to raise and invest capital to meet electronic health record requirements. We do appreciate that the final FY2012 IPPS rule did reduce the amount of the proposed cut for changes in documentation and coding from 3.15 % to 2.0 %.

33. Washington, DC

What is CMS’ view of the current environment in Washington and how it will affect funding for rural health care safety-net programs? How can CMS reduce the current “understanding gap” between itself and rural hospitals?

As Congress will continue to debate the nation’s debt and look to cut spending. We hope that CMS will prioritize safety-net programs that guarantee local medical access to rural Americans.