RAC
Rural Assistance Center

www.raconline.org

An update from the National Advisory Committee on Rural Health and Human Services

April 26, 2013

1:00 p.m. CT

Kristine Sande, Moderator

Presentation

- Q & A to follow – Submit questions using chat tab directly beneath slides
- Slides at www.raconline.org/webinars
- Do not close webinar window
- Technical issues: 701.777.6305

Presenters

NACRHHS Committee Chair

Ronnie Musgrove

Committee Members

Karen Madden

Dr. John Cullen

Roger Wells

The National Advisory Committee on Rural Health and Human Services (NACRHHS)

Rural Assistance Center

Webinar

April 26, 2013

What is the NACRHHS?

- An independent advisory board to the Department of Health and Human Services (DHHS) on issues related to how the Department and its programs serve rural communities

What Does the NACRHHS Do?

- Serves as an independent, external voice to DHHS Secretary
- Prepares an Annual Report and/or White Papers to the Secretary on key rural issues
  - In the past two years, the Committee has sent White Papers to the Secretary

Committee Background

- **1987** Established by the Secretary of HHS
- **2002** Secretary Thompson expanded the focus to include human services
- **21** Members currently on the Committee

Membership

- Comprised of 21 leaders in rural health and human services
- Chaired by Ronnie Musgrove, former governor of Mississippi
- Members represent 16 states

Meetings

- In 2012, the Committee conducted a winter meeting in Washington, D.C.
- Meets in the spring and fall, usually in the field
  - Members hear presentations from national and regional experts on the selected white paper topics
  - The field visits include site visits to rural locations and panel discussions around the selected white paper topics

2012 Field Meetings

- Kansas City, Missouri
  - June 18-20, 2012

- Austin, Texas
  - September 26-28, 2012

Rural Challenges

- Rural America has 20% of the Total Population
- Rural America has 10% of the Nation's Physicians
- There are 2,157 Health Professional Shortage Areas (HPSA's) in rural and frontier areas of compared to just over 900 in urban areas

Rural Challenges - 2

- More Dependent on Individual Market
- Small Businesses as Key Employer
- Around One Quarter of All Rural Adults Are Uninsured
- Heavy Dependence on Public Programs

White Paper Topics

- Implications of Proposed Changes to Rural Hospital Payment Designations
- Options for Rural Health Care System Reform and Redesign
- Rural Implications of the Center for Medicare and Medicaid Innovation (CMMI)

Implications of Proposed Changes to Rural Hospital Payment Designations


National Advisory Committee
On Rural Health and Human Services

Implications of Proposed Changes to Rural Hospital Payment Designations
Policy Brief December 2012

Editorial Note: *At its June 2012 meeting in Kansas City, Missouri, the National Advisory Committee on Rural Health and Human Services discussed the short-term policy implications of proposed changes to the designation and payment guidelines for small rural hospitals, as well as medium- to long-term visions for the future of rural health care infrastructure. Given the current fiscal and legislative environment, this first paper focuses on short-term questions related to possible revisions to the special payment designation criteria for rural hospitals, reserving consideration of broader systemic changes for the companion policy brief to be produced after the Committee's September 2012 meeting in Austin, Texas. In that companion paper, the Committee will attempt to look beyond incremental changes to rural health care infrastructure and use ideas introduced in this brief to take a more comprehensive approach toward prioritizing equitable access, encouraging consolidation and affiliation where appropriate, and simplifying systems of payment. The data referenced in this paper, unless otherwise indicated, come from a study conducted at the Committee's request by the North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina at Chapel Hill (Research Center[1]).*

INTRODUCTION

In recent months, plans to restrict or abolish special Medicare payment designations for categories of rural hospitals have been proposed by a variety of groups, including the Congressional Budget Office (CBO), the Administration, and the Medicare Payment Advisory Commission (MedPAC).

The current system of differential designations for paying rural hospitals has worked effectively to address the inequities and instability which followed the 1983 Medicare hospital payment reforms. The Committee agrees with the groups proposing reforms that these enhanced payment designations could be more efficiently targeted than under current law. It is concerned, however, that some current cost-saving proposals do not appear to accomplish this result in the most equitable or harmless fashion. In this paper, the Committee evaluates these proposals and examines additional principles and considerations that could guide more nuanced reform.

Two-Part Brief

- This policy brief serves as a companion to the next policy brief, Options for Rural Health Care System and Redesign.
- While this first brief takes a shorter-term, data-driven approach to examine several proposed changes to the payment system for rural hospitals, the second paper looks in the longer-term at the rural health care system as a whole.
- The Committee believes properly examining these proposals requires a short and long-term perspective

Proposed Changes to Rural Hospital Payment Designations

- Congressional Budget Office's "Mandatory Spending Option Number 24"
  - Proposed eliminating Medicare payment designations for CAHs, SCHs, and MDHs
  - Exists among a broad range of possible options laid out by the CBO to reduce government spending
    - CBO itself recognized that outright elimination of these designations might decrease health care access in rural areas
- Administration
  - Proposed eliminating the low-volume add-on payment, reducing CAH reimbursement from 101% to 100% of allowable costs, and revoking the CAH designation for CAHs within 10 miles of another hospital.
- MedPAC
  - Suggested that higher costs at CAHs may not be necessary, citing that 16% of CAHs are within 15 miles of each other.

Proposed Changes to Rural Hospital Payment Designations

- Administration outlined three proposals to revise the CAH payment system in its FY2013 budget:
  1) Eliminating the low-volume add-on payment;
  2) Reducing CAH reimbursement from 101% to 100% of allowable costs; and
  3) Revoking the CAH designation for CAHs within 10 miles of another hospital.
- The Administration estimated that these three changes would together save $6 billion over the next 10 years
- MedPAC
  - Suggested that higher costs at CAHs may not be necessary, citing that 16% of CAHs are within 15 miles of each other.

Proposed Changes to Rural Hospital Payment Designations

- MedPAC June 2012 Rural Report
  - Suggested that higher costs at CAHs near other hospitals may not be necessary, citing that 16% of CAHs are within 15 miles of another hospital
  - Stated that Medicare should not pay higher rates to two competing low-volume providers in close proximity
    - But are all nearby providers necessarily competing?
  - Concluded that Medicare payments to rural providers is currently “adequate”

Committee Analysis

- The Committee's analysis of these proposals relied on data drawn supplied by the North Carolina Rural Health Research and Policy Analysis Center.
  - Spatial analysis showed that revoking the CAH designation would have a large ripple effect across the rural health care system
    - Because of distance-based designation criteria, SCHs would revert to the PPS if CAHs were forced to revert to PPS.
  - Financial data indicated that CAHs nearby other hospitals generally have a higher Average Daily Census than more isolate CAHs.

Number of Hospitals Affected by Changes in Distance Criteria

Cutoff for Driving Distance from the Nearest Hospital for CAHs	Number of CAHs Converted to PPS	Number of SCHs Converted to PPS	Total Number of Hospitals Converted
<5 miles	13	4	17
<10 miles	55	13	68
<15 miles	245	39	284
<20 miles	571	87	658
<25 miles	872	135	1005

Source: The North Carolina Rural Health Research and Policy Analysis Center.
Analysis of hospital data as of December 31, 2010, presented to the Committee on June 18, 2012.

Committee Findings

- The data examined by the Committee brought assumptions implied in the proposals into question
  - CAHs nearer other hospitals did not appear to be competing for patients, often receiving higher patient volumes than average
  - While CAHs comprise 28% of all U.S. hospitals, they only account for 2% of overall Medicare spending
  - 19% of CAHs are at a mid-high to high risk of experiencing financial distress in the next two years. These hospitals are dispersed across the country, both near to and far from other hospitals.

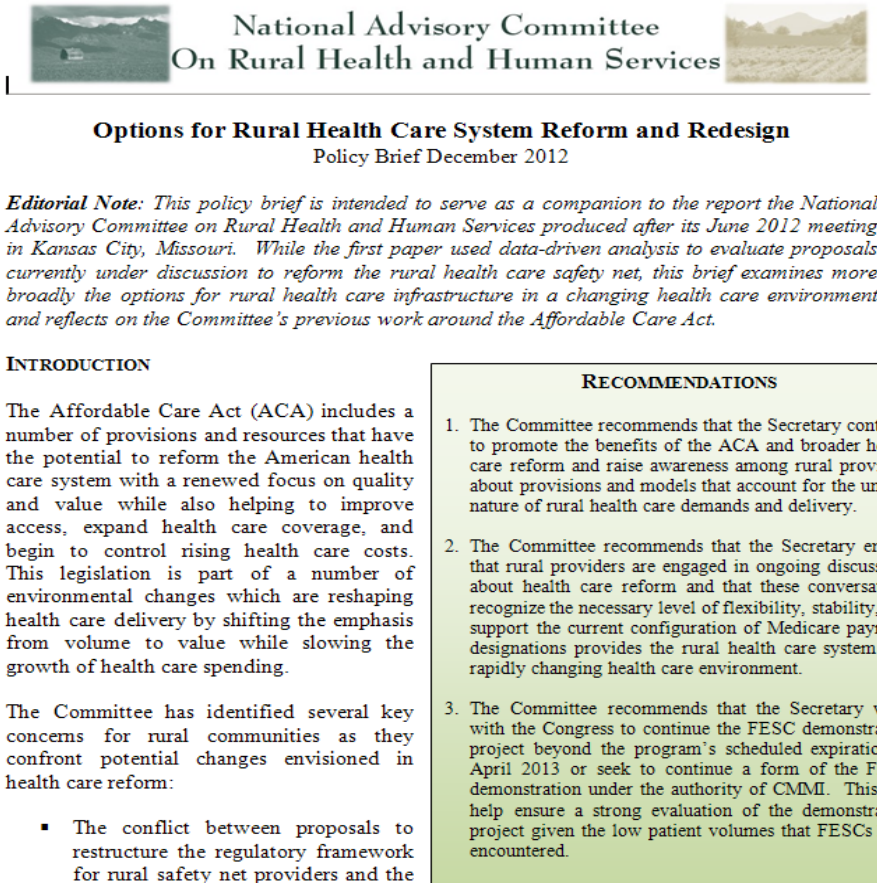
ADC DISTRIBUTION OF CAHs BASED ON DISTANCE FROM THE NEAREST HOSPITAL

Driving Distance in Miles to Next Closest Hospital						
Acute+Swing ADC	**Data Missing**	**<10**	**10 to <20**	**20 to <35**	**35+**	**Total**
Data Missing	0	0	3	3	2	8
<2	2	2	33	50	34	121
2 to <5	0	8	123	180	65	376
5 to <10	0	17	222	182	69	490
10+	0	28	135	134	24	321
Total	2	55	516	549	194	1316

Committee Conclusions

- The Committee concluded that the three proposed changes were too sweeping in nature and did not sufficiently consider the nuances highlighted in the Committee's analysis
- Revisions to payment designations for rural providers should reflect a longer-term vision of the future of rural health care infrastructure
  - Changes prompted primarily by fiscal measures may not best serve the needs of rural communities or prove sustainable

Options for Rural Health Care Reform and Redesign



National Advisory Committee
On Rural Health and Human Services

Options for Rural Health Care System Reform and Redesign
Policy Brief December 2012

Editorial Note: *This policy brief is intended to serve as a companion to the report the National Advisory Committee on Rural Health and Human Services produced after its June 2012 meeting in Kansas City, Missouri. While the first paper used data-driven analysis to evaluate proposals currently under discussion to reform the rural health care safety net, this brief examines more broadly the options for rural health care infrastructure in a changing health care environment and reflects on the Committee's previous work around the Affordable Care Act.*

INTRODUCTION

The Affordable Care Act (ACA) includes a number of provisions and resources that have the potential to reform the American health care system with a renewed focus on quality and value while also helping to improve access, expand health care coverage, and begin to control rising health care costs. This legislation is part of a number of environmental changes which are reshaping health care delivery by shifting the emphasis from volume to value while slowing the growth of health care spending.

The Committee has identified several key concerns for rural communities as they confront potential changes envisioned in health care reform:

- The conflict between proposals to restructure the regulatory framework for rural safety net providers and the

RECOMMENDATIONS

1. The Committee recommends that the Secretary continue to promote the benefits of the ACA and broader health care reform and raise awareness among rural providers about provisions and models that account for the unique nature of rural health care demands and delivery.

2. The Committee recommends that the Secretary ensure that rural providers are engaged in ongoing discussions about health care reform and that these conversations recognize the necessary level of flexibility, stability, and support the current configuration of Medicare payment designations provides the rural health care system in a rapidly changing health care environment.

3. The Committee recommends that the Secretary work with the Congress to continue the FESC demonstration project beyond the program's scheduled expiration in April 2013 or seek to continue a form of the FESC demonstration under the authority of CMMI. This will help ensure a strong evaluation of the demonstration project given the low patient volumes that FESCs have encountered.

Longer-Term Concerns of Committee

- Conflict between proposals to restructure regulatory framework for rural safety net providers and the need to meet short-term fiscal goals
- Lack of awareness among rural providers about ACA provisions and initiatives and other emerging national health care trends
- Need for further examination of new models and approaches to health care which take rural considerations into account

Observations from Site Visits

- Significant variation of health status and hospital financial condition even between neighboring rural counties
  - No two rural counties are the same
  - Rural counties are more vulnerable to boom-bust economies
- Surprising lack of awareness of ACA provisions and models
  - Preference for current models because the system was already understood
  - Interested in exploring potential of new models of care

New Models of Care: FESC

- Frontier Extended Stay Clinic
  - Five clinics completed this CMS Demonstration in April 2013
    - CMS Evaluation forthcoming
  - Program has saved CMS at least $14 million but extended services have cost an additional $25 million
  - Eligible clinics must be located at least 75 miles away from the nearest hospital
  - Provides communities unable to maintain a conventional inpatient facility emergency care capability
    - FESCs deliver normal clinic services as well as 24-hour emergency care and up to 48 hours of patient monitoring

New Models of Care: F-CHIP

- Frontier Community Health Integration Project
  - Authorized by MIPPA in 2008 but awaiting final design of demonstration project
    - Designed to explore ways to increase access to acute care, extended care, and other essential health care benefits by evaluating regulatory and payment challenges in frontier areas
  - CAHs in AK, MT, ND, and WY are eligible and must
    1) Have an acute-care daily census of <5 patients;
    2) Be located in a county with a population density of <6 people per square mile; and
    3) Offer at least one of the following: Home Health Services, Hospice Services, and/or Physician services.

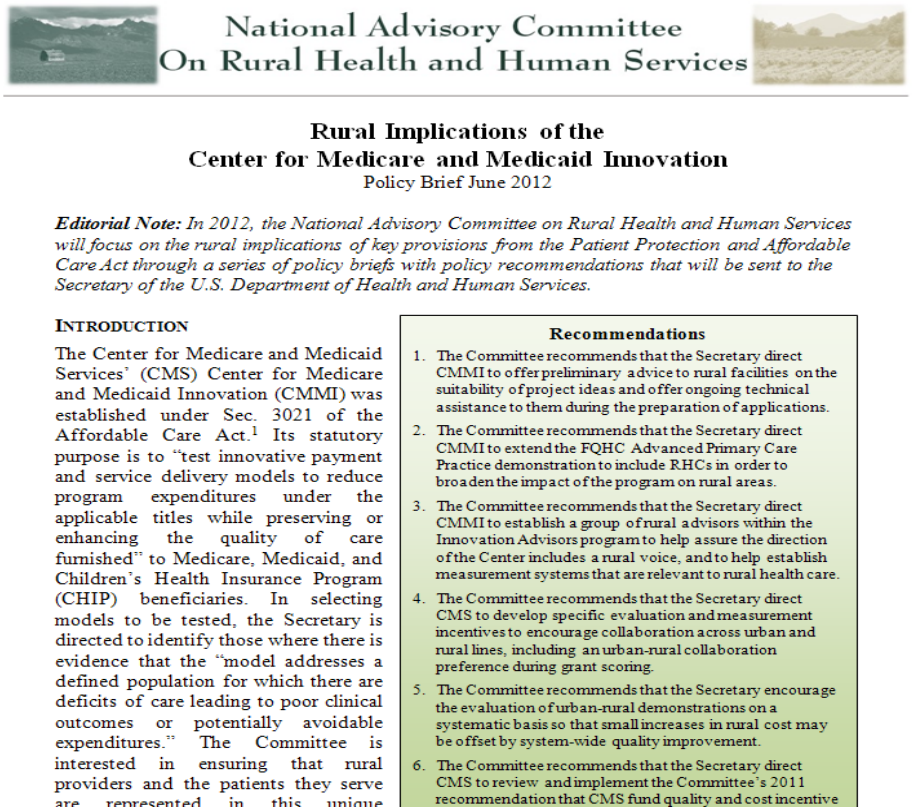
Key Recommendations

1) The Secretary should continue to promote the benefits of the ACA and broader health care reform and raise awareness among rural providers about provisions and models that account for the unique nature of rural health care;
2) The Secretary should ensure that rural providers are engaged in ongoing discussions about health care reform and that these conversations recognize the flexibility, stability, and support provided by the current payment system.

Key Recommendations

3) The Secretary should work with the Congress to continue the FESC demonstration or seek to continue a form of the project under CMMI's authority; and
4) The Secretary should encourage CMS to consider the full range of costs and savings when evaluating the FESC and F-CHIP demonstration projects.

Rural Implications of CMMI



National Advisory Committee
On Rural Health and Human Services

Rural Implications of the
Center for Medicare and Medicaid Innovation
Policy Brief June 2012

Editorial Note: *In 2012, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of policy briefs with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.*

INTRODUCTION

The Center for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMMI) was established under Sec. 3021 of the Affordable Care Act.[1] Its statutory purpose is to "test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished" to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. In selecting models to be tested, the Secretary is directed to identify those where there is evidence that the "model addresses a defined population for which there are deficits of care leading to poor clinical outcomes or potentially avoidable expenditures."[2] The Committee is interested in ensuring that rural providers and the patients they serve are represented in this unique

Recommendations

1. The Committee recommends that the Secretary direct CMMI to offer preliminary advice to rural facilities on the suitability of project ideas and offer ongoing technical assistance to them during the preparation of applications.
2. The Committee recommends that the Secretary direct CMMI to extend the FQHC Advanced Primary Care Practice demonstration to include RHCs in order to broaden the impact of the program on rural areas.
3. The Committee recommends that the Secretary direct CMMI to establish a group of rural advisors within the Innovation Advisors program to help assure the direction of the Center includes a rural voice, and to help establish measurement systems that are relevant to rural health care.
4. The Committee recommends that the Secretary direct CMS to develop specific evaluation and measurement incentives to encourage collaboration across urban and rural lines, including an urban-rural collaboration preference during grant scoring.
5. The Committee recommends that the Secretary encourage the evaluation of urban-rural demonstrations on a systematic basis so that small increases in rural cost may be offset by system-wide quality improvement.
6. The Committee recommends that the Secretary direct CMS to review and implement the Committee's 2011 recommendation that CMS fund quality and cost incentive

CMMI Authorization

- Section 3021of the Affordable Care Act establishes CMMI within CMS "to test innovative payment and service models that:
  1. Reduce program expenditures;
  2. Preserve or enhance the quality of care furnished to Medicare, Medicaid, and CHIP beneficiaries; and
  3. Address a defined population for which there are deficits of care leading to poor clinical outcomes or potentially avoidable expenditures."

CMMI: Unique within CMS

- CMMI has the ability to expand successful demonstrations outside of the formal rulemaking process
  - Can test and scale up projects rapidly
- Budget neutrality only applies to the continuation or formal adoption of projects, not for their approval or commencement
  - Requirement is written broadly

Promising Early CMMI Projects

- CMMI made 26 initial awards, some of which include a rural dimension:
  - FQHC Advanced Primary Care Practice Demonstration
  - Advanced Payment Accountable Care Organization Model
  - Partnership for Patients Initiative
  - Health Care Innovation Challenge
- Projects must be aware of the smaller scale and evidence base of rural providers and the need for regional integration and collaboration

Key Recommendations for CMMI

1) The Secretary should direct CMMI to offer preliminary advice to rural facilities on the suitability of project ideas and offer ongoing TA during application preparation;
2) The Secretary should direct CMMI to extend the FQHC Primary Care Practice Demonstration to RHCs;
3) The Secretary direct CMMI to establish a group of rural advisors within Innovation Advisors Program to establish a rural voice within CMMI;

Key Recommendations for CMMI

4) The Secretary should direct CMS to develop specific evaluation and measurement incentives to encourage urban-rural collaboration, including preference during grant-scoring;
5) The Secretary should encourage the evaluation of urban-rural demonstrations on a systematic basis so that small increases in rural cost may be offset by system-wide improvement; and
6) The Secretary should direct CMS to review the Committee's 2011 recommendation that CMS fund quality and cost incentive payments for rural hospitals from actuarially projected savings resulting from increased efficiency.

2013 Committee Meetings

- Grand Junction, Colorado
  - April 3-5, 2013
  - Looked at hospice and palliative care services in rural areas
  - Policy brief should be sent to the Secretary and made public this summer
- Bozeman, Montana
  - September 4-6, 2013
  - Will look at outreach and enrollment efforts around the ACA and unique challenges and opportunities in rural areas

Uses for the Committee Reports

- Inform the policy decisions of the Secretary for HHS
- Resource for rural providers who can then share findings and recommendations with others in the field
- Resources for policy makers

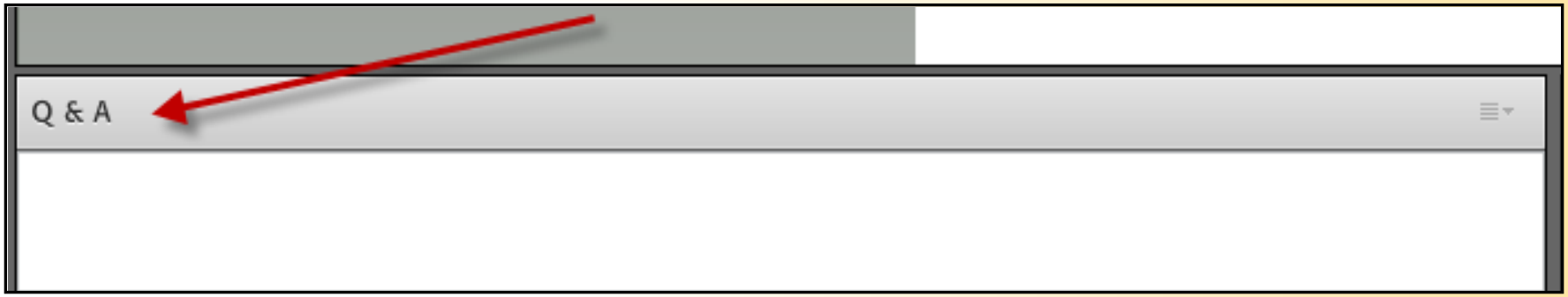
For More Information…

To find out more about the NACRHHS please visit our website at http://www.hrsa.gov/advisorycommittees/rural/ or contact:

Steve Hirsch
Executive Secretary, NACRHHS
Office of Rural Health Policy
Rockville, Maryland
301-443-0835
shirsch@hrsa.gov

Q & A

- Submit questions using Q & A tab directly beneath slides.



Thank you!

- Contact RAC at info@raconline.org with any questions
- Please complete webinar survey
- Recording with be available on RAC website