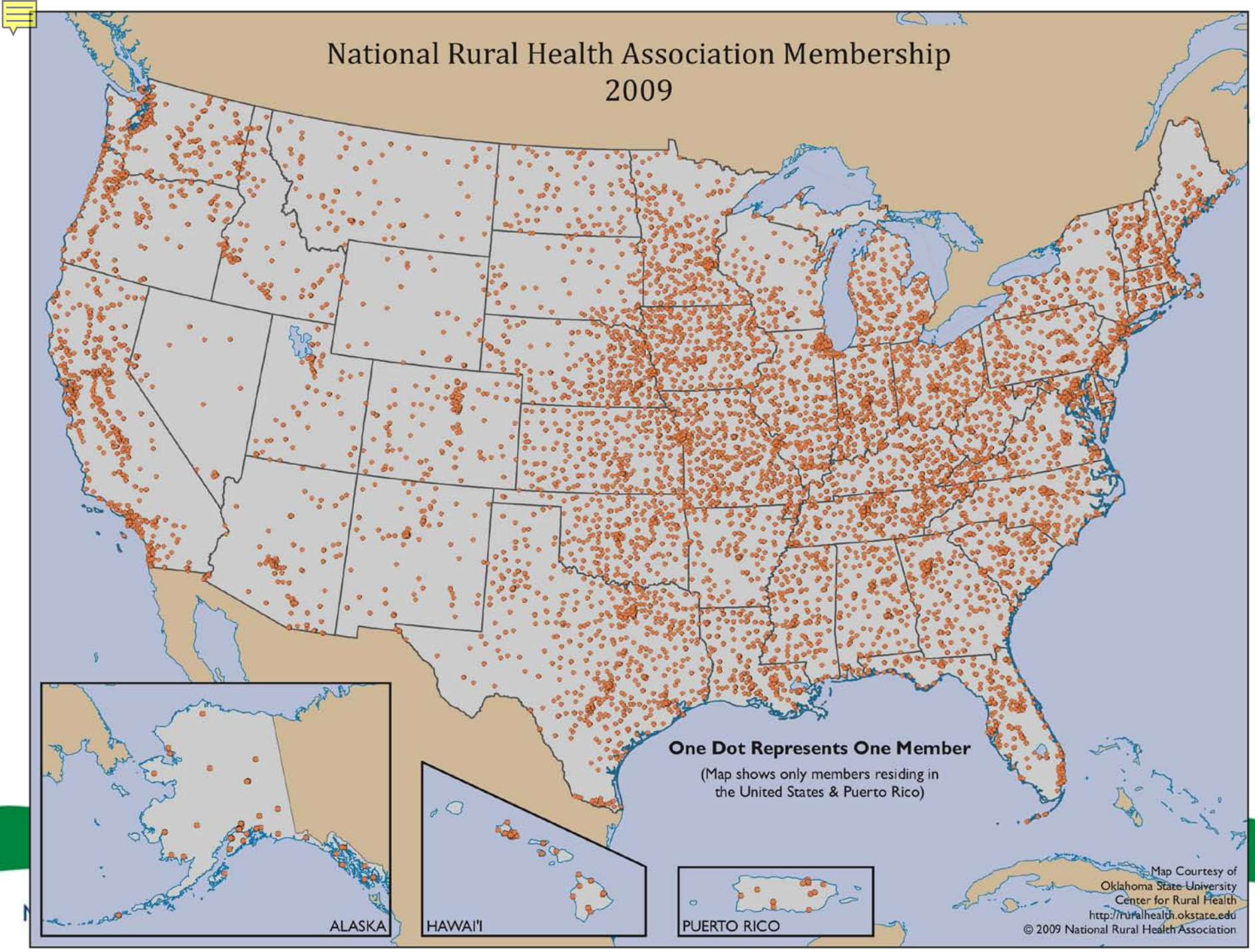
Health Reform: Update November 6th

Beth Landon, President
National Rural Health Association


National Rural Health Association Membership
2009
One Dot Represents One Member
(Map shows only members residing in
the United States & Puerto Rico)
ALASKA
HAWAI'I
PUERTO RICO
Map Courtesy of
Oklahoma State University
Center for Rural Health
http://ruralhealth.okstate.edu
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Quick Recap

- Senate bills are being blended, still waiting on score.
- House Floor debate - - underway.
- Possible vote on Saturday.
- Hoyer's office seeking NRHA's support.

The House Bill

- Tuesday night released 42 pages of amendments. (Hoping to pick up needed 218 votes.)
- 72 hour review.
- Abortion language not resolved.

Rural Provisions of Concern

- MedPAC Rural Rep
- 340 B
- SGR

Unclear in House and Senate if Democratic votes are there.

- Harry Reid (D-NV) announced public option will be a part of the blended Senate bill (Finance and HELP Committee).
  1. Now indicating possibly not ready this year.
  2. Dems still do not have the votes.
- House Leadership claims vote is possible on Saturday - - but a lot is up in the air.

It's still a heavy lift…

- Several Senate moderate Democrats non-committal.
- Lieberman (I-CT) – indicates he may support a filibuster.
- Two liberal Senators non-committal.
- Snowe (R-ME) now non-supportive.
- Likely posturing. Expect the arm twisting to begin.

Do we still need Snowe in the Fall?

- Support from Snowe back-fired with some liberal Ds.
- Snowe (R-ME) may possibly bring other Rs
- May provide cover for moderate Ds
- Negotiators likely will still do what they can to keep her support

The Time Table

- Still possible before Christmas, but time is running out.

CAHs: What NRHA is fighting for…

- Reinstatement of “Necessary Provider” for CAHs;
- Extension of the Flex grant program;
- Expansion of the 340B drug program to CAHs;
- Equity for CAHs in Medicare stimulus dollars for health information technology;
- Flexibility in stringent bed count requirements for CAHs;
- Improving a CAH’s access to capital;
- Elimination of CAH “Isolation Test” for ambulance reimbursement;
- Ability for a CAH to negotiate reimbursement rates of a “public plan” health care option;
- Greater ability for a CAH to recruit and retain physician residents and physicians; and
- Ensuring equitable reimbursement for CAHs for anesthesia services.

RHCs: What NRHA is fighting for…

- Increase cap on RHCs from $76.84 per visit to $92.
- Expansion of 340B program to RHCs
- Provide grants for residency program development.
- Allow access for rural veterans.
- Improve provider shortages for RHCs.

Senate Health Reform Bills

Finance Rural Positives

- **Workforce Provisions**
  - Expands Rural Residency Programs
  - Encouragement of Rural Training Track Programs
  - Bonus payments for primary care and general surgery
  - Workforce Shortage Advisory Committee

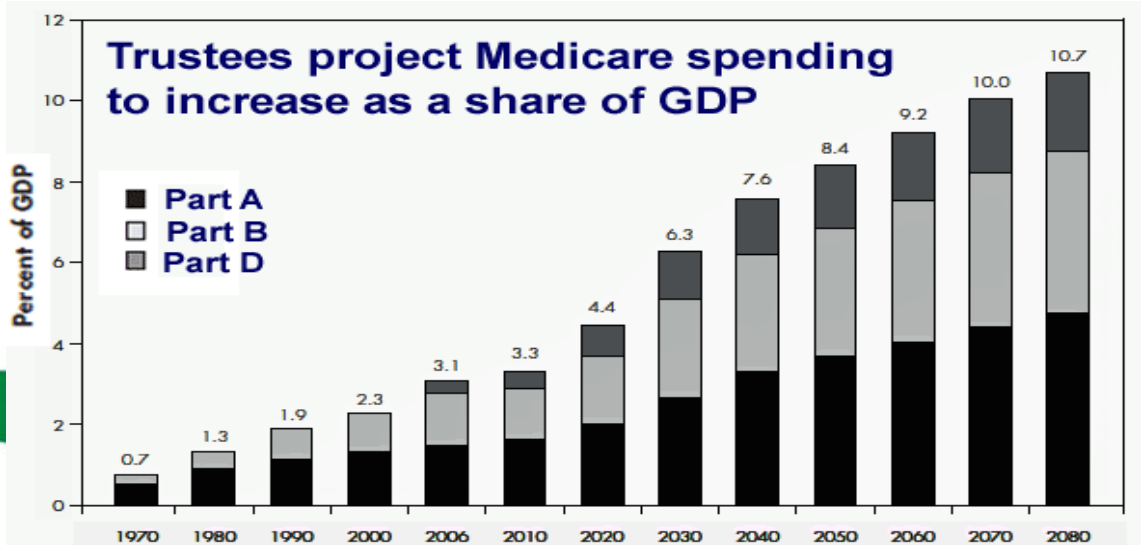
- **Medicare Provisions**
  - Extension of Floor on Medicare Work Geographic Adjustment
  - Two-year extensions of important Medicare provisions for Rural Providers
    - Rural Hospital Flex Program
    - Therapy Cap Services
    - Physician Pathology Services
    - Ground Ambulance Services
    - Medicare Mental Health Services
    - Rural Hospital Flexibility Program
    - Lab Services
    - Medicare Dependent Hospital Program
  - Temporary Relief to Low-Volume Hospitals
  - Home health add-on for home health in rural areas.

Rural amendments passed

- **Bingaman** – Ensuring GME redistribution is available to rural and other underserved states – 50% of redistributed slots to rural
- **Bingaman** – Establishing "Teaching Health Centers" to increase number of primary care physicians – Grants to develop residency programs at ambulatory care centers (RHCs, FQHCs, etc)
- **Bingaman –** Ensures Appropriate Consultation with Mental Health and Substance Abuse Experts
- **Conrad** – Two-year extension of "super rural" bonus payment for ambulance services
- **Lincoln** – To restore the ratios used in determining geographic hospital wage index reclassification to the pre-October 1, 2008 levels until the first fiscal year after the secretary makes a proposal(s) that considers the nine points specified in the Tax Relief and Health Care Act of 2006
- **Carper –** Provides workplace wellness tax credits
- **Stabenow** – To provide training for advance practice nurses
- **Stabenow** – To establish a National Center on Hospital Quality
- **Rockefeller –** Would add free clinics to list of provider eligible for Medicare and Medicaid incentives under the American Recover and Reinvestment Act of 2009
- **Technical Correction on page 121 of Mark** – Clarifies that CAHs are eligible to receive 101% of reasonable cost for providing outpatient services regardless of billing method and for providing ambulance services.
- **Grassley - - GPCI**
- **Rockefeller - - Medicare Commission**

Medicare Commission

- Finance proposal:
  - Requires the commission to implement policies that reduce cost growth in Medicare by at least 1.5% annually beginning in 2014.
  - If cost reductions weren't met, HHS Secretary would have authority to make up the balance of the decrease necessary through a cumulative reduction in provider reimbursement.
  - Congress would have 30 days to review; Congress would need 2/3 majority to override.
  - Saves $23 billion over 5 years.
- Republican amendments to strike commission failed
- Not in House bill



Rural Improvements to Medicare Commission

- Must protect access to care in rural and frontier.
- HRSA Administrator permanent member
- Commissioners confirmed by Finance Committee.

Is the HELP bill good for rural?

- HELP bill contains very strong workforce provisions
  - AHEC funding quadrupled - - patterned after Clinton reauthorization bill
  - Strong investment in NHSC
  - 340B Expansion

Much work still needs to be done…

- **Floor Amendment Strategy**
- **Allies are strong**
- **$$$ can be our enemy**
- **Our fight continues**

Floor Fight

- Public Option
- Subsidies
- Tax on Cadillac plans
- Remember: the score is significant ($829 billion – Finance)
- SGR ($250B!!)

Possible Amendments

- Necessary Provider (Pryor - AR)
- Rural Residency Improvements (Bennet - CO)
- Workforce pipeline improvements (Udall – CO)
- CAH HIT (Bennet - CO)
- State Offices of Rural Health (Bennet - CO)
- RHC 340B (Bennet - CO)
- Rural Representation (Johanns – NE)
- Frontier Clinic Grant program (Begich – AK)
- Medical Liability Reform
- Residency IRTT

Legislative Priorities

1. Payment Disparities
2. Workforce Disparities
3. Health Disparities

Pernicious causal factor?

Annals of the New York Academy of Sciences Vol. 896, 1SOCIOECONOMIC STATUS AND HEALTH IN INDUSTRIAL NATIONS: SOCIAL, PSYCHOLOGICAL, AND BIOLOGICAL PATHWAYS Pages: 3-15

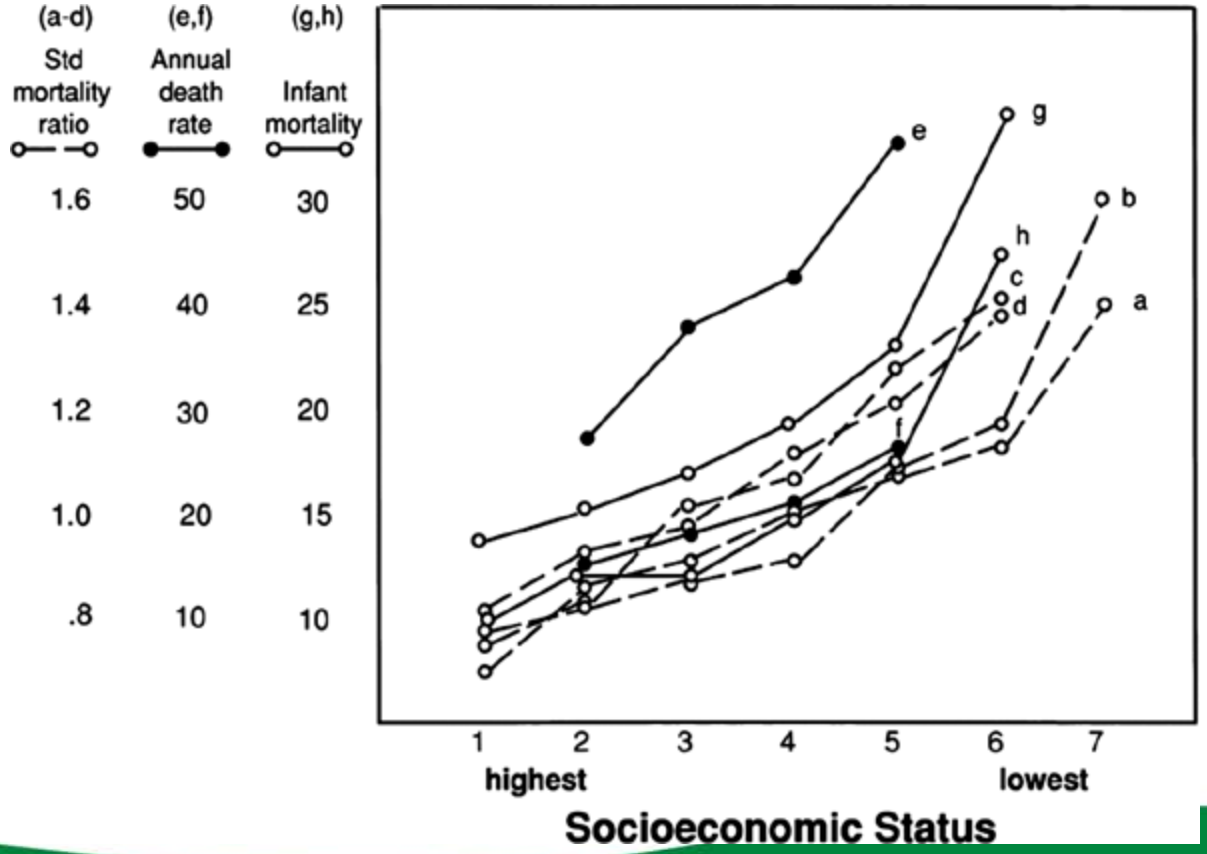
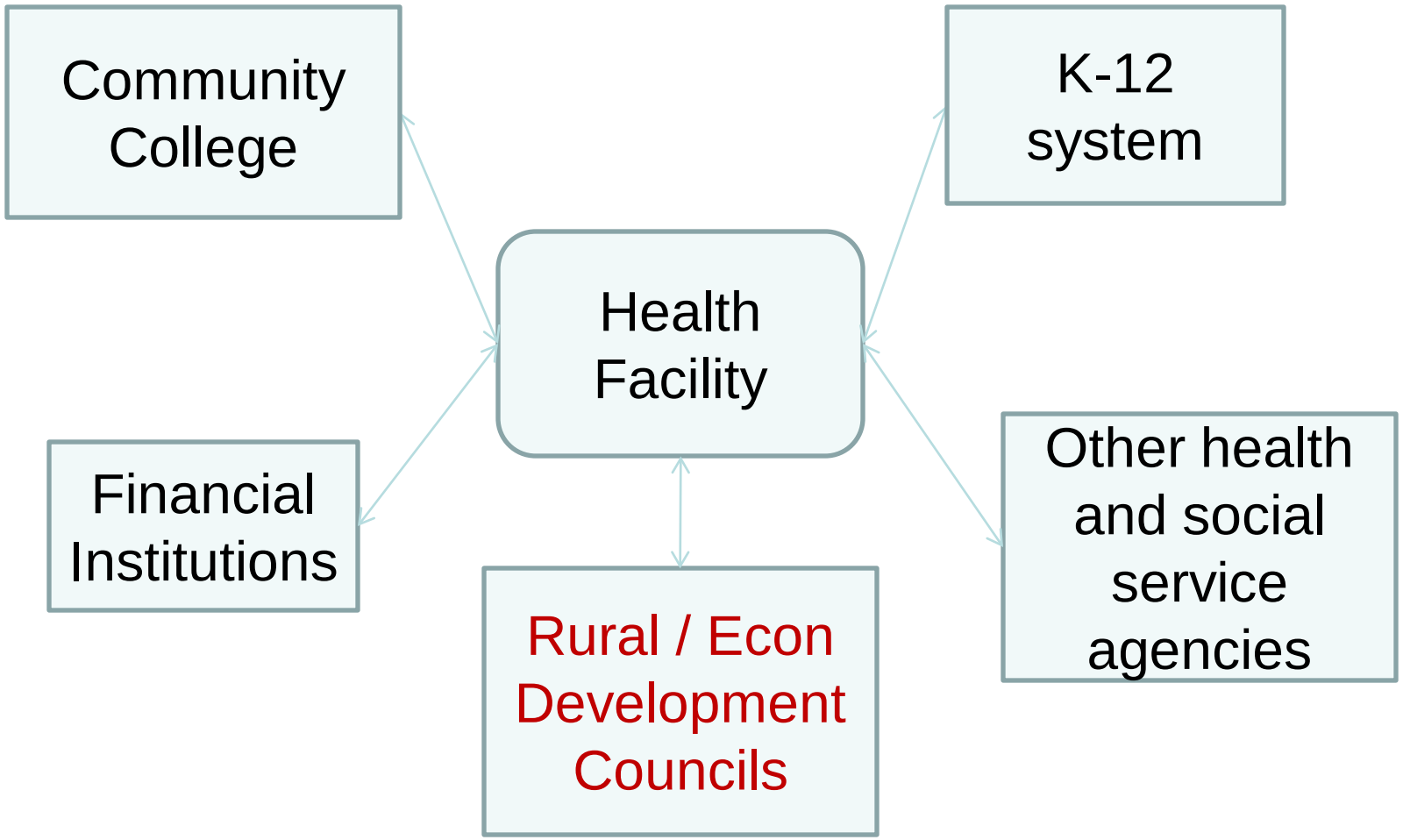


FIGURE 4. Mortality rate by socioeconomic status level. (Taken from the *American Psychologist*, January 1994, **49**(1): 15-24; used with permission.)

Community Economic Development
- Partners and Strategies



Final Thought – 4 Pillars for Rural Economic Development

1. Education
2. Public Infrastructure
   - Health, broadband, utilities
3. Social Infrastructure
   - Childcare, social services
4. Entrepreneurialism

Rural Provisions in New House Bill

- **Provides Coverage for Uninsured Rural Individuals: In rural areas, the uninsured rate reaches 23 percent,** almost five percent higher than in urban areas, and the current recession means that more people may lose access to their employer-based health coverage. The bill guarantees that individuals without access to affordable health insurance would have options for obtaining affordable, quality health care coverage.

- **Addresses Rural Payment Disparities: The bill directs the Institute of Medicine (IOM) to study geographic** inequities in Medicare reimbursement rates.

- **Protects Rural Consumers from Discriminatory Practices that Make Coverage Unaffordable: The bill** includes insurance market reforms that prohibit insurance companies from denying coverage based on preexisting conditions, protect consumers from high annual out-of-pocket spending, and prohibit charging higher premiums based on gender. These provisions will all help make health insurance more accessible and affordable for rural residents.

- **Provides Bonuses to Reward Primary Care Doctors that Practice in Shortage Areas: Only 9 percent of** physicians practice in rural America even though 20 percent of the population lives in these areas. The bill provides a 10 percent incentive payment for primary care doctors practicing in underserved areas, which, combined with a current bonus for physicians in shortage areas, will help recruit and retain primary care physicians where they are needed most.

- **Ensures that Rural Doctors Are Paid the Same Rate for Their Work as Urban Doctors:** Prior to 2003, the Medicare reimbursement formula paid doctors practicing in rural areas relatively less for their work, even though they have the same training as their urban counterparts. The bill helps rural physicians by extending an existing provision that addresses this payment inequity.
- **Rewards Rural Physicians for Coordinating Care for Patients**. Creates a pilot program for patient-centered "medical homes" in order to reward physicians for spending time coordinating care for their patients.
- **Supports Community Health Centers in Rural Areas.**
- **Trains Primary Care Providers for Rural Areas.** Encourages training outside of the hospital and significantly expands National Health Service Corp.
- **Includes Rural Extenders.**
- **Ensures Access to Preventive Services in Rural Areas:** The bill eliminates cost-sharing for preventive care.
- **Expands Access to Mental Health Services in Rural Areas: There is a widespread shortage of mental health** providers, particularly in rural areas, with nearly 75 percent of American counties lacking a psychiatrist. The bill addresses this disparity for seniors living in rural America by making marriage and family therapists and mental health counselors eligible for payments under Medicare.

Provides Certain Hospitals the Resources They Need to Compete in an Increasingly Competitive Labor
Market: The Medicare Modernization Act enabled certain hospitals, commonly referred to as "Section 508
Hospitals," to be more appropriately reimbursed by Medicare for the services they provide to rural
communities. The bill continues these critical payment improvements, enhancing the ability of these rural
hospitals to recruit and retain essential staff to care for Medicare beneficiaries in their communities.
Addresses Rural Health Disparities: The bill spends $15 billion over five years on grants to deliver
community preventive services to fight things like diabetes, obesity, tobacco use, and substance abuse. Half
of these dollars must be spent on programs whose primary purpose is to reduce health disparities, including
disparities between urban and rural chronic disease outcomes.
Expands 340B Drug Program.