Rural Health Care Funding in Jeopardy
September 22, 2011
Impact of Federal Government on Rural Health

- Legislation
- Regulations (eg, “meaningful use,” ACOs)
- Funding/Appropriations
Game Changer: I took a “Shellacking”
President Obama

- **House:** Democrats lost over 60 seats lost - - Not since 1948 has a party captured so many seats in one election. Republicans control at least 242 seats.

- **Senate:** Loss of 6 seats. Democrats retain majority, but far short of magic 60 seats.

- Why does it matter?
Election Impact

• Nearly half of the House Blue Dogs lost on Nov. 2\textsuperscript{nd}.

• Rural Champions
  – House: 37 losses in House Rural Health Care Coalition
  – Senate: 10 losses in Senate Rural Caucus.
Offense to Defense
Agenda: Unprecedented Assaults on Rural Funding

• The Budget, Federal Spending and Rural Health
  – Appropriations
  – Budget Deficit Reductions

• Health Reform, it’s Future and How it Impacts Rural America
The Rural Hospital

- Critical Access Hospitals: 1,320
- Sole Community Hospitals: 480
- Medicare Dependent Hospitals: 550
- Rural Referral Centers: 240
Oregon

- Critical Access Hospitals: 25
- Rural Health Clinics: 64
- Sole Community Hospitals: 1
The picture on Capitol Hill

- “Nothing will pass if it costs money.”
  – Democratic Response

- “Nothing will pass unless it saves money.”
  - Republican Response

- “I thought I would spend the year defending health care reform. Instead, I am defending Medicare itself.”
  - Senate Finance Committee staffer
The Debt Ceiling Agreement...2-Part

Part I:

• Raised the debt ceiling by $900 billion – $400 billion immediately and $500 billion in September

• Cuts of $917 billion over 10 years. Medicare and Medicaid is not impacted by the initial cuts.

  – Appropriation Cycles Impacted: Total discretionary spending in Fiscal Year 2012 and 2013 will be reduced about $7 billion and $3 billion, respectively, below current levels.
Part 2: Form a 12-member, bipartisan congressional committee.

- Committee was appointed by Majority and Minority Leaders in each chamber.

- Committee to make recommendations for **$1.2-1.5 trillion** in additional savings by Nov. 23.

- Everything is on the table, including Medicare, Medicaid, Social Security and revenues.

- Committee’s recommendations would be subject to a simple up-or-down vote before Dec. 23. If the recommendations pass, the president could request an additional increase in the debt ceiling of $1.5 trillion.

- If Congress fails to either act on the committee’s proposal or send a balanced budget amendment to the states before the end of the year, automatic across-the-board spending cuts totaling $1.2 trillion would go into effect.

- The cuts would apply to both mandatory and discretionary spending programs beginning in 2013.

- Medicaid would not be subject to the cuts, but Medicare provider payments would face a cut of no more than 2 percent over nine years (2013-2021).

- The President would then be authorized to request an additional increase in the debt ceiling of $1.2 trillion.
Sequestration will use balanced approach to spending cuts/Trigger

- 50% of sequestration will come from defense (which would amount to approximately $50 billion/year).

- Social Security, Medicaid, Veterans Benefits, and other “Essential Benefits” are exempt from sequestration (Fed retirement benefits, child nutrition programs, SSI, WIC, etc.)

- Medicare savings are capped at 2% of the program’s cost and are limited to providers and insurance plans - - no benefit cuts.
The “SUPER-COMMITTEE”  
Who’s in the room

<table>
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<tr>
<th>Senate:</th>
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<tr>
<td>Patty Murray: Co-Chair</td>
<td>Jon Kyl (AZ)</td>
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<td>(WA)</td>
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<td>John Kerry (MA)</td>
<td>Pat Toomey (PA)</td>
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<td>Max Baucus (MT)</td>
<td>Rob Portman (OH)</td>
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<th>House of Represenatitives</th>
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<td>Jeb Hensarling: Co-Chair</td>
<td>James Clyburn (SC)</td>
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<td>(TX)</td>
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<tr>
<td>Dave Camp (MI)</td>
<td>Chris Van Hollen (MD)</td>
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<td>Fred Upton (MI)</td>
<td>Xavier Bacerra (CA)</td>
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What does this mean for rural?

• Important to remember how we got here.
Super Committee could revisit old ideas

- Simpson/Bowles
- Senate Gang of 6
- Vice President
- President
- “everything is on the table” including rural Medicare payments.
House GOP Plan

• Paul Ryan (R-WI) – GOP goal: to reduce federal health care spending from 8% of GDP to 5% of GDP by 2050.

• Attempts to make Medicare spending predictable, by eliminating open-ended entitlement and capping the govt’s contribution.

• Create block grants for Medicaid
Unprecedented NRHA Advocacy Efforts Launched Because of Leaked Document

- President Obama

**Senate**
- Reid – D-NV
- Durbin – D-IL
- McConnell – R-KY
- Kyl – R-AZ

**House**
- Boehner – R-OH
- Cantor – R-VA
- Pelosi – D-CA
- Hoyer – D-MD

- $16 billion in specific rural cuts.
## Health Care

<table>
<thead>
<tr>
<th>Policy</th>
<th>Savings Over Ten Years (Billions of $)</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>EHR Penalties for Medicare Financing 1</td>
<td>1</td>
<td></td>
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<tr>
<td>Quality Improvement Organizations (QIO) Charges Medicare</td>
<td>0.3</td>
<td></td>
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<tr>
<td>Validate Physician Orders for High-Cost/Fraud Risk Services Medicare</td>
<td>1.8</td>
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<tr>
<td>Prepayment Review for Power Wheelchairs Medicare</td>
<td>0.2</td>
<td></td>
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<tr>
<td>Rebase Medicaid 1SP in 2021</td>
<td>4</td>
<td></td>
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<tr>
<td>Strengthen Third-Party Liability Medicaid</td>
<td>1.4</td>
<td></td>
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<tr>
<td>Change Utilization Factor for Advanced Imaging Payments Medicare</td>
<td>0.8</td>
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<tr>
<td>Diabetic Stripe Pharmacy Payments Medicare</td>
<td>0.2</td>
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<tr>
<td>Recoup Hospital Coding Incidence Adjustment Medicare</td>
<td>3</td>
<td></td>
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<tr>
<td>Medicaid DME Payments</td>
<td>5</td>
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<td>Dual Eligible Care Coordination Medicaid/Medicare</td>
<td>0 - 5</td>
<td>Savings dependent on scoring</td>
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<td>Prior Authorization for High-Cost Imaging Services Medicare</td>
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<tr>
<td>Reporting of Items for Drug Coverage Medicaid</td>
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## Health Care Cont’d

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<tr>
<th>Policy</th>
<th>Savings Over Ten Years (Billions of $)</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Reduce Bad Debt Payments (Medicare)</td>
<td>14 to 26</td>
<td>Savings range based on the phase-out / elimination of payments</td>
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<tr>
<td>Post-Acute Care Payments / Cost Sharing</td>
<td>50</td>
<td>Discussion of savings from co-pays or payment reductions</td>
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<tr>
<td>for SNFs and Home Health</td>
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<tr>
<td>Reduce Prevention and Public Health Fund</td>
<td>8</td>
<td>Discussion did not include a final number. $8 represents not allowing the fund to grow</td>
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<tr>
<td>Clinical Lab Payments/Copays/Etc</td>
<td>8.5 to 16</td>
<td>Discussion on Method of achieving Savings. $1 copay = $8.5</td>
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<tr>
<td>(Medicare)</td>
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<tr>
<td>Medigap</td>
<td>up to 53</td>
<td>$53 is achieved by prohibiting first dollar coverage or approx $530 supplemental premium for those who choose first dollar coverage</td>
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<tr>
<td>(CEHBP Medigap Style Reform)</td>
<td>11</td>
<td>Change the subsidy from first dollar coverage to Part B premium</td>
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<td>Medicaid I/MAP Reform</td>
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<tr>
<td>Medicaid Flexibility</td>
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# Health Care Cont’d

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<tr>
<td>Reform Rural Hospital Programs (Medicare)</td>
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<tr>
<td>Repeal Frontier State Adjustments in ACA</td>
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<td>Medicare Part B Drugs (ASP)</td>
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<tr>
<td>Reclassify Part B Drugs</td>
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<td>??</td>
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<tr>
<td>Reform DGME and IME Payments</td>
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<td>14</td>
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<tr>
<td>Income-related Premiums</td>
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<td>38</td>
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**Total:** $334 to $353 Billion

*Freeze brackets after 2019 and increase current cost-sharing by 10%*
Mandatory Spending—Option 24
Eliminate the Critical Access Hospital, Medicare-Dependent Hospital, and Sole Community Hospital Programs in Medicare

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<tr>
<td>Change in Outlays</td>
<td>-3.8</td>
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<td>-4.5</td>
<td>-5.0</td>
<td>-5.5</td>
<td>-6.3</td>
<td>-7.0</td>
<td>-7.8</td>
<td>-8.6</td>
<td>-9.5</td>
<td>-23.0</td>
<td>-62.2</td>
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Hospitals designated as critical access hospitals (CAHs), Medicare-dependent hospitals (MDHs), and sole community hospitals (SCHs) are exempt from the Inpatient Prospective Payment System (IPPS) through which Medicare pays for services provided by most acute care hospitals. Eligibility for the CAH, MDH, and SCH designations is based on several factors, including size and location. Most of the hospitals exempt from the IPPS are small, rural facilities. Some of those hospitals receive payments equal to 101 percent of the costs of providing care, while others receive payments based on a blend of IPPS rates and their costs. Hospitals benefiting from the special adjustments for CAHs, MDHs, and SCHs are paid about 25 percent more, on average, for inpatient and outpatient services than the payments that would otherwise apply. Currently, one-third of hospitals benefit from those designations and account for about 10 percent of total Medicare spending for hospital inpatient services.

This option would eliminate the CAH, MDH, and SCH programs and end the higher Medicare payments made to those facilities. Instead, payment to those hospitals, as with other hospitals paid through the IPPS, would be determined prospectively on the basis of the following: patients’ diagnoses and the severity of their illness or injury; geographic variations in hospital “input” costs (for example, for professional labor or medical supplies); and certain other hospital- and patient-specific factors, such as the hospital’s teaching status and Medicaid caseload. By eliminating the CAH, MDH, and SCH programs and the higher payments to hospitals participating in those programs, this option would reduce federal outlays by $23 billion over the 2012–2016 period and by approximately $62 billion over the 2012–2021 period.

An argument in favor of eliminating the CAH, MDH, and SCH programs is that doing so would move Medicare toward a payment structure that compensates all hospitals in a consistent manner. Smaller rural hospitals would no longer be able to participate in programs that compensated them at relatively higher rates. Additionally, this option might improve efficiency in the health care system. IPPS payments are intended to encourage efficiency by compensating hospitals for the costs that reasonably efficient providers would incur in furnishing high-quality care (including adjustments for local input costs). By placing CAHs, MDHs, and SCHs under the IPPS, those hospitals would face greater incentives to provide efficient care.

A potential drawback of this option is that the special payments currently made to the CAHs, MDHs, and SCHs may offset the higher costs of operating smaller facilities in rural areas. If those hospitals are not able to reduce their costs under the IPPS, the increased financial pressure resulting from the elimination of special payments to CAHs, MDHs, and SCHs might force some of those hospitals to convert to outpatient facilities or even to close. To the extent that occurred, patients who reside in those areas might have difficulty getting access to care.
House Democrats

- Recommend CBO rural hospital changes.
- House Ways and Means Committee
And now, the President...

- “Better align Medicare payments to rural providers with the cost of care. Medicare makes a number of special payments to account for the unique challenges of delivering medical care to beneficiaries in rural areas. But these programs have expanded so that they now include one-third of all hospitals and have exceeded the scope and purpose for which they were created. The Administration proposes to improve the consistency of payments across hospital types, provide incentives for efficient delivery of care, and eliminate higher than necessary reimbursement. Together, these rural proposals will save approximately $6 billion over 10 years.”
Higher than necessary reimbursement?

• Currently, 41 percent of CAHs operate at a financial loss.

• If the President’s proposal to cut billions in Medicare reimbursements hits these facilities, over half of CAHs would lose money.

• Such devastating cuts will cause rural hospital doors to close, resulting in loss of access to health care and needed rural jobs.

• CAHs account for only 5 percent of Medicare hospital inpatient expenditures, yet they provide critical care and jobs.

• It’s a sound investment not a “higher than necessary reimbursement.”
Specifcics

- Reduce cost-based reimbursement from 101% to 100%
- Eliminate CAH status if it is located within 10 miles of another hospital.
Other Medicare Concerns
Medicare Extenders

- **Hospital wage index improvement** □ Extended reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173). The estimated cost is approximately $300 million over ten years.  
  □ Medicare and Medicaid Extenders Act § 102 extends the reclassifications through FY 2011.
- **Extension of improved payments for low-volume hospitals** □ Applied a percentage add-on for each Medicare discharge from a hospital 15 road miles from another hospital that has less than 1,600 discharges during the fiscal year. The estimated cost is approximately $200 million over ten years.  
  □ Patient Protection and Affordable Care Act § 3125 made this policy effective through fiscal years 2011 and 2012.
- **Extension of outpatient hold harmless provision** □ Extended outpatient hold harmless provision and allows Sole Community Hospitals with more than 100 beds to also be eligible for this adjustment. The estimated cost is approximately $200 million over ten years.  
  □ Medicare and Medicaid Extenders Act § 108 extends the outpatient hold harmless provision 2011.
- **Extension of exceptions process for Medicare therapy caps** □ Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately $900 million over ten years.  
  □ Medicare and Medicaid Extenders Act § 104 extends the therapy caps exception process through 2011.
- **Extension of payment for the technical component of certain physician pathology services** □ Extended provision that allows independent laboratories to bill Medicare directly for certain clinical laboratory services. The estimated cost is approximately $100 million over ten years.  
  □ Medicare and Medicaid Extenders Act § 105 extends through 2011.
- **Extension of the work geographic index floor under the Medicare physician fee schedule** □ Extended a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately $600 million over ten years.  
  □ Medicare and Medicaid Extenders Act § 103 extends through December 31, 2011.
- **Extension of ambulance add-ons** □ Extended bonus payments made by Medicare for ground and air ambulance services in rural and other areas. The estimated cost is approximately $100 million over ten years.  
  □ Medicare and Medicaid Extenders Act § 106 extended through 2011.
• **Extension of physician fee schedule mental health add-on** □ Increased payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent. The estimated cost is approximately $100 million over ten years.
  □ *Medicare and Medicaid Extenders Act § 107 through December 31, 2011.*

• **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** □ Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals. This provision in the Medicare and Medicaid Extenders Act was scored by CBO as a 0.
  □ *Medicare and Medicaid Extenders Act extended this policy through July 1, 2012.*

• **Extension of Medicare Dependent Hospital Program** □ Extended the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. This provision in the Patient Protection and Affordable Care Act was scored by CBO as a 0.
  □ *Patient Protection and Affordable Care Act § 3124 extended this policy through September 30, 2012.*

• **Extension of Community Health Integration Models** □ ACA removed the cap on the number of eligible counties in a State. This provision in the Patient Protection and Affordable Care Act was scored by CBO as a 0.
  □ *Expires September 30, 2012.*

• **Extension of Payment for Qualifying Hospitals** □ § 1109 of the Health Care and Education Reconciliation Act of 2010 provides for additional funding of $400 million in FY2011 and FY2012 for hospitals located in counties that rank in the lowest quartile for Medicare Parts A and B per capita spending.
  □ *Expires September 30, 2012.*
The daunting doc problem

• Sustainable Growth Rate Fix legislation will occur likely in November

• Temporary fix averts crisis until December. Near 30% cuts in January, 2012 projected.
  – 11 times in past 8 years, physicians have faced Medicare payment cuts that were avoided only after Congress intervened.
  – Each temporary congressional fix, merely put off cuts to some date in the future.
  – Long term fix - - replacing the formula - - $210 billion.

• This will be the a moving health vehicle in the first half of the 112th Congress.
Strategy…Need Unprecedented Grassroots Campaign

• Launched significant Hill campaign:
  – Direct meetings on Capitol Hill and District Offices
  – Calls
  – Letters
  – Op-ed pieces

• Administration; WH call, HRSA
• Outreach to all rural associations
• All rural allies must have unified message
The Message

• The Rural Health Care Safety Net is fragile. Rural patients and the rural economy are dependent upon it.
  • Challenges of delivering health care in rural America
  • An investment in rural health care pays off
  • Rural Providers not only treat patients, they provide jobs and are vital to rural economy.
  • Cuts would decimate rural health safety net because they are *disproportionately harmful* due to small operating margins. (For example, 41% of all CAHs currently operate in the red. Cuts will inevitably mean doors will close, access will suffer.)

• Like Medicaid, Medicare payments to rural safety net providers should be shielded from cuts.
Message that sells on Capitol Hill – Healthcare Critical to Rural Economy

• Healthcare is the fastest growing segment of rural economy.

• The average CAH supports over 100 jobs and provides around $5 million in wages, salaries, and benefits to the local community.

• In most rural communities, rural hospitals are one of the two biggest employers in the area.

• Around fourteen percent of total employment in rural communities is attributed to the health sector.

• Studies have shown that quality rural health services in rural communities are needed to attract other business and industry.
Tools from ruralhealthweb.org

Schedule district meetings with Members of Congress. Visit their offices or invite the Member to tour your hospital or clinic. You can find contact information here. For tips to arrange or conduct a meeting, click here.

Attend town hall meetings. Town Hall meetings are the best ways to communicate to your Congressperson directly. You can find out when and where town hall meetings will occur by going to your Congressperson’s website or calling their district office. Information for your member can be found here.

Send a letter to the editor. Here’s a template you can customize highlighting the importance of access to health care for Rural America.
2. Health Reform/
Let’s Take a Step back…

• Goal: Significant expansion of the uninsured.
• Goal: Significant advancements to improve the delivery of health care in rural America
• **Two separate bills - - together referred as the “Affordable Care Act”**
• Remains highly controversial
  – No Republicans vote in support. 34 Ds vote no.
  – Nearly all Rs in November ran against it.
  – Legal challenges persist against “mandate” requirement.
Unhappy 1st Anniversary

- Polls haven’t changed much.
- The most recent Gallup Poll has -- 46% favor the Health Care law and 44% are against the Health Care Law.
- Much Confusion around law, much misinformation
- Candidates who ran on “repeal and replace” are attempting to act on campaign promise.
  - House Vote: **245-189 in favor of repealing**
  - Current attempts to slow-walk through hearings, refusal to confirm Berwick, underfund health reform
Is the ACA the right prescription for rural America?
Why Rural Americans Need Health Care Reform

• Greater proportion of rural residents are uninsured than urban residents (23% compared to 19%).

• Fewer rural Americans have employer-based insurance than their urban counterpart. (64% compared to 71%). A higher number of self-employed is in rural America.

• Rural workers pay higher costs for health insurance plans than their urban workers.
Three reforms are crucial for health reform to work in rural America:

– The workforce shortage crisis must be abated;
– Equity in reimbursements must occur;
– Disparities must be eliminated.
Workforce Improvements

• Significant Expansion of NHSC
• Significant funding of Title VII and Title VIII
• Rural Physician Training Grants
• Graduate Medical Education Improvements
• Increased Residency Slots in Rural Areas
• Grants to Improve Primary Care Training
• New Residency Slots for RHCs
• Health Care Workforce Commission (Sept. 2010)
Payment Improvements
Medicaid

- Expands coverage (up to 133 percent of federal poverty level)
- Federal Government pays 100% of costs for covering newly eligible Medicaid recipients for 2014 through 2016.
- Medicaid payment rates to primary care physicians providing primary care services no less than 100% of Medicare payment rates in 2013 and 2014. This includes: E and M services; Immunizations; Primary Care as defined as Family Practice, Internal Medicine or Pediatrics
• New Medicare provider payments

• Reductions in Medicare spending
Physician Payment Improvements

• 10 percent incentive payment for primary care physicians.
  – All physicians, nurse practitioners, clinical nurse specialists and physician assistants.
  – Will receive bonus if at least 60 percent of Medicare allowed charges in a prior period were for primary care services. (Effective 2011-2015.)

• 10 percent bonus payment to general surgeons.
  – Must perform major procedure (with a 10- or 90- global service period) in a health profession shortage area. (Effective 2011-2015.)

• 5 percent incentive payment for mental health services.
  – For 2010 Medicare will increase payment for psychotherapy services by 5 percent.

• Geographic Practice Cost Index (GPCI) increases.
  – for both “work” and “practice expense” factors, meaning some areas could receive up to 17% payment increases.
  – Physicians in 56 localities in 42 states, Puerto Rico and the Virgin Islands will receive increased reimbursement rates.

• Medicare quality reporting incentive payments extended.
  – Incentive payments of 1 percent in 2011 and 0.5 percent from 2012–2014 will continue voluntary participation in Medicare’s Physician Quality Reporting Initiative (PQRI).
Important CAH and small hospital provisions

• Extension of the Medicare Rural Hospital Flex Program
  – Original authorizing language for the CAH program is extended for two years
    Quality (low-cost) bonus payments, 2011-2012
  – CAH Technical Correction for Method II Payments
    • Allows 101 percent reimbursement regardless of billing method

• Low –Volume Hospital Payment Program Extended and Expanded.
• Extension of Medicare Dependent Hospital Program until 2012 and extends certain MDHs to decline reclassification through 2012.
• Extension and expansion of Rural Community Hospital Demonstration Program – 10 new states will be eligible.
• $400 million for Low-cost Hospitals (to award to efficiency)
• Expansion of 340B drug program to CAHs, MDH, RRCs.
• TREMENDOUS INVESTMENT IN COMMUNITY HEALTH CENTERS
Important Provisions for Rural Health Clinics

• Prevention and wellness grants for RHC and CHC
• Teaching health center development grants
• Primary care training and enhancement grants.
Federal Grants/HRSA

Grant opportunities: health professions, maternal and childhood, primary care, general rural health.

Get a notice each time a new grant becomes available…

• http://www.hrsa.gov/grants/default.htm
• http://www.Recovery.gov
• http://www.Grants.gov
Reductions in Medicare spending.
• Medicare Advantage
  – $136 billion in savings over 10 years.

• Hospital DSH Payments
  – $22 billion savings over 10 years

• Market Basket Reductions
  – “Productivity adjustment” will be applied to save $157 billion in savings over 10 years.

• Misc.
  – Imaging services
  – Home health (grants authority to Secretary to take into account urban and rural providers)
  – Part D – subsidy for higher income will be reduced.
New Advisory Board

• Independent Payment Advisory Board (IPAB)
  – $16 billion in savings over 10 years (initial score)
  – 15 member board within HHS
  – Similar to MEDPAC
    • Key difference…authority to implement rather than simply recommend to Congress
  – HRSA Administrator – ex officio full time member
  – Hospitals free from IPAB authority until 2020
    • Possible technical correction needed for CAHs
What was left out?

Short answer…a lot
Long Answer…
• CAH HIT Fix (ARRA)
• 340B for RHCs
• 340B expansion to inpatient drugs
• Continued support for State Offices of Rural Health
• Reinstall “Necessary Provider” for CAH status
• CAH Bed Flexibility
• RHC Payment Cap Increase
• Improve Rural Workforce Development
• Ensure Rural Access to Anesthesia Services
• Eliminate CAH "Isolation Test" for Ambulance Reimbursement
• Ensure Rural Representation on MedPAC and newly created similar Commissions (IPAB, HIT Policy Committee, etc.)
• Implement an Occupational Safety Program for Agricultural Workers
• Protect Access to Care for the Most Geographically Remote Americans
• And many more…
Repeal and Replace? More Likely…

- Most Republicans acknowledged that a full repeal is impossible with a Democratic majority in the Senate and the likelihood of presidential vetoes.
- Likely efforts to whittle away…
  - Mandate
  - Funding
  - Certain IRS filing requirements
Bipartisanship? Maybe…

• Senators Ron Wyden (D-OR) and Scott Brown (MA-R) support expanding state waivers in ACA

  – The Wyden-Brown plan would move up the date for waiver requests from 2017 to 2014, when state or regional “exchange” markets are expected to open.
  – Under measure, state officials who got a waiver could avoid imposing controversial requirements that most people buy insurance and most companies offer it to their employees.
What about legal challenges?

Battle will likely end up in Supreme Court.
  – Anticipate close decision
  – Severability?

Currently law of the land - - must prepare for implementation.
A Constitutional Battle

• 10th Amendment – “powers not delegated to the United States by the Constitution…are reserved to the states respectively, or to the people.”

• Article 1 – Commerce Clause, grants authority to regulates interstate commerce has been enshrined in court decisions since Justice Marshall. New Deal tested Commerce Clause. Broadly interpreted.
New Legislation in 112th Congress
Rural Bills

• R-Hope in Senate
• H-Care in Senate
• Bill and Expand on ACA (example: low-volume hospital provision)
• Possible modifications:
  – Necessary Provider
  – 340B orphan drug fix
  – NHSC rural surgeon
  – CAH HIT fix
The daunting doc problem

• Sustainable Growth Rate Fix legislation will occur likely in November
• This will be the a moving health vehicle in the first half of the 112th Congress.
3. Appropriations process more important than ever.
FUNDING FOR THE RURAL HEALTH SAFETY NET

NRHA FY 2011 Request (dollars in millions)

- Program funding requests have been decreased in comparison to past years in light of the current economic and budgetary outlook.

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*Title VII and VIII Programs of Particular Interest to Rural

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<th>Program</th>
<th>Program newly created under the Patient Protection and Affordable Care Act</th>
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<td>Geriatric Programs</td>
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Source: National Rural Health Association

1 Says that this should ignore section k and therefore fully fund SORHs.
2 Section k notwithstanding
3 The Patient Protection and Affordable Care Act provided significant additional funding for NHSC through the HHS Secretary’s Community Health Center Fund. The NRHA will support the President’s request, which will ensure that the NHSC has access to additional dedicated funding through the CHC Fund.
The Oregon Delegation

Senator Jeff Merkley
Senator Ron Wyden
Representative David Wu – 1st
Representative Greg Walden – 2nd
Representative Earl Blumenauer – 3rd
Representative Peter DeFazio – 4th
Representative Kurt Schrader – 5th
Please Get Involved!

• Thank you!!!
• www.Ruralhealthweb.org