

Background for Congressman Kevin Cramer's Health Care Reform Roundtable

February 22, 2017

Consideration of Rural Health in Health Care Reform

- In rural health, health reform really means **maintaining and improving access to care and the availability of care.**
 - Access is directly related to a rural health care organization's viability and survivability.
 - Medicaid expansion, authorized under the ACA has contributed to viability of CAHs –an estimated \$20 million to CAHs.
 - 340 B drug discount program authorized under the ACA has contributed to viability of CAHs.
 - In 2015, 19 CAHs (53%) had positive operating margins whereas, in 2014 only 8 (22%) had positive margins. By 2015 of the 19 with positive margins, 12 had adopted 340 B.
 - Only real variables that changed between 2014 and 2015 were the advent of Medicaid expansion and 340 B so the ACA is having a positive impact on CAHs in ND.
 - ND CAHs – 35 of the 36 own another health care business (primary care clinic - 89%, nursing home -36%, ambulance – 25%, assisted living -22%, basic care – 19%).
 - In ND, CAHs are a hub provider and key to a rural health safety net.
 - In ND, if the CAH closes there is a strong likelihood of losing the physician and other providers, access to outpatient services, threat to the viability of the nursing home and other important aging services, and threat to the ambulance system.
 - ND CAHs, on average, contribute about \$6.4 million a year to their local economy based on both primary or direct dollars (health related impact in hospital and health care jobs and spending) along with secondary or indirect dollars (additional non-health related impact). They contribute, on average 224 primary and secondary jobs. Statewide this is an economic impact of \$230 million and about 8,000 rural jobs (Source *CRH data*). One rural physician can have an economic impact of \$2.4 million (primary and secondary) and produce 23 health care jobs (Source: *National Center for Rural Health Works*).
 - Maintaining access improves viability and sustainability of the local rural health system which in turn contributes jobs and income in the rural community helping the rural community to remain viable- rural health is economic development (see above). Rural health accounts for 10-15 percent of the local economy and if secondary impacts are added, it is 20-25 percent (Source: *National Center for Rural Health Works*). The rural hospital, clinic, nursing home,

public health agency are not just important for better health, they are important for rural economic development in producing health care and additional community jobs, and in producing rural income. A viable health system attracts people to the community; whereas, the absence of a local health system drives them to other rural communities with health care or the more urban communities.

- While access to insurance and financial access are critical issues in rural America, a concern is if we only focus on financial access but forget about the viability of the rural health system (e.g., access to care) how are rural people helped if they have insurance but their hospital closes or they lose their physician? Both are important in rural communities. Health reform needs to benefit the consumer or patient and another way to benefit them, particularly in rural North Dakota, is to secure the survivability of rural providers like CAHs, primary care clinics like federally certified Rural Health Clinics and Community Health Centers, nursing homes, EMS, elder services, and other key parts of the rural safety net.
- Rural citizens do not expect more or better health care than urban Americans; however, they do expect to have access to essential, quality, health services. They do not expect to have a cardiologist or gastroenterologist available every day; however, they do expect to have reasonable access through their local health system working as part of a network or collaborative arrangement with urban, tertiary providers. Many rural hospitals are able to provide follow-up care such as therapies and rehab with their current staff saving patients from expensive and time consuming trips back to Bismarck, Fargo, or the other tertiary centers. The rural health system is not only local, it is regional. Federal policy should support reasonable access to quality health services for rural citizens and support better coordination of care and collaborative models. Additionally, much federal rural health policy is “hit-and-miss” or a patchwork where it works in one place but not another. Just as there is a difference between urban and rural there is a difference between rural and frontier. Frontier states like ND suffer because “one size does not fit all” even in rural. For more frontier areas there needs to be policy that recognizes unique demographic trends; the imperatives of distance, weather, and physical access; and that in some cases “low volume” means “no volume.” However, citizens in frontier deserve access to quality care as do citizens in larger rural areas. In some places the standard hospital model based on inpatient—acute care needs to be rethought as one focused on primary, outpatient, and emergency care as part of a focus on population health. Opportunities to provide population health co-located with, for example, a nursing home with and emergency department
- **Health workforce** is still a serious problem – either shortages or maldistribution of providers – but health reform needs to address this.

- Nationally, projections forecast a physician shortage of from 60,000-95,000 physicians by 2025. For primary care the shortage is in the range of 15,000-35,000 (Source: *Association of American Medical Colleges, The Complexities of Physician Supply and Demand Projections from 2014-2015, 2016 Update*).
- According to the UND School of Medicine and Health Sciences Biennial Report, the estimated shortage for physicians is 100-200 (it was 50 in the 2011 report).
- ND has shortages in many health professions, and physicians can be characterized as both a shortage and a maldistribution – the ratio for physicians to population is 6:10,000 in rural ND (populations of 9,999 or less); Micropolitan is 16:10,000 (populations of 10,000-49,999); 38:10,000 in metropolitan ND (populations of 50,000 or more such as Bismarck-Mandan, Fargo, and Grand Forks).
- Another way to look at the maldistribution is the percentage of physicians by geographical area and the actual population. Metropolitan areas in ND have 67 percent of the direct care physicians, but only 49 percent of the state’s population. Micropolitan areas (large rural such as Dickinson, Jamestown, Minot, and Williston) have 19 percent of the physicians and 24 percent of the population. Rural areas have 15 percent of the physicians but 26 percent of the population (*UNDSMHS Biennial Report, 2017*).
- Nationally, 77 percent of counties have been designated as Primary Care Health Professional Shortage Areas (HPSA) while in ND, 92 percent of all counties or part of a county are designated (49 of 53 counties).
- CRH has seen more rural communities build their medical practice on NP and/or PA (no local physician, but an out-of-town physician is contracted to consult). About 10-12 rural communities have this model (*CRH data*).
- CRH analysis shows unacceptable vacancy rates for: RNs, PAs, and NPs (*UNDSMHS Biennial Report, 2017*).
- CRH workforce specialists has placed or facilitated placement of 32 health and medical providers over last six years. In 2016, CRH worked directly with 18 rural communities to assist them with recruitment and retention (*CRH data*).
- Additionally, the Center for Rural Health through the UNDSMHS Health Workforce Initiative, supports scrub camps in rural communities where children from grade school through high school experience a health care career emersion with local/area health professions to learn about health careers. The Center also hosts a three day Scrub Academy at the School of Medicine and Health Sciences during the summer for middle school students.
- UNDSMHS Rural Med program (scholarships to cover medical school tuition in return for 5 years of service in rural) has about 21 medical students in the pipeline. This is part of the School’s Health Workforce Initiative.
- Federal health policy needs to recognize the rural health workforce problem by supporting not only additional education and training opportunities, but also

building awareness of health careers so school children can have experiences with health careers (e.g. state supported efforts like North Dakota's scrub camps and scrub academies where students learn directly from health professionals and are involved with interactive, hands-on projects) and support of Health Occupation Student Associations (HOSA; ND has about 14 with almost 300 high school students conducting projects and competitions on health subjects. HOSA, which is national, was developed in ND by our Area Health Education Center). This is what is called "the pipeline." Focusing health career opportunities on people already in college is too late; it is better to start when they are in grade school.

- Federal health policy needs to recognize that for many rural communities medical care relies not on the primary care physician, but on the Nurse Practitioner and the Physician Assistant. Regulations that prevent the full use of the capabilities of a PA or NP are counterproductive. A NP or PA can typically engage in most of what a primary care physician can do (some studies have said about 80 percent); thus, they are an important rural health provider. Federal rules that prevent a provider from working at the highest level of their state approved scope of practice hurts rural ND.
- **Population health** has been the focus under the ACA and that needs to be retained under a new version of health reform. Population health is a key redesign element for health delivery system reform. Population health is the conduit to reach the goals of better care, better health, and lowered costs. By focusing on prevention (especially when offered as a free service without co-payments to make it more attractive to the patient) there is an opportunity to work directly with a patient in a manner that produces greater understanding not only for the provider, but also for the patient to be more involved and in control of their health. There is a need in health reform to facilitate greater patient control and responsibility. Population health emphasizes better care coordination and patient health data and metrics. Much of health reform moves the delivery system to more of a merit-based system for providers: if metrics for patient outcomes improve and costs decline, the provider can be rewarded with additional payment. It is not reward providers for doing less; it is reward associated with results.
 - Reimbursement is moving from "volume to value." Instead of dollars following the number of encounters, the number of tests, the number of procedures, it is gradually moving to outcomes, performance, merit, or results.
 - Pay for performance for Prospective Payment System (PPS) providers (all six larger tertiary hospitals in ND). Accountable Care Organizations (ACO) are growing in numbers (about 900 in the country). Over 90 percent of Medicare ACOs are the Shared Savings model. This model saved Medicare over \$465 million nation-wide in 2015. CHI/St. Alexius in Bismarck had a Medicare Shared Savings ACO for a year and Altru in Grand Forks initiated a private-based ACO in 2016. Additionally, Blue Cross Blue Shield of North Dakota unveiled, (2016) an

alternative payment model (APM). ACO, Patient Centered Medical Homes, pay for performance methodologies are examples of Alternative Payment Models (APM) and all are based on paying providers based on the outcome of improving population health not volume. Prevention becomes the focus.

- Care coordination (i.e., working directly with the patient to map out a patient care plan along with patient education, patient counseling, and better coordination between primary care providers and other providers) becomes a focus on improving health status with reimbursement that rewards providers more on quality outcomes. It is not just the number of times the patient is seen by the health system (previous model) more reimbursement is now associated with actual outcomes. If the metrics indicate that patient outcomes for a condition have improved there is the opportunity to share in the savings. Under some models (two sided risk ACO) if the metrics indicate that there is no improvement or costs increased the provider may share in the risk by being assessed a penalty. Before health reform providers were not compensated for additional care coordination now they are. This affords better care that can lead to better health, and lower the overall cost of care as it lessens hospital admissions, readmissions, and high cost visits to the emergency department.
- A population health focus is better for the patient – chance to address potential needs that have not previously been diagnosed generally because the patient did not have insurance to pay for a clinical visit.
- Prevention is key of population health – the importance of the annual health visit (sometimes called a population health assessment), which is provided at no cost to the patient, becomes paramount as it is a chance to assess patient needs, develop a health care plan, and to determine cost savings for the system.
- **CMS Innovation Center and the Accountable Care Organization Improvement Model (AIM).**
 - The ACA authorized the Centers for Medicare and Medicaid Services Innovation Center to support new models including APM. ACOs are networks of providers (physicians and or hospitals); they are neither a managed care organization nor a health plan. They are networks that are “accountable” for the care of patients that are assigned to the network. ACOs are the most prevalent APM with 894 ACOs in operation in 2016. There are 477 (53%) that are Medicare supported and 417 (47%) private. The Shared Savings Model is the most common type of Medicare ACO accounting for 434. Shared Savings ACO are one sided in that there is no risk to the ACO. There are also a small number of two sided ACOs (risk to provider and Medicare) in the form of the Pioneer Model and the Next Generation (*UNDSMHS Biennial Report, 2017*).
 - A new entrant in the ACO mix (2016) is the Accountable Care Organization Improvement Model (AIM) which at this early stage is a grant to assist in the development of rural-based or rural oriented ACOs. These are capacity building

grants and greatly benefit CAHs and others looking to target population health. Because of the requirement that an ACO have 5,000 Medicare patients as part of the network it has been hard for rural providers to participate. For example, in 2015 there were only 31 Critical Access Hospitals (CAHs) that were part of an ACO (*UNDSMHS Biennial Report*). This initiative is specifically designed to assist rural providers. It still has the 5,000 threshold but there does not appear to be a limit on the number of providers involved to reach that threshold.

- ND has 5 CAHs involved in an AIM grant with the National Rural Accountable Care Consortium (now called Caravan Health). There is neither a requirement, nor a need for some level of geographical proximity in an ACO; thus, to meet the 5,000 requirement the 5 ND CAHs also network with 2 CAHs in California. The distance and the fact they are in two non-contiguous states is not an issue. The five ND CAHs are Bowman, Hazen, Park River, Rugby, and Watford City. There is at least one more ND CAH expressing interest in the possibility of joining.
- CAH CEOs involved with the AIM grant are very supportive of continuation. Interviews with CEOs found they view the three year process as preparation and capacity building to become an ACO at the end of the process. They believe without AIM funding they would not have the resources to prepare themselves and their organizations (including their medical and nursing core) for delivery system reform. Specific benefits included training their nurses on care coordination. Care coordination offers better engagement with the patient, monitoring and management of their conditions, and better integration or coordination with other providers. The grant supports 27 hours in care coordination training, including patient coaching, motivational interviewing, and increased understanding of health determinants and their relationship to patient care. The Five ND CAHs have access to extensive patient data that they did not have before. One remarked “we know more about our patients than we had ever known” and this assists in planning better care. There is also a 24-hour nurse advice line which assists the rural nurses (Caravan refers to them as population health nurses) in addressing patient health needs particularly for comorbidities and high utilization. The AIM grant assists in developing workflow redesign which is a comprehensive approach to delivery system change to address care coordination, data analytics, utilization metrics, and the annual wellness visit. The workflow redesign assists the rural ACO to better manage care for the patient and the facility.
- One financial consultant working with this rural ACO arrangement has noted: “We are seeing a lot more follow-up care. You do see more clinic visits, that is good as ambulatory is cheaper than an inpatient stay, readmission, or heavy emergency [department] use. So more clinic contact is good with more contact leading to better opportunity to monitor and manage the patients. Then you have better outcomes, which means an increase in revenue.”

- **HR 3225 Save Rural Hospital Act**

- Rural health bills do not necessarily find their way into law as a stand-alone bill, they are usually taken up or at least cornerstone ideas are placed in more comprehensive bills that can be enacted. Currently, there is HR 3225 the Save Rural Hospital Act introduced in 2015. The Save Rural Hospital Act should be considered as an element of a reform package. In many respects it is an “**access and availability to care**” bill that speaks to many issues in rural health. Key features are as follows:
 - The bill is in many ways a response to the new rash of rural hospital closures and the potential for many more (80 closed since 2010 and over 670 are at risk including at least 17 in ND). Nationwide close to 12 million rural citizens could lose access to their hospital/physician.
 - A key feature is rural hospital stabilization.
 - ✓ Elimination of Medicare Sequestration – 2 percent cut in Medicare payments to rural hospitals. The total amount in 2014 (most recent data) was \$2.8 million for CAHS and over \$11 million for the larger PPS hospitals in the state. Most CAHs in ND experienced about a \$100,000 to \$150,000 decrease in their Medicare reimbursement. Some were lower and some were around \$200,000
 - ✓ Reversal of bad debt reimbursement cuts that were initiated in the Middle Class Tax Relief and Job Creation Act of 2012. This reduced the reimbursement to hospitals to cover bad debt. CAHs were reduced from 100 percent of the bad debt being covered to 65 percent and PPS from 70 percent being covered to 65 percent.
 - A second key feature is rural Medicare beneficiary equity.
 - ✓ Rural Medicare patients pay a higher level of copays for outpatient services in CAHs. This is because the payment is based on total charges, not the allowed Medicare charge. Across the country, rural Medicare beneficiaries are paying almost half the costs for outpatient CAH services. The DHHS Inspector General has recommended that CMS seek legislative authority to modify the calculation. The recommendation was made in 2014.
 - A third key feature is regulatory relief.
 - ✓ Elimination of the CAH 96 hour condition of payment. This CMS regulation requires the physician to certify that a Medicare beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. Previously, the 96 hour rule has been enforced as an annual

average length of stay of 96 hours. Some stays require a different set of services and the stays go over 96 hours; however, it has been the average of the stays that was the metric. This “hard 96” means some patients cannot be seen in their local hospital which threatens access to care.

- ✓ Rebase the supervision requirements for outpatient therapy services at CAHs and rural PPS. This means direct supervision by a physician, not a NP or PA. ND is seeing more rural medical systems that are completely staffed by the NP or PA with a consulting physician who makes periodic visits to the CAH and clinic. CMS had approved a delay in 2014 but started to enforce this in January 2015. The Protecting Access to Rural Therapy Services Act of 2015 would provide permanent relief.
- Finally the Save Rural Hospital Act strengthens the future of rural health care through a new innovation model with grant support.
 - ✓ The Act creates the “community outpatient hospital program.” (COH).
 - ✓ The community outpatient hospital would be located in a rural area and would provide emergency medical care and observation bed care. It would not have acute care beds. This is not a CAH. Patients could stay in an observation bed (non-acute) for up to two consecutive midnights. The COH model would likely work best in areas where even a CAH cannot be supported but the people there should still have access to primary, outpatient, and emergency care. The observation bed allows for an assessment of care that may be 24 or more hours (but less than 48) in which the patient can be treated or transferred to an acute care or other setting. This could work well with a population health focus and would keep access to quality care available to a vulnerable rural population. The bill does not really address it but like a CAH a COH should have required communication and transfer arrangements with more full-scale hospitals.
 - ✓ Would be certified as a Level IV or higher trauma center or has available 24 hour consultation with someone certified as Advanced Trauma Life Support.
 - ✓ Could also provide extended care services so it could be, I assume, part of a nursing home.
 - ✓ Reimbursement for qualified outpatient services would be equal to 105 percent of the reasonable cost (CAHs are reimbursed at 101 percent; however, the key word is reasonable thus CAH CEOs will say in reality, in ND, they are reimbursed at about 90-93

percent of total costs. Not all costs are treated as reasonable costs, but they are still costs. Some critics have questioned 101 percent on fairness grounds. Should a hospital be reimbursed for all of their costs and then be guaranteed a 1 percent profit? In reality, as was previously stated CAHs do not get reimbursed on all costs so criticism is likely originating from people who do not understand reasonable cost reimbursement. The 105 percent would most likely not be 105 percent for the same reasons.

- ✓ For outpatient services a telehealth system connecting the facility with a provider is considered a reasonable cost.
- ✓ A CAH can be designated as a COH.
- ✓ Both CAHs and COHs (or rural PPS hospitals with less than 50 beds) would be eligible for Quality Improvement and Compliance grants to assist in preparing for value-based reimbursement and reporting on quality of care measures. This is important for hospitals seeking to be part of the population health movement. The AIM grants in ND show there is support for alternative models. There is a specific grant in the bill to assist COHs on population health, (below), so this measure would assist CAHs and small PPS hospitals.
- ✓ Population Health grants would be available to COHs (up to \$650,000 a year to a COH) to address population health issues that are determined by a community health needs assessment.
- ✓ EMS grants would be available to CAHs, COHs, and rural hospitals of less than 50 beds to develop and implement strategies to develop successful EMS programs to meet community needs, provide quality, and address workforce and funding problems.
- ✓ And finally, the Save Rural Hospital Act would expand the CMS Shared Savings efforts (accountable care organization) to CAHs, COHs, and other rural hospitals of 50 or less beds.

- **Other Regulatory Issues.**

- Readmission penalty. As was stated by the Nurse Practitioner from Cando, in our meetings with your office for the NRHA Policy Institute, CAHs are penalized with a readmission penalty when a Medicare beneficiary is admitted to an urban tertiary, discharged, sent home (sometimes too early), and if they have to be admitted again in the hometown CAH, it is the CAH that is penalized. The penalty needs to be either applied to the first hospital or at the very least not applied to the second hospital that was not originally responsible for the admission.
- Cardiac rehab and supervision. Cardiac rehab rules require that a physician be in the building. Having a NP or PA who has had more training in cardiac events is not an alternative under those rules. ND has a growing number of rural

hospital/clinic systems that are solely staffed by NP and PA (no physician on site) that are precluded from offering cardiac rehab. There are also communities such as Oakes where they do have physicians; however, in the case of Oakes, they are married and when they leave for a vacation cardiac rehab services are halted. This has not only caused disruptions in scheduling cardiac rehab, it has also caused some patients to simply quit in frustration.

- ACA reporting. The ACA requires a great deal of reporting from health providers as employers. One rural hospital found they put in an estimated 50 hours in gathering information that is provided to Eide Bailly (the large accounting firm in Fargo that works with most ND CAHs along with CAHs in other states) to complete the appropriate federal forms for which they are billed about \$4,500, on an annual basis.