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ON

RURAL HEALTH

BEFORE THE
UNITED STATES SENATE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICE AND EDUCATION

MAY 7, 2015

U.S. Senate Appropriations Committee
Subcommittee on Labor, Health and Human Services, and Education
Hearing on Rural Health
May 7, 2015

Chairman Blunt, Ranking Member Murray, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to preserve access to quality health care for Medicare beneficiaries in rural areas. Effectively providing health care to the quarter of all Americans who live in rural areas presents unique challenges. Medicare beneficiaries in rural areas often reside a significant distance from the nearest health care providers and in medically underserved areas. Medicare beneficiaries often represent a higher percentage of the total patients served by rural providers than urban providers, making these businesses particularly sensitive to changes in Medicare payment policy. Rural areas often have fewer physician practices and hospitals, and face longer travel times to specialists. Due to higher rates of uninsured, rural providers rely disproportionately on Medicare payments.

CMS has a number of efforts to improve access to services for rural Medicare beneficiaries. CMS has rural health coordinators at each of our Regional Offices, who meet monthly with participation from CMS central office staff and the Health Resources and Services Administration (HRSA) to discuss emerging issues. Through the Rural Health Open Door Forum, CMS engages with stakeholders to provide current information on CMS programs, answer questions, and learn about emerging rural health issues. Through Medicare's teleheath benefit, Rural Health Clinics, and Critical Access Hospitals, CMS is making sure that rural beneficiaries have access to physician and hospital services that may not otherwise be available in their communities. Moving forward, the Center for Medicare and Medicaid Innovation is testing new payment and delivery models such as Accountable Care Organizations (ACOs) with a focus on how to explore and support efforts to make further strides in improving the quality of care in rural areas.

Working with Stakeholders to Minimize Burden

Last year, CMS finalized a rule that included reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers, which will save nearly $660 million annually, and $3.2 billion over five years. This rule specifically outlined ways to reduce burdens on rural health care providers. For example, a key provision reduces the burden on very small Critical Access Hospitals, as well as Rural Health Clinics and Federally Qualified Health Centers, by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. This provision seeks to address the geographic barriers and remoteness of many rural facilities, and recognizes telehealth improvements and expansions that allow physicians to provide many types of care at lower costs, while maintaining high-quality care.

The Rural Health Open Door Forum (ODF) provides an opportunity for stakeholder input on any issue that affects health care in rural settings. We cover topics such as Rural Health Clinic, Critical Access Hospital, and Federally Qualified Health Center issues, among others. For example, CMS recently had a call devoted exclusively to Veterans Affairs issues and had an expert from VA to assist rural providers with billing for services provided to veterans. Topics

that frequently arise in this forum often deal with payment policies, claims processing and billing for services, cost report clarifications, classifications for & qualifications of rural provider types, and the many special provisions of law designed specifically to improve rural healthcare. Timely announcements and clarifications regarding important rulemaking, quality program initiatives, and other related areas are also included in the Forums.

Promoting Access to Care in Rural America

CMS administers a number of programs that seek to expand access to services in rural areas. Medicare's telehealth benefit allows beneficiaries to receive certain services from physicians located outside their community. Rural Health Clinics, help to provide access to primary care services in rural areas while Critical Access Hospitals provide access to inpatient and outpatient hospital care where care would otherwise be unavailable.

Expanding Telehealth Access for Rural Areas

Advances in telecommunications technology have improved access to rural health care for such services as radiology and remote monitoring without the need for special provisions of regulation or statute. These technologies allow the transmission over great distances where the practitioner and the patient are remotely located. Medicare's telehealth provisions also allow services that would normally require the patient and their practitioner to be in the same location to be delivered via an interactive telecommunications system. Telehealth can help to expand access to specialized services that may not otherwise be available at facilities in some rural areas. Medicare payment for telehealth services is prescribed in section 1834(m) of the Social Security Act. According to the statute, Medicare pays for telehealth services that are furnished via a telecommunications system, by a physician or practitioner, to an eligible telehealth individual, where the physician or practitioner providing the service is not at the same location as the beneficiary. The telecommunications system generally must include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient at the originating site and the physician or practitioner at the distant site.

Beneficiaries eligible for telehealth services are those enrolled in Medicare Part B who receive such services at an originating site identified by statute, which includes the office of a physician or practitioner, a hospital, a rural health clinic, and a skilled nursing facility. An originating site must be located in a Rural Health Professional Shortage Area or in a county that is not designated as part of a Metropolitan Statistical Area. Entities participating in a Federal Telehealth Demonstration as of December 31, 2000 also qualify as originating sites.

A variety of practitioners are authorized as telehealth practitioners, including physicians, physician assistants, and nurse practitioners. Payment for the physician or practitioner furnishing telehealth services is made under the Medicare Physician Fee Schedule. The statute requires that this payment be equal to the payment for a face-to-face service. The originating site, where the beneficiary receives telehealth services, is paid a facility fee under Medicare Part B.

Currently, 75 codes are covered as telehealth services under Medicare. The statute specifically requires that Medicare pay for professional consultations, office visits, and office psychiatry services. The statute permits the Secretary to pay for other telehealth services which are considered through the annual physician fee schedule rulemaking process.

As we have established in rulemaking, services can be added if they are either:

- Similar to existing telehealth services, or
- Dissimilar to existing telehealth services and will produce demonstrated clinical benefits to a patient if delivered by a telecommunications system.

For 2015, CMS added psychoanalysis, family psychotherapy, annual wellness visits, and prolonged evaluation and management services as telehealth services.

In addition to Medicare payment for telehealth services as prescribed by statute, telehealth is a component of various initiatives currently being tested by the Centers for Medicare and Medicaid Innovation. For example, under the Health Care Innovation Awards initiative HealthLinkNow, Inc. is pairing aspects of telemedicine and telephyschiatry, with virtual care navigators and behavioral health specialists, to serve patients with a variety of chronic mental and behavioral health conditions in frontier and rural communities in Wyoming, Montana and Washington State. Also, organizations participating in the Bundled Payments for Care Improvement Initiative are eligible to waive some of the geographic restrictions so that they can bill for telemedicine services and receive Medicare fee-for-service payments. The Innovation Center's work may help us better understand the potential value of telehealth for improving the quality of care and reducing expenditures.

Critical Access Hospitals

Critical Access Hospitals (CAHs) are small rural facilities that serve communities that might otherwise lack access to emergency or basic inpatient care. Medicare reimburses CAHs at 101 percent of their reasonable inpatient and outpatients costs, rather than at the rates set by the applicable prospective payment systems or fee schedules. There are currently more than 1,300 CAHs in the United States. In order to be designated as a CAH, a Medicare-participating hospital must meet the following criteria:

- Be located in a State that has established a State Medicare Rural Hospital Flexibility Program;
- Be designated by the State as a CAH;
- Be located in a rural area or an area that is treated as rural;
- Be located either more than a 35-mile drive from any other CAH or hospital, or more than a 15 mile drive in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified by CMS as a CAH based on State designation as a "necessary provider" of health care services to residents in the area.
- Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units);and
- Furnish 24-hour emergency care services 7 days a week;

Since their creation, CAHs have provided needed hospital services to millions of Medicare beneficiaries. CMS is committed to preserving the CAH program and believes in ensuring that CAHs provide quality care to isolated communities without another nearby source of acute inpatient and emergency care.

When the program was created, states were permitted to designate hospitals as "necessary provider" (NP) CAHs. Designation as a NP CAH exempted the hospital from the CAH distance requirement, although these CAHs are still required to comply with all other CAH Conditions of Participation, including the rural requirement. Although Congress eliminated the ability to designate new NP CAHs after January 1, 2006, all existing NP CAHs remain permanently exempt from the distance requirement. Currently, about 75% of all CAHs are designated as necessary providers.

In 2013, the HHS Office of Inspector General (OIG) found that 64% of CAHs would not meet the distance requirements, including a number that are grandfathered and currently exempted from the distance requirement and recommended that CMS seek legislative authority to remove the distance requirement exemption, thus allowing CMS to reassess these CAHs.[1] OIG conducted an analysis of the services provided by nearby hospitals and found that approximately 93 percent of hospitals located near CAHs that would be affected provided emergency services.

The President's FY 2016 Budget proposes a more limited change than OIG called for that would prevent CAHs, including those currently designated as necessary providers, which are within 10 miles of another CAH or hospital from maintaining certification as a CAH. This change is necessary to ensure that only facilities whose communities depend upon them for emergency and basic inpatient care will be certified as CAHs and receive reasonable cost-based reimbursement. Under this proposed change, CAHs that are within ten miles of another CAH or hospital would be provided the opportunity to convert to certified hospital status, and would then continue to receive Medicare reimbursement through the ordinary inpatient and outpatient prospective payment systems, under which the majority of acute care hospitals are paid.

As requested by this Committee, CMS conducted an analysis on the impact of this proposal on access to services in rural communities.[2] Our analysis estimated that a maximum of 47 CAHs, out of a total of 1,339 certified CAHs, might be affected by this proposal. Moreover, facilities losing their CAH designation would not necessarily close. Instead, it is anticipated that many of these CAHs would continue to participate in Medicare as hospitals paid under the applicable prospective payment system, and would continue to provide hospital services to their communities without reliance on CAH designation. Hospitals that transitioned from their CAH status would be eligible for the Hospital Value-based Purchasing Program, which provides financial incentives for high quality of care and improvement in quality.

In the event that some of the potentially affected CAHs were to close, CMS analysis found that there likely is sufficient capacity in nearby facilities to provide the services any closed CAH had previously provided. CMS conducted an analysis of recent Medicare and cost report data for the potentially affected CAHs, as well as for the hospitals located within 10 miles of these CAHs. Overall, the data suggests that there would be no significant issues related to access to inpatient acute care services or skilled nursing services for the communities currently being served by the

[1] Department of Health and Human Services Office of Inspector General, *Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-enroll in Medicare*, August 2013, OEI-05-12-00080
[2] Centers for Medicare and Medicare Services, *Report on Critical Access Hospitals*, March 26, 2015

potentially affected CAHs should the CAH cease to provide services rather than convert its Medicare agreement to participate as a hospital.

The President's FY 2016 Budget also proposes changing reimbursement of CAHs to pay them for their actual costs of providing care. This change would generate savings to the Medicare program while protecting access to care by reimbursing hospitals for 100% of their costs.

Rural Health Clinics

The Rural Health Clinic (RHC) program was created to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners and physician assistants in rural areas. Approximately 4,000 RHCs nationwide provide access to primary care services in rural areas. Through this program, CMS provides advantageous reimbursement as a strategy to increase rural Medicare and Medicaid patients' access to primary care services. An RHC is a clinic that is certified by CMS to receive special Medicare and Medicaid reimbursement. RHCs are required to employ a nurse practitioner (NP), or a physician assistant (PA), and a NP, PA, or certified nurse midwife must be on-site to see patients at least 50 percent of the time the clinic is open, subject to state and federal supervision requirements. RHCs provide outpatient primary care services and basic laboratory services. RHCs must be located within non-urbanized areas that have health care shortage designations.

Rural Health Efforts at the Center for Medicare and Medicaid Innovation

Congress created the CMS Innovation Center for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits. The Innovation Center is uniquely positioned to test and evaluate efforts to identify and address challenges to access and quality of care for rural communities. In addition to these efforts to test improvements to telehealth, the Innovation Center is testing two models designed to support Accountable Care Organizations (ACOs) in rural areas. The Advance Payment ACO Model is meant to help entities such as smaller practices and rural providers with less access to capital participate in the Medicare Shared Savings Program. The ACO Investment Model is a new model of pre-paid shared savings that builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas.

Several projects focused on rural areas are also being tested through the Innovation Center's Health Care Innovation Awards initiative:

- The University of Kansas Hospital Authority is testing a model to implement the Rural Clinically Integrated Network (RCIN) to improve heart health and stroke survival for rural Kansas.
- Catholic Health Initiatives Iowa Corporation received an award to test a model to transition a network of rural critical access hospitals in Iowa to value-based care through improved chronic disease management, increased clinical-community integration and 'lean' process improvement initiatives.
- Northland Healthcare Alliance is implementing a modified version of the Program of All-Inclusive Care for the Elderly (PACE) model in rural North Dakota.

- St. Luke's Regional Medical Center is testing remote intensive care unit (ICU) monitoring and care management in rural areas of Idaho and Oregon.

In addition, the Innovation Center is implementing the Congressionally-mandated Frontier Community Health Integration Project (FCHIP) demonstration, focused on supporting essential health services in sparsely populated rural counties served by CAHs

Conclusion

CMS recognizes the challenges faced by beneficiaries and providers in rural areas. We are helping to address provider shortages through the Critical Access Hospital and Rural Health Clinic programs, and expanding the use of telehealth. We continue to test new delivery models to improve rural health care through the Innovation Center**.** I look forward to continuing to work with HRSA and the Congress on further improvements to deliver quality health care to Medicare beneficiaries, regardless of their location.