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Health Panel

Keith J. Mueller, PhD, Chair
www.rupri.org/ruralhealth
(402) 559-5260 • kmueller@unmc.edu

Highlights of Rural Perspective/Commentary Regarding Proposed Options to Improve Patient Care and Reduce Health Care Costs

The RUPRI Health Panel offers the following comments on the Senate Finance Committee document for the purpose of discussion on rural implications of proposed policy options. Panel comments parallel the sections of the Senate Finance Committee document excerpted from a longer Panel document (available at www.rupri.org/healthpanel).

Section I: Payment Reform

- Among additional hospital measures, consider clinical processes of care typically delivered in rural hospitals such as patient transfers, ED handoffs.
- Distribute all unearned withholds as local/regional quality improvement technical assistance, and provide quality improvement technical assistance to rural hospitals.
- A CAH VBP program is essential, and should include measurement of services commonly provided by CAHs, including outpatient care. Assisting CAHs with developing and acquiring appropriately scaled quality-enhancing knowledge, skills, and health information technology should be a priority.
- Calculating physician incentive payments without regard to geographic adjustment will make this more meaningful to rural providers.
- Opportunities for technical assistance and funding assistance to implement new information systems in small rural practices need time to have an impact prior to any use of penalties.
- The proposed level of bonuses for primary care will be only marginally beneficial for rural providers, and therefore insufficient to effect change in physician distribution.
- Benefit of payment increases for office and other visits may be partially offset within rural primary care practices by reductions in other codes those physicians also use because their practices are more likely to engage in procedures than are their urban counterparts.

Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

- Innovations in chronic care management should include ways of adapting approaches to low patient volume environments.
- Many rural residents receive inpatient services at larger urban hospitals. Bundling through hospital payment may create disincentives for urban hospitals to use rural providers for post-acute care services, creating access burdens for patients and possibly affecting quality of care and outcomes.

- Contracting issues in bundled payment schemes (and the lack of attractiveness to larger hospitals of negotiating with low-volume providers such as rural practices) may inadvertently also affect the patient base and financial status of rural providers.
- Operational definition of "formal legal structure" will be important for rural provider networks formed without unified governance but with signed agreements among providers (such as single signature capability).

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

- Health information technology incentives for physician assistants and nurse practitioners will support technology implementation in rural health clinics and other rural practices.
- Measures related to coordination of care across episodes of care and care transitions will be especially meaningful in rural places.
- Policies to address rural physician shortages should be supported by increases in primary care and general surgery residency slots and additional financial incentives to enter those career paths.
- Assuming effective policies generating interest in primary care careers, the strategies for reallocating unused residency slots as outlined in this proposal appropriately target areas of high priority need.
- Funding should support a national health workforce commission and state or regional commissions charged to assess provider supply/distribution and recommend policies to address specialty and geographic shortages.
- Legislation should support new outpatient practice models that optimize the training, experience, and licensure of all rural health care professionals.

Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management

- Rural residents are less likely to enroll in MA plans, especially those from remote rural areas; more balance between the support given to the MA and traditional Medicare fee-for-service programs would benefit rural beneficiaries.
- The option to blend to local and national FFS rates would seem in theory to raise many rates in rural areas because spending is below the national average, however benchmark rates would fall below current rates in many if not most rural areas due to historical payment changes (e.g., floor payments). Thus this change would lead to significant payment reductions in rural areas, potentially leading to reductions in benefits and drops in the number of plans available.
- Changes to the calculation of payment to MA plans should include analysis of changing the geographic area used as the basis for rate setting, moving from county boundaries to more rational service areas to smooth wide variation in payments
- Making bonus payment a flat payment and not dependent on current payment would be geographically neutral providing the full benefit in rural areas.
- Any specification of extra benefits should require that those benefits be available at the same out-of-pocket cost to all beneficiaries enrolled in the plan, regardless of where they live or receive care.