

House Tri-Committee Health Reform Discussion Draft

A Rural Commentary – July 13, 2009

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The RUPRI Panel provides this commentary as a means of contributing to the ongoing dialogue. The considerations we suggest are intended to spark additional discussion of legislative intent.

ADVANCES RURAL INTEREST

Several provisions in this title address long-standing barriers to securing adequate, affordable insurance coverage for rural Americans. Individuals and small groups (either single businesses or associations of small businesses), which are prevalent in rural areas, have been precluded from competitively priced insurance, which will change because of these provisions:

- Guaranteed issue
- Guaranteed renewability of coverage
- Prohibition of preexisting condition exclusions or other discrimination based on health status

Connecting rural residents to new insurance opportunities is currently a challenge. This proposal recognizes this in Section 205 by requiring provisions to ease enrollment. The tax credit for small business (Section 421) will be especially helpful in rural areas, where employment through small businesses paying low to moderate salaries is more prevalent than in urban areas. Reinsurance for early retirees will also be especially helpful in rural areas, where the elderly are a high percentage of the total population.

Increased payment for primary care services as compared to other services will help attract the needed primary care workforce, more essential in rural areas. However, the financial differential will have to be substantial to shrink current differences in starting income.

While the increase for selected primary care services in Section 1303 is helpful, we caution against high expectations; a 5% E&M code reimbursement increase for Medicare patients will result in only approximately a 2.6% increase in total physician income (based on a prototypical primary care practice, per analysis by the RUPRI Center for Rural Health Policy Analysis, available upon request). Further, rural primary care physicians also render services that are coded as procedures because other proceduralist physicians are not locally available.

Increased funding and loan repayment ceilings for the National Health Service Corps should help place professionals in rural areas. Other provisions related to workforce, including establishing a National Center for Health Workforce Analysis, could help address rural needs for all types of health professionals. Granting fellowships to physicians who plan to teach or conduct research in a family medicine, general internal medicine, general pediatrics, or geriatrics training program may help with recruiting rural preceptors.

GENERAL CONSIDERATIONS

The discussion draft includes some provisions that could create problems for rural areas. Some concerns could be addressed with changes to the legislation, while others involve questions of interpretation to be addressed during implementation.

Legislation

- Section 115 leaves ensuring adequacy of networks to the Commissioner; network adequacy is critical to insuring access for rural people. The legislation could establish a general rule, taken from regulations applied to Medicare Advantage plans, that networks must be, at a minimum, consistent with historical, prevailing patterns of community utilization.
- Given low incomes among rural residents and for employers of small groups, the legislation could declare annual out-of-pocket cost limits and forbid lifetime limits.
- Requirements to contract with essential community providers could be strengthened if there were minimum payment requirements, such as the Medicare payment plus a percentage (but less than current average private level).
- Considerations of changes in disproportionate share payments to hospitals afford an opportunity to include all hospitals (e.g., Critical Access Hospitals) in the DSH program.
- Considerations for changes in payment for home health care should include travel distance and fixed costs that are incurred regardless of low volume of visits.
- Pilot programs involving Accountable Care Organizations (Section 1301) must include rural sites where there are currently no models for integrating practices that are not part of single governance organizations. These sites might implement independent practice associations and other innovative methods of linking physician practices, including agreements with hospitals.
- When considering patient-centered medical homes, the Secretary should require evidence of team-based care for a practice to qualify as a medical home.
- Coverage of preventive services (Section 1305) could be guided by the recommendations of the US Preventive Services Task Force.
- Section 1441 could set an expectation in legislation that the priority list include conditions unique or common to rural and/or low-volume providers. Patient-centered and population-based measures include measures of care coordination that cross differing geographic areas, such as rural and metropolitan areas.
- Section 2211 could include Community Paramedics as "other Professionals" and define them as licensed EMS providers supervised by a physician, nurse practitioner or physician's assistant.
- Section 2213 could specifically give priority to applicants with a record of placing providers in rural underserved areas.

Implementation

- Oversight of the Health Choices Commissioner should include monitoring equitable treatment of all legal residents.
- Rural organizations should become involved in the outreach and enrollment activities sponsored by the Health Choices Commissioner, similar to the "partners" that have helped enroll Medicare beneficiaries into Part D plans.

- The effects of linking physician payment to Medicare rates in the public plan should be monitored, and perhaps levels reconsidered, to assure adequate primary care physician participation in the program.
- This legislation drastically changes physician payment policy, and in a direction that is generally favorable for increasing access to primary care in rural areas. The actual impact on the attractiveness of careers in primary care and locating in rural areas should be monitored and inform further annual adjustments.
- While reducing preventable hospital readmissions is laudable, local circumstances will need to be considered, such as availability of post-discharge services interacting with pressure for timely discharge to create situations of readmission.
- The Secretary's report required by Section 1152 regarding bundled payment must include considerations of how such payment would be distributed in a rural environment.
- The distribution of unused residency positions (Section 1501) should allow unused positions to continue if they are in primary care, the assumption being that other sections of this legislation encouraging primary care careers will have an effect on residency choices.

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