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Health Panel
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Highlights of Rural Perspective/Commentary Regarding Proposed Health System Savings and Revenue Options

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: Health System Savings

- Policies deriving savings from provider payment should account for differences in current and expected margins such that low margin but essential rural providers are not threatened.
- Accounting for differences in conditions and service areas should be sensitive to special circumstances in serving sparsely populated rural areas, which often include substantial drive times for a home visit and therefore fewer visits per day.
- Any change in DSH policy, including downward adjust over time, creates an opportunity to make all hospitals, including critical access hospitals (CAHS), eligible for DSH payments. CAHs are not currently eligible for DSH because they are not paid under PPS, but if the policy purpose of these funds is to cover the costs of treating the uninsured, CAHs should be eligible for payments.
- If income of physicians in shortage and underserved areas is reduced as a consequence of capturing savings, it could result in increased difficulty recruiting and retaining physicians in these areas.
- Exploring accuracy in payment for services in rural areas should account for increased costs of providing DME due to distance to clients and low volume.
- A single productivity adjustment should be based on verification of productivity gains across all providers regardless of size and geographic location.
- Current methods of assessing health status rely on claims history; typically an individual with more claims will appear to have poor health status. Adjustments based on claims history will result in lower payment in places where use is affected by lack of access to services. Therefore prior utilization is not an appropriate indicator of health status, especially in rural areas.
- A modest percentage of savings captured by these options could be dedicated to leveling payment between high-spending urban and low-spending rural areas, thereby both addressing current inequities and increasing the financial rewards for providing services in rural areas.

SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage

- The actuarial value of plans offered in rural and urban areas is currently not comparable; the overall actuarial value of plans offered in nonmetropolitan counties is 79.9%, compared with a value of 83.9% in metropolitan counties. When considering geographic variation in setting policy the committee should consider market factors influencing premiums as well as benchmark actuarial value.

SECTION III: Other Health Care Related Revenue Raisers

- The requirement for minimal level of charitable patient care should apply to all hospitals providing patient care; this should be done in tandem with changes to Medicare DSH eligibility making hospitals eligible for DSH payments.
- A requirement to conduct a community needs analysis, while appropriate, implies a cost to small charitable hospitals in rural areas; this may be met through collaboration with regional or state organizations that can provide appropriate tools and technical assistance for analysis, if appropriately funded.