WISCONSIN RHC WEBINAR

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Congress

- Congress adjourned a few weeks ago to go home to campaign.
- Congress has yet to pass any of the 12 Appropriations bills necessary to fund the federal government.
- Prior to adjourning, Congress adopted a Continuing Resolution effectively extending the current fiscal year through December 11th.

Congress will reconvene after the election for a lame duck session.

Lame Duck sessions are notoriously unproductive and there is no reason to believe that this one will be any different than previous lame duck sessions.

This is particulalry true now that we know that the GOP will be taking control of the Senate come January.

Beyond dealing with appropriations bills to prevent a government shut-down and potentially dealing with some expiring tax provisions, no substantive legislation is likely to be considered during the November/December lame duck session.

Post Election (2014)

During the lame duck, Congress will enact another Continuing Resolution keeping the government open; however, it is not clear how long that CR will last. It could be short-term (1 - 3 months) or long-term (9 months) or somewhere in between.

Who are We?

Number of RHCs Per State – Top 10

Missouri	374
Texas	313
California	286
Illinois	221
Kansas	179
Michigan	172
Mississippi	163
Kentucky	147
Florida	143
Iowa	142

RHCs per 100,000 population

North Dakota	8
Montana	7.5
Nebraska	7.3
South Dakota	7
Kansas	6
Minnesota	6
Mississippi	6
Missouri	5.5
Iowa	5
Ohio	5

Comparison

Missouri	**374**
Texas	313
California	286
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Michigan	172
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Kentucky	147
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North Dakota	8
Montana	7.5
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Kansas	**6**
Minnesota	6
Mississippi	**6**
Missouri	**5.5**
Iowa	**5**
Ohio	5

RHC National Issues

Sequester Update

- Beginning in 2013, Sequester mandated 2% cut in RHC Medicare payments was adopted. This applied to ALL providers.
- Beginning April 1, 2013, Medicare RHC payments were reduced from 80% of the approved amount to 78.4% of the approved amount.

What will this mean for 2014 and beyond?

On January 1, 2014, the RHC Cap was set at $79.80 per visit.

With the allowable for the RHC in 2014 of $79.80, then the actual payment from Medicare has been: **$62.56** per visit ($79.80 X .784). The calculation of the beneficiary coinsurance (20% of fee schedule amount) is un-changed.

Sequester

- We do not expect any NEW sequester related cuts for Medicare HOWEVER, the existing reduction remains in place.
- Absent Congressional action, Medicare will continue the 1.6% reduction in provider payment for the foreseeable future.

Sequester

Although the sequester reduction is scheduled to go away in 2023*, providers should anticipate that this reduced amount (78.4% compared to 80%) will remain in place forever!

We expect that Congress will extend the back-end of this cut year-by-year for the foreseeable future.

Issues of Interest

Reduce the amount of Bad Debt RHCs, CAHs and others can claim from 65% to 25% over three years.

Close CAHs that are within 10 miles of one another.

Reduce CAH payments from 101% of costs to 100% of costs.

Of these, the most likely candidate for adoption is the Bad Debt proposal. At this time, we see no movement on the other proposals.

RHC Legislative Issues for 2014 and beyond

- Raise the RHC Cap
- Increase flexibility for RHCs
- Remove unnecessary regulatory burdens on RHCs
- Establish a long-term payment methodology that allows All RHCs to recoup costs for care provided to Medicare and Medicaid patients
- Improve EHR incentive payments for RHCs

Raise RHC Cap

NARHC has been working with key Members of Congress to raise the RHC cap to $92.00 per visit.

RHC Payments

Establish a long-term payment methodology that allows All RHCs to recoup costs for care provided to Medicare and Medicaid patients and incorporates RHC specific quality measures. ORHP has funded an initiative to identify quality measures appropriate for the RHC setting.

The Muskie Institute is still looking for RHCs to participate in their quality survey. Please contact John Gale:

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RHC Payments

The Rural Health Clinic all-inclusive payment methodology was the first bundled payment under the Medicare program.

But despite the national move to bundled payments, the RHC payment system has come under some criticism of late.

AND…

Allow RHC to be the "providers of care" in telemedicine arrangements rather than just the originating site.

Medicaid EHR incentive Payment Program

- Modify "Needy" Threshold
- Open to ALL PAs, not just those who "lead" RHCs.

RHC Regulatory Issues

This Summer, we had several regulatory victories for RHCs and their patients

1. Eliminated the regulatory requirement for physician on-site availability and instead, defer to applicable state law/state regulatory mechanism.

   New Rule went into effect in early July, 2014.

And…

2. Changed the RHC rule from 60% PA/NP staffing to mirror the law – 50%.

New Rule went into effect in early July, 2014.

And…

3. Allowed some PAs and NPs to be independent Contractors in the RHC setting rather than "employees"

New Rule went into effect in early July, 2014.

And…

4. Allow certain preventive services visits to be billable visits when performed in the RHC setting when delivered as "stand alone" services.

   CMS "clarified" their policy in mid-August to allow the following services to be billed when performed as "stand alone" visits in the RHC:

Service	HCPCS Code	Long Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance Deductible
Initial Preventive Physical Examination (IPPE)	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	Yes	Yes	Waived
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	Yes	No	Waived
	G0439	Annual wellness visit, including PPPS, subsequent visit	Yes	No	Waived
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes	No	Waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	Yes	No	Not Waived
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	Yes	No	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist	Yes	No	Not Waived

ACA Implementation

Medicaid Expansion

Due to the Supreme Court ruling last year, Medicaid expansion is voluntary rather than mandatory. Each state must determine whether they wish to expand Medicaid coverage to the levels identified in the ACA (138% of poverty for all).

It appears that MOST states are agreeing to expand Medicaid eligibility. This should be good for RHCs.

Medicaid Expansion

Several states have sought and obtained Medicaid Waivers allowing the state to ignore various federal mandates, including recognition and payment for RHC services.

To date, those states seeking waivers have agreed to continue to pay RHCs using the PPS methodology. NARHC has communicated with those states and played a role in helping to preserve the PPS payment methodology for RHCs.

State Innovation Waivers

Several states have submitted Medicaid "Private Option" Medicaid waiver requests and these have been approved by CMS:

Submitted and approved Private Option Waivers:

- Arkansas
- Iowa
- Pennsylvania

Medicaid Expansion

28 States have authorized Medicaid Expansion (i.e. covering everyone up to 138% of poverty) and additional states are actively considering expansion.

What is "Private Option" Medicaid?

In lieu of expanding traditional Medicaid, state pays the premium for an eligible individual to enroll in a private plan sold on the Exchange that has benefits comparable to what would have been covered by Medicaid.

How did RHCs fare?

All of the Innovation proposals are for those individuals NEWLY eligible for Medicaid.

ACA Update

ACA

- **Mandatory coverage for <u>individuals</u> began January 1, 2014.**
- **The employer mandate has been delayed until January 1, 2015 for large employers (over 99 employees) but for "medium sized employer (50 – 99 employees) it has been delayed until January 1, 2016**

New Supreme Court Case

On Friday, November 7th, the Supreme Court announced that they have agreed to accept the case known as King Vs. Burwell. This case challenges the tax subsidies and whether they are available to all individuals or only those purchasing health insurance through an Exchange Operated by a state.

Oral arguments could be heard in January and a decision in late Spring.

The outcome of this case is HUGE in terms of the future of the ACA.

When is the next ACA Open Enrollment?

Open Enrollment begins again on **November 15, 2014** and will go until **February 15, 2014**.

Originally, open enrollment was to be from October – December; however, the Administration is delaying the open enrollment for 2014. It is expected that for future years – October – December will be the open enrollment period for coverage beginning January 1.

Individuals can change plans, sign up for a new plan if they missed enrollment in the previous year.

Once the open enrollment period ends, individuals will be prohibited from purchasing a Qualified Health Plan until the NEXT open enrollment period UNLESS there has been a "qualifying event" that would allow the individual to go back into the marketplace.

ACA Open Enrollment

Automatic Re-enrollment will be available this year. The Administration expects that 90% of people will re-enroll in the plan they chose last year.

What is Auto Enrollment?

CMS expects that as many as 95% of the 7 million individuals who enrolled in a health plan through an Exchange in 2014, will "auto enroll" in that same Health Plan for 2015. In other words, people won't necessarily "shop around" but instead, will take the path of least resistance, and automatically re-enroll in the Health Plan they are already in. Most people will not be required to do anything to keep their existing premium tax credits or cost-sharing subsidies.

Health Reform – Is the Debate Over?

Even with Republicans taking control of the Senate and increasing their majority in the House, changes to the ACA will be largely on the margins. The heart of the ACA will remain intact. The GOP controlled Congress will be unable to repeal the ACA.

Why?

President Obama has shown no indication that he is any more prepared to compromise than House or Senate Republicans

Likely?

NETWORK ADEQUACY
PLAN OPTIONS
THE URGE TO MERGE
MEDICAL DEVICE TAX
MANDATES?

Network Adequacy

- Plans will come under increasing pressure to demonstrate that their networks are "adequate".
- Pressure will come from both Congress (Republicans and Democrats) and CMS
- This will be especially important in rural areas…

Skinny Network or Anorexic?
Specialty Physician's within 30 mile radius of zip code 22153

	CareFirst Silver	CareFirst Platinum	CareFirst Commercial
Specialty Physicians	9 total	178 Total	206 Total
	5 Board Certified*	83 Board Certified	105 Board Certified

What Can or Will Be Done?

CMS has made some minimal efforts to encourage plans to be more inclusive but major gaps remain. 30% of safety net providers in the service area MUST be in-network. RHCs are considered "safety net" providers – BUT YOU MUST PUSH THE PLANS on this

CMS has suggested that one option under consideration is using the Network Adequacy standards currently in use for Medicare Advantage plans.

What Will be Done?

Some stakeholder groups are pushing for "Any Willing Provider" language.

Health Plans will vigorously oppose these efforts

The Urge to Merge

A substantial majority of hospitals are now part of health systems.

In 2012, 247 hospitals merged, according to the American Hospital Association, three times as many as in 2008.

Ten years ago, hospitals owned a quarter of the physician practices in the country.
By 2011, they owned half.

ACOs Are they the Answer?

There are an estimated 500 to 600 ACOs in the U.S. providing care to 15 to 17 percent of the population. ACOs exist within three different models: Medicare Shared Savings Programs, Pioneer ACO models and commercial ACOs.

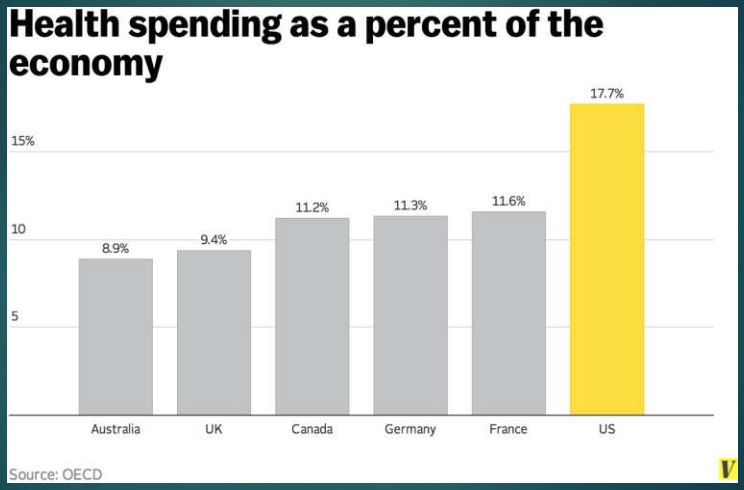
Medicare Shared Savings Program ACOs

Bonus Payments are calculated based on the ability of the designated physicians to achieve preset cost savings targets. The hope is they will help save $940 million over the first four years.

CMS approved 114 ACOs for participation in the Medicare Shared Savings Programs.

54 achieved savings in the first year.

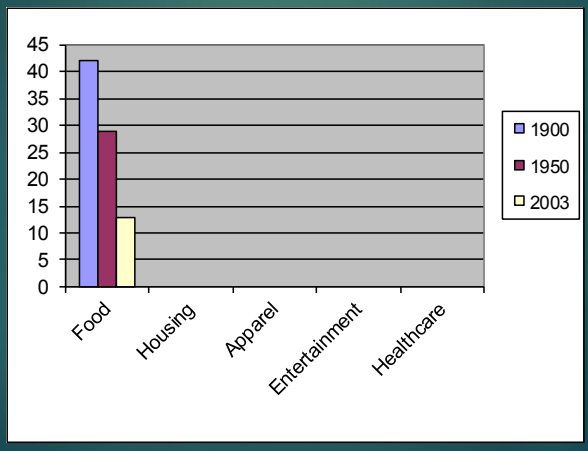
Of those, 29 have generated enough savings to offset the necessary investment costs.



But what if we looked at this differently?

Percentage of Household Income devoted to various goods and services 1900 – 2003.

Source: Bloomberg Business



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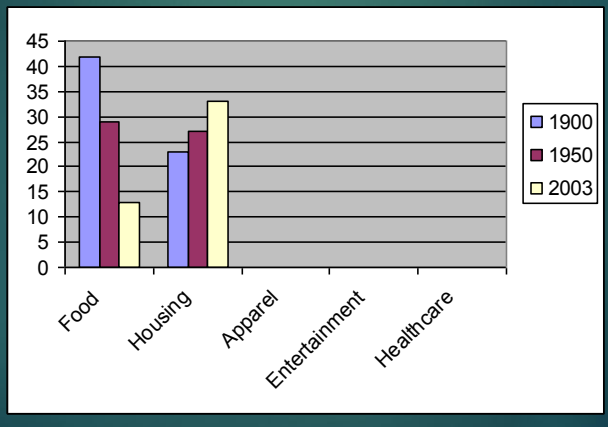

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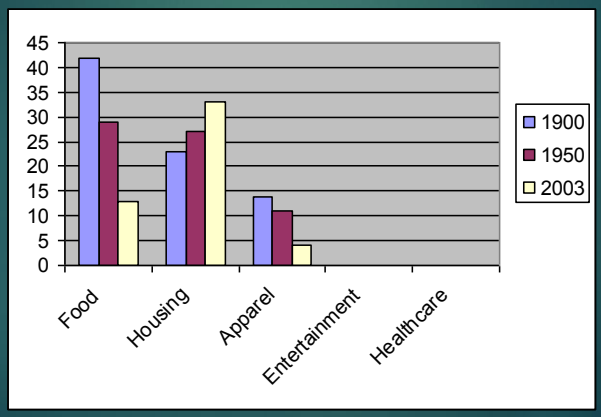

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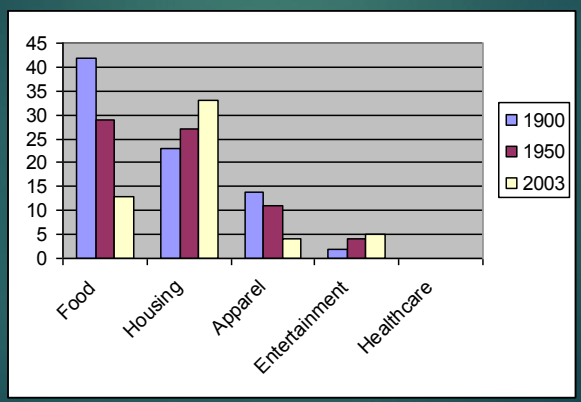

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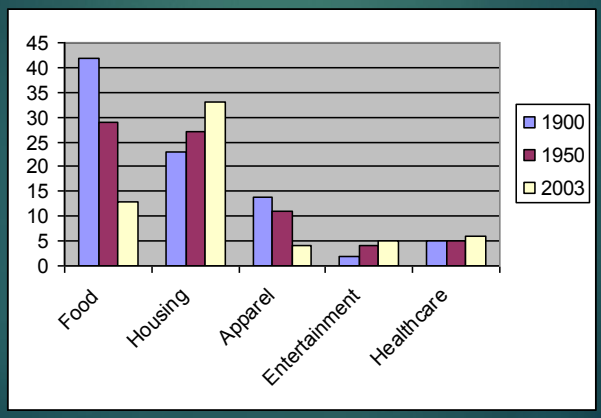

Are we truly spending too much on healthcare?

Is healthcare too expensive?

Concluding thoughts

Sir Winston Churchill once said of Democracy, "Many forms of Government have been tried, and will be tried in this world of sin and woe. No one pretends that democracy is perfect or all-wise. Indeed, it has been said that democracy is the worst form of Government except all those other forms that have been tried from time to time."

The healthcare corollary to that is, "Many forms of payment for healthcare have been tried, and will be tried in this world of sin and woe. No one pretends that fee-for-service is perfect or all-wise. Indeed **it has been said** that fee-for-service is the worst form of payment except for all those other forms that have been tried from time to time.…

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