STATEMENT OF

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CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"AGING IN RURAL AMERICA: PRESERVING SENIORS' ACCESS TO HEALTH CARE"

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Testimony of John Hammarlund
Regional Administrator, Seattle & Chicago Regional Offices
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Good morning Chairman Kohl, Senator Smith and distinguished members of the Committee. Thank you for the opportunity to testify today regarding the role of the Centers for Medicare & Medicaid Services (CMS) in issues impacting seniors in rural America. I am John Hammarlund, Regional Administrator for the Chicago and Seattle offices of CMS. In this role, my primary focus is outreach and education about CMS programs to Medicare, Medicaid, and State Children's Health Insurance Program stakeholders in ten states: Alaska, Idaho, Illinois, Indiana, Michigan, Minnesota, Ohio, Oregon, Washington, and Wisconsin. I also am the national lead for rural health issues on behalf of all the CMS regional offices, and help to disseminate and explain CMS policy to rural providers and beneficiaries.

CMS is working to transform itself from a passive payer for services into an active purchaser of higher quality care by linking payment to the value of care provided. This transformation is intended to shift Medicare away from paying for services based solely on volume and to promote higher quality, more efficient health care using techniques such as performance-based financial incentives, public reporting of quality information,

and medication management to encourage improvement in all aspects of quality, including patient safety.

CMS serves beneficiaries and providers in all parts of the nation- urban, suburban, and rural- and we recognize that each geographic area is unique. While fee-for-service Medicare's benefit design and statutory payment systems generally follow a broadly uniform, nationwide approach, we recognize the special needs of rural beneficiaries and strive to address those needs and ensure access. In addition, the Medicare Advantage (MA) program and prescription drug benefit under Part D offer a wide range of benefit options and meaningful choices for beneficiaries throughout the country, including rural areas.

In early 2008, CMS formed the Rural Health Council, an internal working group designed to more effectively respond to legislation that affects rural beneficiaries and address issues of concern from rural health care providers. Through improved internal coordination, this group will facilitate an effective process for working on regulatory and other issues that affect rural health care providers. We also regularly share information with National and State Rural Health Associations, the National Organization for State Offices of Rural Health and other such organizations to ensure we understand the environment where rural health care providers and rural Medicare beneficiaries are living and working.

CMS is committed to working hard to ensure that rural beneficiaries have access to quality providers. We are the primary payer of healthcare services in geographically rural areas. To this extent, we have an obligation in ensuring the quality of and access to healthcare in these areas. In recognition of the special needs for rural areas, Congress has established and CMS has implemented a number of key rural programs with incentives to ensure quality, access, and beneficiary choice such as:

- **Critical Access Hospital (CAH) Designation**: This designation allows hospitals of 25 beds or fewer and that meet certain other conditions to receive 101 percent of cost as reimbursement for treatment of Medicare beneficiaries. This payment approach ensures small hospitals in rural areas will have their costs of caring for beneficiaries covered. In April of 2008, CMS issued guidance that allows CAHs to maintain observation beds that don't count against the 25 bed limit, giving them even greater flexibility. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) further improved CAH payments by permitting CAHs to receive 101 percent of cost payments for lab services under certain conditions. Additionally, MIPPA offers grants of up to $1 million each ($5 million total) for some Critical Access Hospitals that decide to convert to a Skilled Nursing Facility or Assisted Living facility. This provision was designed to allow better access to long term care options in communities where patients and their families live.
- **Rural Health Clinic (RHC) Designation and Federally Qualified Health Centers (FQHC) Proposed Rule:** Clinics that are certified by Medicare as Rural Health Clinics (RHC) receive cost-based payments, subject to a per-visit limit) for

outpatient physician and certain non-physician services. The new proposed rule issued in June 2008, would implement statutory requirements such as establishing location requirements and exception criteria for RHCs (required by the Balanced Budget Act of 1997); revising the RHC and FQHC payment methodology to comply with the Medicare Prescription Drug Improvement and Modernization Act of 2003; and requiring RHCs to establish a quality assessment and performance improvement (QAPI) program. We have taken this opportunity to propose other programmatic changes that have been requested by the RHCs, such as allowing RHCs to contract with RHC non-physician providers under certain circumstances and allowing one year waivers of the requirement that an RHC have an Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife when efforts to hire one of these practitioners has not been successful. These proposed changes would give RHC providers the support they need to assure that rural beneficiaries get the care they need, and will assure that this program continues to be available to clinics, practitioners, and beneficiaries in rural areas.

- **Sole Community Hospital Designation:** This is a designation for hospitals with 50 beds or fewer that are geographically isolated. These hospitals are paid based on the higher of the Federal inpatient prospective payment rate or a hospital-specific rate. They are eligible for disproportionate share hospital payments, and depending on their location, may be eligible for a higher wage index. They may also be eligible for help with fixed costs if they experience a decline in patients due to circumstances beyond their control.

- **Flu and Pneumonia Vaccine Incentives:** RHCs and FQHCs receive 100 percent of reasonable costs for flu and pneumococcal vaccines and administration. This assures that rural and underserved beneficiaries who get their care in an RHC or FQHC will not have a financial barrier to receiving these vaccines.
- **Health Professional Shortage Area Bonus Payments**: Physicians furnishing Medicare services in an area that has been designated by Health Research Services Administration as a geographic Health Professional Shortage Area (HPSA) receive a 10 percent bonus on those services. This bonus is an important tool in the recruitment and retention of physicians to underserved areas, and is especially crucial in rural areas where the loss of even one physician can have an impact on the community.
- **Telemedicine:** CMS recognizes the utility and the necessity of a telehealth program in the delivery of certain health care services. Since 2001, CMS has paid for professional consultations, office visits, psychotherapy and pharmacologic management delivered via telecommunications systems. With the passage of MIPPA, Medicare telemedicine services can be furnished in more settings, including hospital-based renal dialysis facilities, skilled nursing facilities, and community mental health centers.
- **Medicare Advantage:** MA enrollment in rural areas has grown significantly. Up until 2006, plan options were concentrated in largely urban areas. Now, plans are available in every region of the country, including rural areas, and virtually all beneficiaries have access to at least one MA plan option. Further, in the past 5 years, MA enrollment in rural counties has increased more than 600 percent. The

use of “floor” payment rates has helped to ensure beneficiaries in rural areas have improved access to MA plans, which typically offer additional benefits, for example, reduced cost sharing, reduced Part B or D premiums, and additional covered services such as dental and vision care.

- **Part D:** With a high value placed on beneficiary choice, CMS developed and enhanced an unprecedented network of support to ensure people with Medicare and their loved ones have access to the information they need to select the plan that serves their health care needs best. Rural seniors, like all Medicare beneficiaries, can find information about Part D Plan options at 1-800-MEDICARE, the Plan Finder tool available at Medicare.gov, and through their local State Health Insurance Assistance Program (SHIP). CMS has been working to reach seniors in rural areas, in collaboration with more than 900 partners across the country including SHIPs, local Area Agencies on Aging, pharmacies, membership organizations, and countless other community partners. In the fall 2007 open enrollment campaign and spring 2008 low-income subsidy campaign, radio was used to specially target beneficiaries living in rural areas, where in many cases, print outlets are not available. Additionally, the SHIP funding formula takes into account the challenges associated with conducting outreach in rural areas.
- **FLEX Grants:** The Medicare Rural Hospital Flexibility Program provides grants to states that rural health care providers can use to improve the quality of care facilities provide, and to strengthen health care networks. Funds can be used for services ranging from ambulance transport to the development of small local

hospitals. MIPPA extended the FLEX Grant program through 2010, and will add a new component making mental health services more accessible to rural Iraq War veterans and other rural residents.

- **Demonstration Programs:** CMS has several demonstration programs that benefit rural providers. One is the Frontier Extended Stay Clinic or FESC demo in my corner of the country, up in the Pacific Northwest. This demonstration allows extremely remote clinics to receive payments for critical patients that cannot be immediately transferred to an acute care facility due to weather conditions or other circumstances beyond their control. FESCs are in five remote villages in Alaska and a remote island in Washington State. Additionally, the new MIPPA law provides for a demonstration project that allows eligible entities in up to four states, to explore ways to improve access to, and better integrate acute care, extended care, and other essential health care services to Medicare beneficiaries.
- **Ambulance Services:** Medicare recognizes the unique challenges facing rural ambulance providers and its fee schedule takes into account these challenges in myriad ways. Until the end of this year, for ground ambulance trips that are longer than 50 miles, Medicare allows a 25 percent mileage payment bonus for each mile in excess of 50 miles. Until the end of next year, Medicare allows a 3 percent bonus on payments made for ground ambulance transports where the point of pick-up is in a rural area. Until the end of next year, Medicare will also pay a "super-rural bonus" of 22.6 percent for ground ambulance trips which originate in rural areas with the lowest population densities, and will determine

payment for ground ambulance services based on a blend of national and regional fee schedules for certain census areas where payment determined under the applicable regional fee schedule is greater than the national ground base rate. Finally, the total payment for rural air ambulance services (base rate and mileage) is increased by 50 percent.

We strive to be comprehensive source of information to rural health care providers to help them provide the best care they can to their patients. The CMS website www.cms.hhs.gov has an extensive array of information and material for rural providers under the link "Rural Health Center" that can assist providers in delivering care to Medicare beneficiaries in rural areas.

Conclusion

Thank you again for the opportunity to testify today. CMS appreciates the Committee's ongoing interest in this important issue. We believe by continuing to support the unique needs of health care providers in rural areas through the initiatives described above, we will ensure seniors and disabled people with Medicare will maintain access to quality services. We are continually considering initiatives to improve access and quality within Medicare and look forward to continued work with the Committee and our partners represented here today to further strengthen our stewardship of Medicare.