

90 YEARS OF CARING, ADVOCACY & IMPACT

Task Force on Ensuring Access in Vulnerable Communities Rural and Frontier

EXECUTIVE SUMMARY AND REPORT • September 2016

Mark Schmidt (Chairperson)
Bryan Breitling
Mike Diedrich
Deb Fischer-Clemens
Nick Fosness
Nick Kotzea
Tammy Miller

Erica Peterson
Tom Richter
Veronica Schmidt
Stephan Schroeder, MD
Bryan Slaba
Sherry Bea Smith
Angelia Svihovec

Tricia Uhler
Larry Veitz
Gale Walker



EXECUTIVE SUMMARY
Task Force on Ensuring Access in Vulnerable Communities
~Rural and Frontier~
August 2016

The South Dakota Association of Healthcare Organizations (SDAHO) Task Force on Ensuring Access in Vulnerable Communities was formed in fall 2015 and concluded their work in June 2016. The Task Force was comprised of 17 members and included learning from a number of professionals who shared their expertise on a broad range of rural health issues.

Following the structure established by the American Hospital Association (AHA) Task Force on Ensuring Access in Vulnerable Communities, members of the South Dakota Task Force identified the characteristics and parameters of a vulnerable rural or frontier community; studied opportunities for innovation and emerging strategies, delivery models and payment models; and determined what, at a state and federal level, will impede or create a climate for transition to those different models.

The Task Force defined a vulnerable community as a rural or frontier area that represents the converging effects of interactions between multiple factors (socioeconomic determinants, financing mechanisms, geographic distances, workforce challenges, and demographic characteristics) that determine individuals' access to health, ultimately influencing the risks of contracting or recovering from illness and conversely the benefits of optimizing health. Communities experiencing multiple vulnerability traits are susceptible to cumulative vulnerability risk that endangers the sustainability of quality health care services for more than 50% of the State's population or greater than 450k individuals living in rural and frontier South Dakota.

Community residents should be able to access essential health care services in rural and frontier areas, including primary care, emergency services, behavioral health, dental services, transportation, diagnostics needs, prenatal care, referral and coordination resources; and long term services and community supports. Access to essential health care services is critical for overall physical, mental, and social needs; prevention, detection and treatment of illness; quality of life, and life expectancy.

A sustainable rural health care delivery system should focus on the Triple Aim: improving the patient experience, improving the health of populations and reducing the per capita cost of health care for the population served as well as:

- ✓ Prevention, primary care, chronic disease management, and emergency services;
- ✓ Coordination of the care continuum from wellness to home and community-based services too acute and post-acute;
- ✓ Providing access to essential health services within a reasonable distance and timeframe;
- ✓ Encouraging collaboration;
- ✓ Pursuing technology;
- ✓ Patient safety and quality; and
- ✓ Fair financing mechanisms by federal, state, and local resources, private payers and patients.

The Task Force identified and reviewed a number of models that have the potential to help ensure access to health care services in the future. In this effort, it became clear that a "one size fits all" approach or solution is not advisable. It was also clear that the current Critical Access Hospitals (CAH) model is vitally important to maintaining access to high-quality health care services in rural/frontier communities.

A number of barriers exist at the state and federal level that would impede implementation of identified alternative models:

- Care coordination between South Dakota health care providers, Indian Health Services and Veterans Administration facilities is critical to provision of quality health care delivery
- A lack of support of Medicaid Expansion in the South Dakota legislature leaves up to 48,000 citizens of the state without adequate health care coverage.
- The Department of Justice focus on South Dakota's high rates of nursing home utilization as a result of insufficient consideration of home- and community-based services.
- Excessive federal regulations put stresses on rural and frontier health care providers whose workforce and finances are already limited.
- Implementation of disruptive and destabilizing policies on providers who already deliver high quality, low cost care
- Need for CMS waivers of the applicable fraud and abuse laws that would otherwise inhibit care coordination for hospitals to form the financial relationships necessary to succeed in alternative payment models
- Challenges in ensuring the availability of a qualified workforce
- Unique challenges in providing emergency and non-emergency transportation critical to the health of rural communities, with response times of particular concern.

The Task Force concluded its work by developing the following axioms as the framework with which to continue efforts.

- ❖ We believe, and strongly support, maintaining the CAH designation. It is an essential component and critically important in ensuring access and caring for rural South Dakotas.
- ❖ We support maintaining the "necessary provider" status and exploring alternative payment models, but they must be funded at levels to cover at least the cost of care.
- ❖ We support the elements of the Triple Aim - quality, cost of care, and access. Opportunities exist for adjusting CAH payment to include a Value-Based Purchasing (VBP) component and Readmission Program to institute Triple Aim practices.
- ❖ We support the development of a network of integrated health care providers capable of meeting the health care needs within their communities that promotes accountability for a patient population, coordinates patient care, and encourages investment in infrastructure and redesigned care processes for high quality and efficient services.

Recommendations:

- ✓ Share the executive summary and full report broadly, encouraging discussions.
 - ✓ Identify/analyze current legislation that has proposed changes in rural/frontier health care delivery models. Create a summary of potential benefits and concerns.
 - ✓ Share with national partners, AHA, LeadingAge, and others, and request feedback/comments.
 - ✓ Seek input/guidance from the Council on Public Policy related to future legislation.
-

Report of Task Force on Ensuring Access in Vulnerable Communities Rural and Frontier

August 2016

Scope of Work

The South Dakota Association of Healthcare Organizations (SDAHO) Task Force on Ensuring Access in Vulnerable Communities was formed in fall 2015 and concluded their work in June 2016. The Task Force was comprised of 17 members and included learning from a number of professionals who shared their expertise on a broad range of rural health issues.

Overall, the work of the SDAHO Task Force was structured to coordinate with the scope of work and time frame of the American Hospital Association (AHA) Task Force on Ensuring Access in Vulnerable Communities.

Task Force members agreed with the following priorities, with an emphasis on supporting the continuum of care for rural/frontier communities.

1. *Identify the characteristics and parameters of vulnerable rural/frontier communities through analysis of hospital and post-acute financial and operational data, along with other data from qualitative sources.*
2. *Identify emerging strategies, delivery models and payment models related to health care services in rural/frontier areas.*
3. *Identify policies/issues at the state and federal level that impede, or could create, an appropriate climate for transitioning to different payment models or models of care delivery, as well as identify policies that should be maintained.*

I. Characteristics of Vulnerable, Rural/Frontier Communities

Health care communities may be vulnerable to health care quality and access problems for one or a combination of underlying reasons. Health care providers in South Dakota cover more than 75,000 square miles to deliver services to more than half of the State's population, approximately 450,000 individuals. The characteristics of vulnerable, rural/frontier communities involve several interrelated dimensions, to include social determinants, financing circumstances, geographic and workforce challenges, and demographic characteristics. Some of the specific dimensions are as follows:

Social Determinants of Health

Social challenges often prevent community members from being able to access health care or achieve their highest potential for health, even when quality care is available. For example, lack of

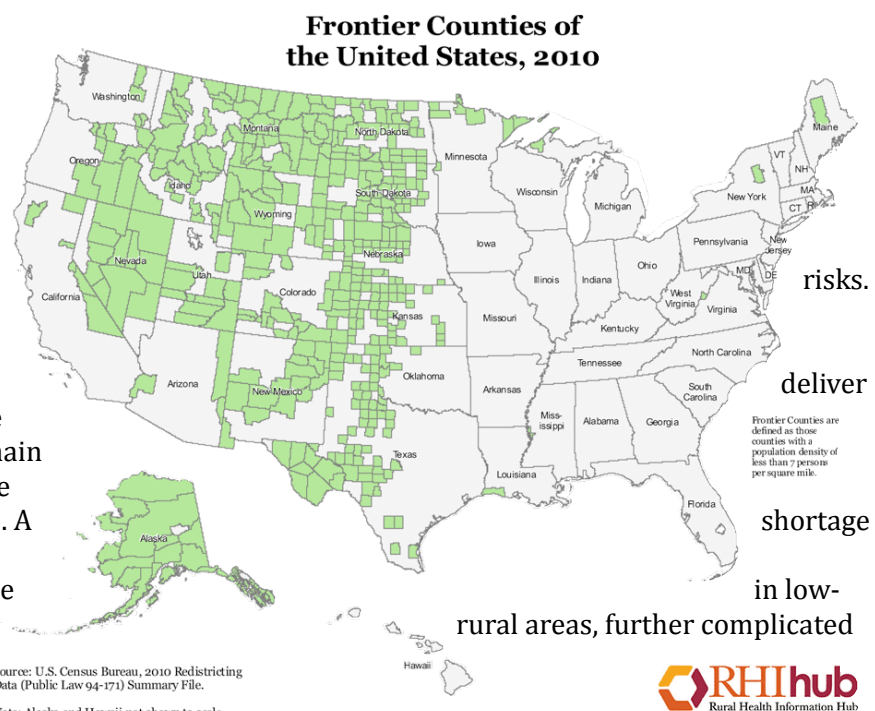
access to transportation may prevent patients from being able to obtain necessary care, or food insecurity may prevent individuals from adhering to specific diets dictated by certain conditions. Health literacy levels impact the ability for patients to advocate for themselves. Other social risk factors are conceptually important to health outcomes, such as socioeconomic status, race, culture, social relationships, access to basic life needs, and community safety risks and environmental hazards. For example, untreated behavioral health conditions, such as substance abuse and depression, and lack of access to behavioral health providers exacerbate health conditions and present safety risks too self and others.

Financing and Reimbursement Conditions

Current financing mechanisms fail to support a sustainable model that is needed to provide essential health services within reasonable distances. Factors such as sequestration, inconsistent regulatory interpretation, ongoing reimbursement reductions and the failure of South Dakota to expand Medicaid all impact rural health care providers. Thirteen percent of South Dakotans under the age of 65 are uninsured, contributing to an increased gap in the so-called “safety net,” while at the same time current federal payment policies are aimed at reimbursement reduction.


Geographic Realities

Communities may be vulnerable by virtue of their geographic location. These factors can present obstacles to delivering health care services and can result in increased exposure to health risks. South Dakota home care providers travel several thousand miles annually to needed health care across the state, and yet many areas remain underserved due to workforce shortages and distance issues. A shortage of qualified health care professionals is a serious issue in low-density and impoverished rural areas, further complicated by transportation barriers, undeveloped technology infrastructure issues and exposure to economic uncertainty. Rural communities are also experiencing an increase in outmigration, resulting in unbalanced age distributions of community populations.



Workforce Challenges

The issue of health care workforce shortages may be the single most challenging issue confronting rural/frontier communities in the future. A rural location or small community population magnifies



the impact of turnover and shortages. An increasingly aging population and the outmigration of younger workers makes retention and recruitment very difficult, especially for those that compete with urban areas to maintain an adequate workforce. South Dakota health care providers anticipate the need will far exceed the availability of additional health care workers through 2022. This includes licensed, certified and frontline positions like physicians, nurses, midlevel providers, dentists, mental health professionals, pharmacists and entry level workers. Unique physician recruitment needs exist in rural/frontier areas where physicians are less likely to choose rural practice, and when they do, they work longer hours and experience spousal career concerns. Provisions in the Patient Protection and Affordable Care Act (PPACA), such as loan repayment programs, support to Area Health Education Centers and increased funding to National Health Service Corps, have helped to alleviate the pressures of workforce shortages. However, rural/frontier areas in South Dakota will continue to face incredible challenges.

Demographic Characteristics

Developmental status and age distribution impact community vulnerabilities, exacerbating the capacity of medical providers to address the unique needs of a disproportionately balanced population. Children have health needs that are markedly different from adults and older adults who have distinctive health care needs due to increased incidence of chronic disease and co-morbidities of illness and disability, complicated by the complex interactions and ties to social networks and lack of needed social supports. South Dakota has a significant percentage of children who live in poverty and single-parent households, increasing their risk of poor health and magnifying their exposure to environmental and safety risks, social and psychological stressors and lack of access to support resources.

Essential Health Care Services

Individuals should be able to access essential health care services in rural/frontier areas, including primary care, emergency services, behavioral health, dental services, transportation, diagnostics needs, prenatal care, referral and coordination resources and long term and community support services. Access to essential health care services is critical for overall physical, mental and social needs, along with prevention, detection and treatment of illness to improve quality of life and life expectancy.

Primary Health Care

Primary health care is at the core of rural/frontier medical services, focused on the wellness, prevention, diagnosis, treatment and management of overall health care needs. A core set of services are necessary for each community and can be provided locally or remotely, through arrangement(s) with regional medical providers.

Emergency and Observation Care

Emergency care is essential for rural/frontier communities and must be available and staffed by highly trained personnel. Emergency and non-emergency transportation is critical to the health of rural communities, with response times of particular concern. Traditionally first responders and emergency medical technicians (EMT) perform a wide range of health care and support services in tandem with other medical providers that enhance access to health care services.

Behavioral Health

Rural/frontier communities need access to behavioral health services for mental health disorders, substance abuse and issues of co-occurring mental health issues. There are inadequate numbers of skilled behavioral providers in rural areas. Likewise, a significant stigma still exists associated with seeking behavioral health treatment. Behavioral health services include, but are not limited to, crisis intervention, diagnosis and treatment, medication management and referral mechanisms.

Oral Health and Dentistry

The availability of good oral health and dental services are critical in rural/frontier communities. This includes providing access to preventive care, basic restorative treatment and referral mechanisms for specialized treatment. Poor oral health can be an indicator of other health care issues that, if untreated, impact the need for additional health care services.

Transportation

Public transportation in many rural/frontier communities is significantly limited or non-existent. Residents without transportation, particularly older adults and low income individuals, are restricted in access to health care services unless they have a social support system to assist with transportation needs. Public transportation in rural areas is often inadequate and fails to meet the needs of residents in obtaining health care services in a timely manner.

Diagnostics

Diagnostics services are required to support physicians and other health care professionals in providing services for patients in rural/frontier communities. Such services typically include laboratory and imaging services.

Prenatal Care

Prenatal care is perhaps the most important factor which determines the outcome of pregnancy, hence an emphasis on adequate prenatal care and reduction of risk factors in pregnant women is critical in rural/frontier communities.

Referral and Care Coordination

Referral and care coordination structures allow for the connection between patients and primary care physicians, specialists, hospitals, behavioral health providers, and social service agencies, assisting patients as they interact with various providers and services. This is especially critical in rural/frontier communities that often experience disparities in access to care, health status, and available infrastructure.

Post-Acute Care and Community Based Services

Older adults and other individuals requiring post-acute care and related community based services face unique challenges in rural/frontier areas. Caring for an aging population is especially challenging where a limited infrastructure strains the capacities of families and communities to care for those needing services. Adequate levels of support and monitoring services should be provided, including a range of home and community-based services and institutional options. Integration with

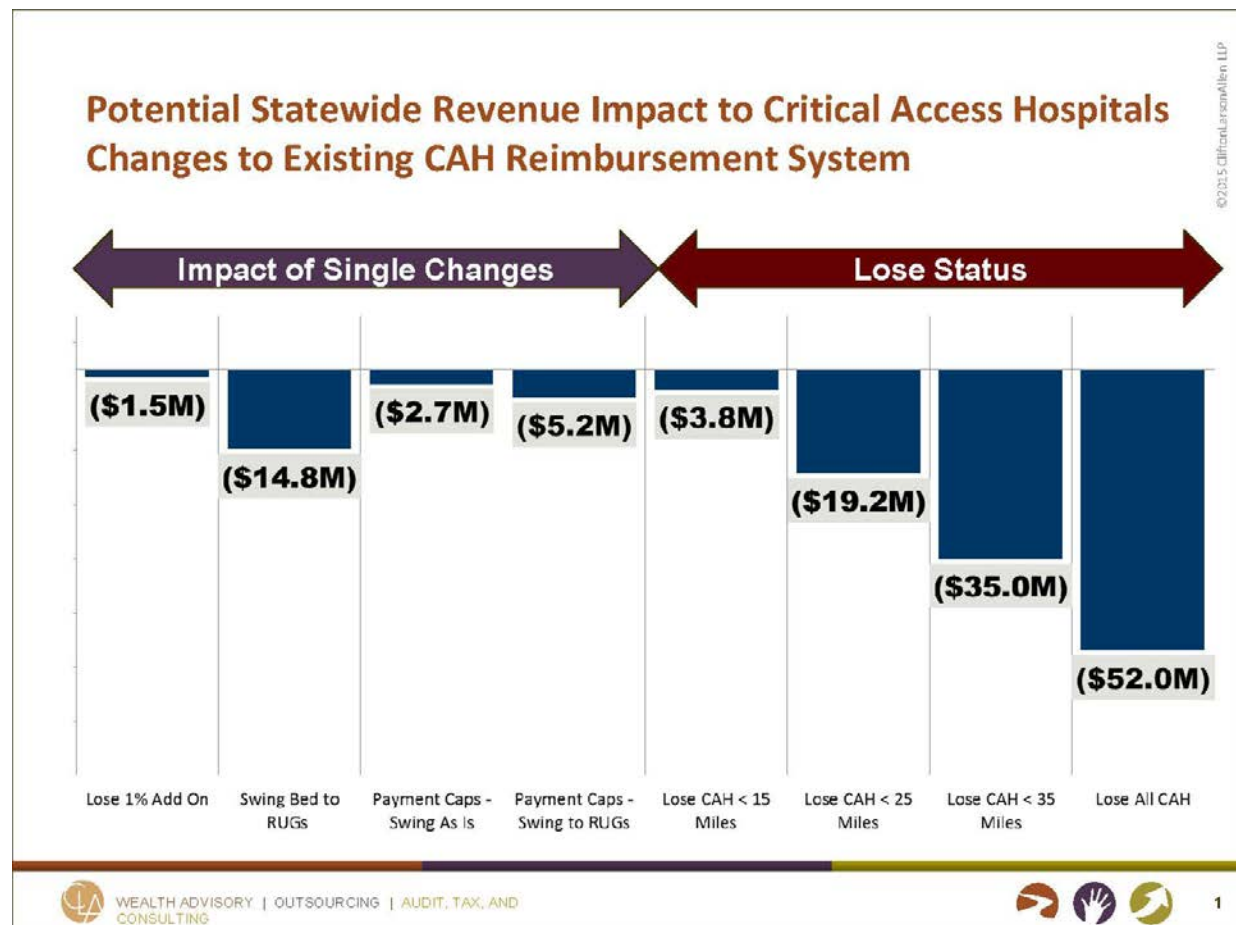
non-medical services such as senior centers, wellness centers, and meals on wheels, are considerations for a comprehensive set of services.

Analyzing Hospital and Post-Acute Financial Data

The Medicare designation for Critical Access Hospital (CAH) status has increasingly come under pressure from legislators and regulators, specifically related to reductions in reimbursements and payment systems. The Task Force evaluated a number of reimbursement models, including the potential reimbursement impact to CAHs in South Dakota. These models included:

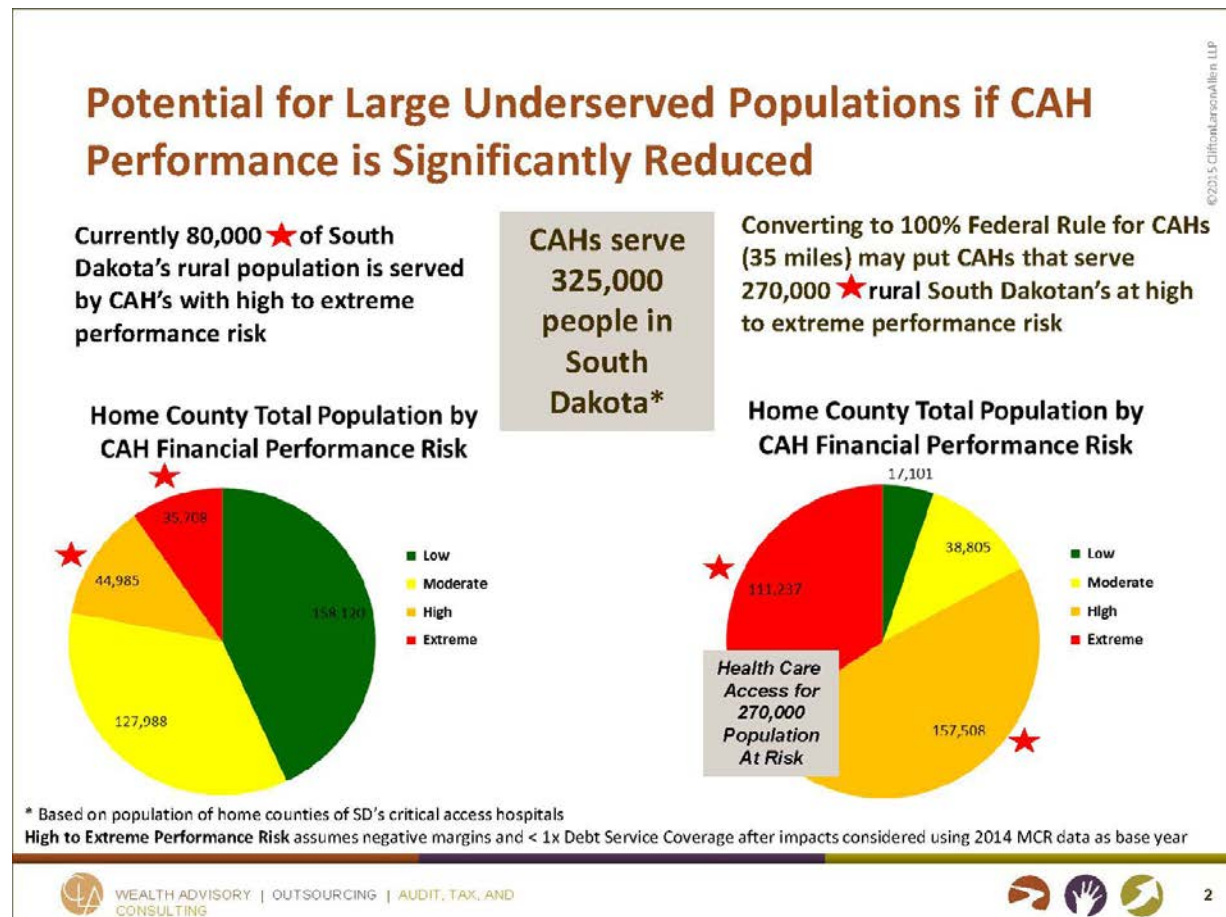
- 101 percent to 100 percent cost reimbursement
- Swing Bed to Research Utilization Groups (RUGs)
- Payment Caps
- Lose <15 miles CAH
- Lose <25 miles CAH
- Lose <35 miles CAH
- Loss of CAH designation

The chart below illustrates the estimated negative financial impact for CAHs in South Dakota:



In addition, the Task Force identified the potential for a significant negative impact on underserved populations in South Dakota if these legislative proposals continue or are enacted. Currently, Medicare sequestration, workforce shortages, cost of temporary staff, and regulatory changes/implementations, such as electronic medical records (EMR) creates increasing risks to access to health care services for rural/frontier South Dakotans.


The slide below illustrates the potential negative impact to CAHs performance:



II. Delivery Models and Payment Reform Concepts

A sustainable rural health care delivery system should focus on: prevention, primary care, chronic disease management and emergency services, improved population health, provide access to essential health services within a reasonable distance and timeframe, encourage collaboration, continue to pursue the highest standards of quality, promote cost and operational efficiencies, embrace the use of technology, and be reimbursed and financed fairly by federal, state and local resources, private payers and patients.

The Task Force identified and reviewed potential care models that may help ensure access to future health care services in vulnerable communities. They focused on five (5) examples which are outlined in further detail below. In this effort, it became clear that a “one size fits all” approach or



solution is not advisable. In addition, the need to strengthen support for the current CAH model is vitally important to maintaining access to high-quality health care services in rural/frontier communities. The models include:

Emergency Medical Center (EMC) Model

This model would allow existing facilities in rural and urban communities to meet the needs of the community for emergency room and outpatient services, without having to maintain inpatient beds or provide inpatient acute care services. EMCs could only be formed from a hospital conversion – that is, they could occur only where a licensed hospital already exists. The EMC would be required to provide emergency services (24 hours a day, 365 days a year) and transportation services (either directly or through arrangements with transportation providers) to allow for the timely transfer of patients who require inpatient acute care services. However, they would also have the ability to provide outpatient services and a variety of post-acute care services. In order for these facilities to remain financially viable, a new reimbursement methodology would need to be developed to account for low volume and other challenges.

Primary Health Center (PHC) Model

This model, which was developed by the Kansas Hospital Association, Rural Health Visioning Technical Advisory Group (TAG), as an alternative for low-volume, rural hospitals who are challenged to maintain either a CAH or a small PPS hospital.

In the PHC, the focus of resources would move from the traditional acute inpatient, episodic care to assuring continued local access to primary care, urgent and emergency services and transportation. It offers communities and their hospitals two options: a PHC open 24 hours a day, 365 days a year, or a PHC that is open 12 hours per day, 365 days per year. The 24-hour option could also provide transitional care and, if needed in the community, post-acute care or specialty services not otherwise available.

The model functions as either a new provider type that fills the gap between Rural Health Clinics (RHC) or Federally Qualified Health Centers (FQHC) and truly sustainable CAH or a refined version of CAH that can be sustainable in a very low population area. It would provide the alternative to the all-or-nothing decisions communities currently face as they struggle to sustain a CAH.

Both options provide ambulatory, initial assessment and interventional services for the hours in the day that they are available. Both are open to the community every day of the year to provide the consistent service array most needed and sustainable by the community. Both would focus their efforts on the primary care needs of the community. Both would be supported by a robust EMS plan and have the flexibility to use telemedicine to support emergency medicine and augment supervision for advanced practice registered nurses (APRNs) and physician assistants (PAs). Both would have a formal relationship with a larger partner organization to assist with operational and clinical aspects of delivering services to their community.

The payment method envisioned for the PHC would incentivize an integrated health system at the local level along with the importance of developing a financing method that recognizes both the need to promote health and value over volume. It will be important to identify current reimbursement levels and how the models will either refocus financial support to services needed by the community or provide sustainable funding.

Virtual Care (VC) Model

The Task Force explored telehealth, VC models that may be used to maintain or supplement access to health care services in vulnerable rural communities. This included a range of health care services that may be offered remotely – including intensive care unit monitoring and emergency services that allow for immediate access to board certified emergency physicians and nurses as well as the reimbursement challenges. In addition to providing immediate, 24-7 access to physicians and other health care providers that otherwise would not be located in these communities, telehealth and virtual medicine models have the potential to result in better access to care, better care and outcomes, lower costs and workforce stability. The full scope and potential of telemedicine opportunities available to vulnerable communities are being explored and implemented.

Kennebec, a frontier community in South Dakota, provides an excellent example of how a frontier community can provide access to health care utilizing telehealth. This VC model uses a "hub-and-spoke" design for the service, with a larger city serving as the hub and the smaller community – in this case Kennebec (population 250) – being the spoke.

The Kennebec Clinic has two exam rooms, a waiting room, a reception area and office space for the providers. A local emergency medical technician (EMT) staffs the clinic five days a week; a nurse practitioner visits for partial days twice a week.


Most of the care at the ambulatory clinic is delivered by telehealth. Community members make an appointment, and the emergency medical technician (EMT) arranges for a remote health care provider to meet with the patient via a teleconference connection. The Kennebec clinic is considered a satellite of a medical group facility in Chamberlain, South Dakota, some 30 miles away, but practitioners throughout the health system can see the patients through the remote connection.

Like most rural/frontier communities in South Dakota, individuals from Kennebec know the challenges associated with large distances from needed services. Now, for many common medical needs, residents can receive care locally. In addition, when residents received treatment from a specialist, they often had to travel the two hours for a brief follow-up appointment.

More importantly the limited health care model does not follow an old paradigm of having a full-time mid-level and full-time resources, and the community partnership shared in the financial risk with a medical group. The community continues to pay for the brick and mortar, staff and the technology while the medical group provides the health care service.

Global Budgets Payment (GBP) Model

The concept of a GBP model brings together all health care providers in a community to "pool" available funding into a single source or global budget. If appropriately structured, a GBP may provide the flexibility needed for hospitals in vulnerable communities to provide care in a manner that best fits a community's needs and circumstances. GBPs may also provide financial certainty, potentially fair payments and incentives to contain health care cost growth and improve quality. The concept is that such a model could function as an "umbrella" option that would provide a community with flexibility to provide care in the manner that best fits its circumstances.



The GBP should include participation by all health care providers; hospitals, clinics, physicians, post-acute, public health, and various payers. This would further help align health care providers and increase accountability for the health care services offered within a community.

For the GBP model to work, payments and reimbursements need to be predictable, stable and sufficient to allow providers to build the infrastructure and capability to redesign care delivery. In some cases, this involves financial support from the local city and county. The model must include payments that take into account the administrative costs and capital expenditures required to maintain operations and facilities. Overall, the GBP model allows for review of the “risk to reward” equation for community focused health care services in a way that encourages everyone to get involved.

Indian Health Services (IHS) Choice Model

There are nine (9) Native American tribes in South Dakota. The US Census Bureau (2010) lists their population at more than 71,000. Native Americans have a proud history and culture in the state, and similar to other vulnerable populations in rural/frontier areas, access to safe, high quality health care services is a priority.

The United States has a treaty, trust and statutory obligation to provide and deliver adequate health care to all enrolled members of tribes and nations. Similar to health care services provided by the federal government for U.S. Veterans, the IHS has the responsibility to provide health care services for Native Americans in South Dakota. The IHS was established in 1956, however over the years the agency has been unable to fully meet its obligations, and today the system is in critical disarray and in need of significant improvements. One consideration to help improve the current challenging situation would be to create a “IHS Choice Model,” similar to the existing Veterans Choice Program (VCP) which is outlined below:

The Veterans Access, Choice, and Accountability Act (VAACAA) of 2014, was passed to improve access to health care for veterans by creating the VCP. The law expands the number of options veterans have for receiving care to ensure timely access to high-quality care. VCP provides primary care, inpatient and outpatient specialty care and mental health care for eligible veterans when the local U.S. Department of Veterans Affairs (VA) health care facility cannot provide the services due to lack of available specialists, long wait times or extraordinary distance from the veteran’s home.

The VCP provides a safety net for veterans who have a wait time for care longer than 30 days or live more than 40 miles from the nearest VA facility. VCP does not impact existing VA health care or any other VA benefit – it just offers other options for care when the VA cannot meet veterans’ health care needs.

In addition, Task Force members encouraged exploring partnerships between IHS and non-IHS facilities with an emphasis on care delivery and coordination. Virtual care strategies should be expanded along with possible linkages to Federally Qualified Health Centers (FQHC). There continues to be a need for additional federal funding and support related to workforce shortages and meeting CMS conditions of participation standards.

Payment Reform Concepts

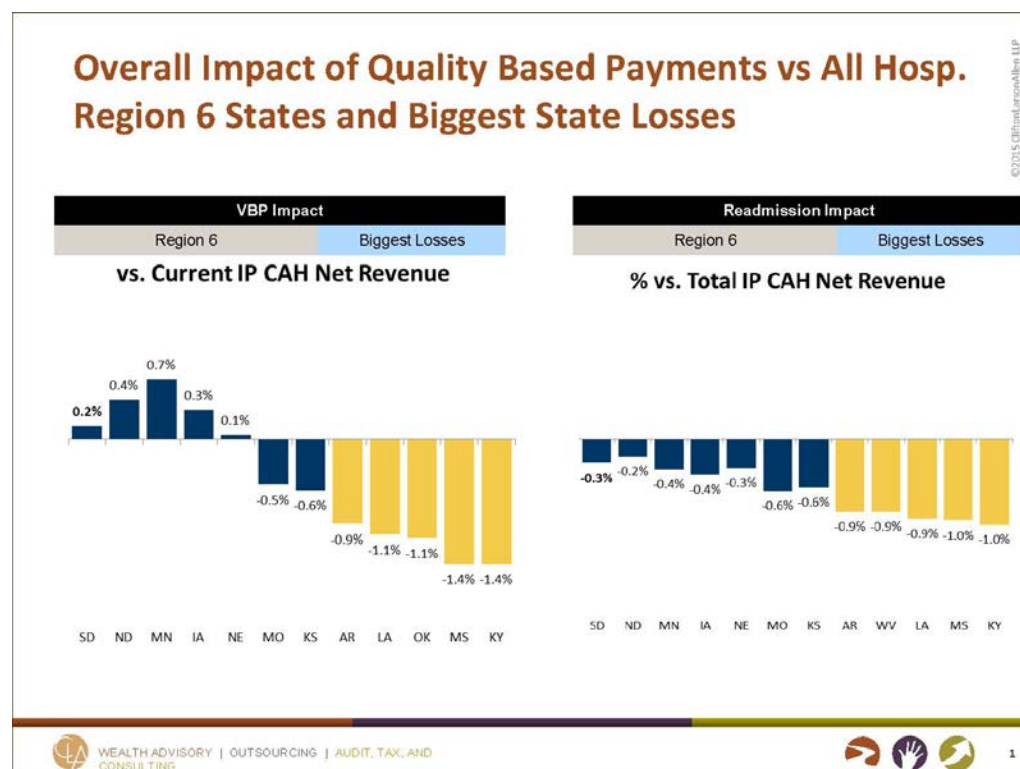
Disproportionate negative impacts from across-the-board payment cuts such as sequestration on providers who deliver high-quality, low-cost care, as well as multiple proposals to significantly cut payments to CAHs or remove the designation entirely, demonstrate the need for new payment reforms concepts. These reform concepts are designed to increase incentives for CAHs to demonstrate quality and low cost care they provide, protect access in rural communities, avoid implementation of more disruptive and destabilizing policies, and ultimately produce savings within the Medicare program.

Task force members reviewed payment models for the potential impact to quality and safety indicators in CAHs. The financial firm CliftonLarsonAllen (CLA) provided detailed analysis and associated impacts of the following reforms:

- Applying the existing Medicare Value Based (VBP) program to CAHs by either combining their performance with PPS hospitals already subject to VBP or establishing separate VBP incentives that what would compare CAHs to one another's performance only
- Creating a readmissions prevention program either with financial penalties, similar to the PPS readmissions program already in place, or with sliding scale financial incentives on a budget neutral basis, similar to those used in PPS hospitals' VBP program

South Dakota on the aggregate fairs favorably on the analysis of a Medicare VBP Proposal for CAHs with a 0.27 percent increase in payment from baseline or \$84,000 while the analysis of a Medicare Readmission Proposal for CAHs has -0.30 percent impact or -\$94,000 loss from baseline.

The slide below illustrates a comparison to others states in the region as well as the states that lost the most in CAH Quality Based Payment Reform concept.



Task force members were in agreement that opportunities to collaborate with other states should be explored. The objectives should include alignment of incentives and performance for rural providers to achieve high quality, safe and cost-efficient outcomes.

III. Policy Environment at the State and Federal Level

Collaboration between organizations whose focus is on quality health care for South Dakotans who reside in rural/frontier communities provides opportunities in the areas of growing and educating a committed workforce, accessing care in vulnerable communities and addressing the unique challenges in providing adequate emergency medical services.

A number of barriers exist at the state and federal level that would impede implementation of alternative models. Care coordination between South Dakota health care providers, Indian Health Services and Veterans Administration facilities is critical to provision of quality health care delivery. A lack of support for Medicaid expansion in the state leaves approximately 50,000 citizens without adequate health care coverage. In addition, the Department of Justice recently announced a focus on the state's nursing home utilization rates as compared to utilization rates for home and community based services.

Care Coordination

Better coordination of patient care is an increasingly critical part of quality health care delivery and shared accountability across providers and care settings. Rural and frontier providers will need to build upon their current infrastructures for technology, patient and family education and care management to integrate care delivery into the community. If optimal health outcomes are to be achieved, participation with other organizations that offer vital community services and resources will be required, and effective care teams will be needed to build strong care management and coordination systems. Care coordination needs to be encouraged and supported, so community-based programs (nutrition services, transportation, ambulance, pharmacy, home care, palliative care, senior centers and adult day services) can be included in emerging models without financial disincentives. Care coordination requires a number of key factors to succeed: qualified providers, trained workforce to help patients navigate health care services, health information tools to facilitate information sharing, communication and cooperation between providers and payers and flexibility to develop strategies that best respond to local community health needs.

Federal Legislation

Advocacy on the federal level is influenced by the need for new strategies for delivery of health care services to serve vulnerable rural/frontier communities. Task force members agreed that more must be done and that current proposed legislation represents opportunities for further analysis and discussions. Current proposed legislative include:

Medicare-dependent Hospitals (MDH) and low volume adjustment

Medicare Rural Payment Extension (S. 332, H.R. 663), would permanently extend MDH and enhance low-volume adjustment programs.

Ambulance Add-On Payment

The Medicare Ambulance Access, Fraud Prevention and Reform Act (S. 377, H.R. 745), would permanently extend the ambulance add-on payment adjustment.

Rural Community Hospital Demonstration

The Rural Community Hospital (RCH) Demonstration Extension Act (S. 607, H.R. 672), would extend the program for five years.

Rural Emergency Acute Care Hospital (REACH) Act

REACH (S. 1648) would allow CAHs and PPS hospitals with 50 or fewer beds to convert to Rural Emergency Hospitals (REH). REHs would provide emergency and outpatient services, but not inpatient care. They would receive enhanced reimbursement rates of 110 percent of reasonable costs to transport patients to acute-care hospitals in neighboring communities.

CAH Payment Policies:

- CAH designation based on mileage between facilities should be no more than 35 miles in order to provide access to care in rural areas.
- Critical Access Hospital (CAH) Relief Act (S. 258, H.R. 169). This bill removes the 96-hour physician certification requirement as a condition of payment while still satisfying the condition of participation.

Helping Hospitals Improve Patient Care Act

This legislation (H.R. 5273) will adjust Section 603 of the Bipartisan Budget Act of 2015, to extend flexibility to hospital outpatient departments in development when the law was enacted, and adjust the Hospital Readmissions Reduction Program to account for the socioeconomic status. It also includes a five-year extension of the Rural Community Hospital Demonstration Program.

Direct Supervision


The Protecting Access to Rural Therapy Services (PARTS) Act (S. 257, H.R. 1611) ensures that CMS appropriately addresses the issue of direct supervisions for outpatient therapeutic services for rural hospitals and CAHs. In addition, the Rural Hospital Regulatory Relief Act (H.R. 5164) permanently extends the enforcement moratorium on “direct supervision” of outpatient therapeutic services for CAHs and small, rural, hospitals with 100 or fewer beds.

Save Rural Hospitals Act

The Save Rural Hospitals Act (H.R. 3225) creates a new model for delivery of emergency care called the Community Outpatient Hospital (COH). The facility must be a CAH or is a hospital with not more than 50 beds. Payment for qualified outpatient services is equal to 105 percent of reasonable costs. Grants for quality improvement, population health, and emergency services. Costs associated with having backup physician available via telecommunications systems shall be considered reasonable.

Veterans Care

The Veterans Choice Equal Cost for Care Act of 2016, sponsored by South Dakota Sen. Mike Rounds, amends the Veterans Access, Choice, and Accountability Act of 2014 by repealing the second payer clause. The clause forces veterans who have private health insurance to pay more out-of-pocket than they would for the same care at a VA facility.



The Veterans Access to Long Term Care and Health Services Act (S. 2000) provides for the partnering with the private sector by authorizing the Department of Veterans Affairs, if unable to furnish hospital care, medical services or extended care at VA facilities or under other authorized contracts or sharing agreements, to enter into a Veterans Care Agreement with an eligible provider to furnish such care and services

Resident Physician Shortage Reduction Act

This bill (S. 1148, H.R. 2124) would increase the number of Medicare funding for indirect medical education and direct graduate Medical Education (GME) and would increase the number of Medicare-funded residency positions.

Establish Beneficiary Equity in the Hospital Readmission Program Act

This bill (S. 688, H.R. 2124) would address the need for sociodemographic adjustment in the Hospital Readmissions Reduction Program.

Coverage for Telehealth and Rural Connectivity

The Rural Health Care Connectivity Act of 2015 (S. 1916, H.R. 4111) and the Veteran's E-Health and Telemedicine Support Act (H.R. 2516).

Federal Rulemaking and Regulatory Policy


Medicare policy changes and payment adjustment often have significant and problematic consequences for rural providers. The administrative burden and cost created by rules that fail to consider the unique circumstances of small or rural community hospitals. This list includes:

- CMS Inpatient PPS Proposed Rule
- Medicare Access and CHIP Reauthorization Act (MACRA) Physician Payment Proposed Rule
- Life-Safety Code Update
- CMS Certification Necessary Providers
- Exclusive Use and Co-Locations of Visiting Specialists
- Compute Radiography (CR) Standards
- Computed Tomography (CT) Diagnostic Imaging Services
- Rural Health Clinic (RHC) Qualified Visits
- Telehealth
- 340B Drug Pricing Program
- Quality Measurement
- EHR Incentive Program
- Reducing Rx Drug Prices

State Collaboration Opportunities

Community Health Clinics

Community Health Clinics (CHC) operate within vulnerable communities that qualify as a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). CHCs provide



comprehensive care including medical, behavioral/mental health and dental service and maintain a mechanism to offer referrals for those services. Services such as transportation, interpretation and case management are provided. CHCs, however, are not free clinics, and payment from uninsured patients, although not always received, is sought.

Office of Rural Health / EMS

The South Dakota Office of Rural Health (ORH) works with our 38 critical access hospitals to assist in improving the delivery of health services too rural and medically underserved communities, emphasizing access, working primarily at the local level. Specific programs that fall under the scope of the ORH include the Rural Healthcare Facility Recruitment Program, which provides a \$10,000 payment to eligible health professionals who complete a three-year, full-time service commitment to a facility located in a community with a population of 10,000 or less. The health professional must enter into a three-way contract between the employing facility and the state. The Recruitment Assistant Program provides qualifying physicians, dentists, physician assistants, nurse practitioners or nurse midwives an incentive payment in return for three continuous years of practice in an eligible rural community. Providers must enter into a contract with the South Dakota Department of Health in order to qualify.

The South Dakota Emergency Medical Services Program comes under the umbrella of the Office of Rural Health. An EMS stakeholders group made up of representatives from hospitals, local government, those in the EMS industry, state legislators and related associations met four times over the summer of 2015 and developed recommendations that were categorized into four main focus areas: workforce, quality, sustainability and infrastructure. Relative to infrastructure, workgroups were formed to address driver competency, leadership training and in-service training.

The South Dakota legislature recently removed the hardship exemption with SB 27, allowing for minimum staffing for ambulance services and eliminating the hardship statute, revising certain personnel requirements for ambulance services. The legislation ultimately realigns minimal standards for crew makeup from two EMTs to one EMT and a driver; a driver who demonstrates specified competencies; competencies that are focused and non-burdensome.

South Dakota Interprofessional Practice and Education Collaborative

South Dakota Interprofessional Practice and Education Collaborative (SD-IPEC) serves as a conduit to support and contribute to the vision of the National Center for Interprofessional Practice and Education and functions in a neutral advisory capacity to foster innovative interprofessional activities. It also fosters an atmosphere of creative dialogue to facilitate the growth of interprofessional activities between education, practice and community while providing consultation and endorsement of emerging IPE projects. The SD-IPEC determines health needs in the state and provides guidance and implementation on bringing education and practice together to address those needs. The SD-IPEC presents an opportunity for innovative demonstration projects to address emerging delivery models and workforce needs.

Medicaid Expansion

Governor Dugaard has developed a unique plan to help working families in South Dakota who are unable to afford health insurance. His proposal would increase the federal government's reimbursement for medical services provided to members of South Dakota's Indian tribes in exchange for the state expanding Medicaid access. The revenue from the increased reimbursement



would more than offset the cost of expanded Medicaid access. And it would increase access to health care services for an estimated 50,000 South Dakotans, including 15,000 Native Americans.

This is also an opportunity to correct a long-standing issue in health care reimbursement. For decades, South Dakota has advocated for the Indian Health Services (IHS) to fulfill our nation's treaty obligations to fully fund health care services for Native Americans through IHS and Medicaid. Now, CMS has agreed to change existing reimbursement practice by increasing payment levels up to 100 percent for certain services provided to Native Americans. That increased reimbursement plan could save the state more than \$80 million annually. The plan is contingent on the state expanding Medicaid.

Stark/Kickback

To allow South Dakota hospitals to form the financial relationships necessary to succeed in a global budget model, it will be critical for CMS to issue waivers of the applicable fraud and abuse laws that inhibit care coordination. Specifically, CMS should waive the Physician Self-Referral Law and the Anti-Kickback Statute with respect to financial arrangements formed by hospitals participating in a global budget model. These laws were designed for a different world of care delivery and payment and are not compatible with a global budget model.

Recommendations:

- ✓ Share the executive summary and full report broadly, encouraging discussions.
- ✓ Identify/analyze current legislation that has proposed changes in rural/frontier health care delivery models. Create a summary of potential benefits and concerns.
- ✓ Share with national partners, AHA, LeadingAge, and others, and request feedback/comments.
- ✓ Seek input/guidance from the Council on Public Policy related to future legislation.

Appendix

Professional Contributors:

- ❖ South Dakota State University Department
- ❖ Ray Montgomery, President/CEO, Unity Health, Searcy, Arkansas, and Rural Subcommittee Chairperson, AHA Task Force on Ensuring Access in Vulnerable Communities
- ❖ Melissa Hungerford, Senior Vice President, Kansas Hospital Association (KHA).
- ❖ Priya Bathija, Senior Associate Director, Policy, AHA.
- ❖ Linda Ross, CEO of the Community Healthcare Association of the Dakotas.
- ❖ Halley Lee, Administrator, and Marty Link, EMS Director, SD Office of Rural Health.
- ❖ Jason Nordling and Scott Holmes, BWBR Architects.
- ❖ Carla Dieter, University of South Dakota, SD Interprofessional Practice and Education Collaborative.
- ❖ John Supplitt, Senior Director, AHA Constituency Sections

Current Legislation:

To read the bill in its entirety, click on the sponsor name.

- ❖ The IHS Accountability Act of 2016. S. 2953).

[Senator Barrasso \(R-WY\)](#)

Co-sponsors: Senator Thune (R-SD)

Senator Rounds (R-SD)

- ❖ Helping Ensure Accountability and Trust in Tribal Healthcare (HEALTH Act of 2016. (H.R. 5406)

[Rep. Noem \(R-SD\)](#)

- ❖ Veterans Choice Equal Cost for Care Act of 2016. (S 2649)

[Senator Rounds \(R-SD\)](#)

- ❖ Veterans Access to Long Term Care and Health Services Act. (S 2000).

[Sen. Hoven \(R-ND\)](#)

- ❖ Medicare-dependent Hospitals (MDH) and low volume adjustment (S. 332, H.R. 663)
Medicare-dependent Hospitals (MDH) and low volume adjustment (S. 332, H.R. 663)

[Sen. Grassley \(R. IA\).](#)

[Rep. Reed \(R-NY-23\)](#)

- ❖ Ambulance Add-On Payment. The Medicare Ambulance Access, Fraud Prevention and Reform Act (S. 377, H.R. 745).

[Sen. Schumer \(D-NY\)](#)

[Rep. Waldon \(R-OR-2\)](#)

- ❖ The Rural Community Hospital (RCH) Demonstration Extension Act (S. 607, H.R. 672).

[S. Grassley \(R-IA\)](#)

[Rep. Young \(R-AK-At large\)](#)

- ❖ Rural Emergency Acute Care Hospital (REACH) Act (S. 1648).

[Sen. Grassley \(R-IA\)](#)

- ❖ Critical Access Hospital (CAH) Relief Act (S. 258, H.R. 169).

[Sen. Roberts \(R-KS\)](#)

[Rep. Smith \(R-NE-3\)](#)

- ❖ Helping Hospitals Improve Patient Care Act (H.R. 5273).

[Rep. Tiberi \(R-OH-12\)](#)

- ❖ The Protecting Access to Rural Therapy Services (PARTS) Act (S. 257, H.R. 1611).

[Sen. Moran \(R-KS\)](#)

[Rep. Noem \(R-SD-At Large\)](#)

- ❖ Save Rural Hospitals Act (H.R. 3225).

[Rep. Graves \(R-MO-6\)](#)

- ❖ Resident Physician Shortage Reduction Act (S. 1148, H.R. 2124).

[Sen. Nelson \(D-FL\)](#)

[Rep. Crowley \(D-NY-14\)](#)

- ❖ Establish Beneficiary Equity in the Hospital Readmission Program Act (S. 688, H.R. 2124).

[Sen. Manchin \(D-WV\)](#)

[Rep. Crowley \(D-NY-14\)](#)

- ❖ The Rural Health Care Connectivity Act of 2015 (S. 1916, H.R. 4111).

[Sen. Thune \(R-SD\)](#)

[Rep. Lance \(R-NJ-7\)](#)

- ❖ The Veteran's E-Health and Telemedicine Support Act (H.R. 2516).

[Rep. Rangel \(D-NY-13\)](#)

Acknowledgments

The South Dakota Association of Healthcare Organizations (SDAHO) expresses gracious appreciation to the individuals and organizations who generously contributed to the work of the task force. The insights and perspectives shared greatly enhanced the overall body of work contained in this report.

In particular, we acknowledge the contributions of the American Hospital Association (AHA) and the work of the national Task Force on Ensuring Access in Vulnerable Communities. Also, we express a sincere appreciation to the professionals who participated at one or more of the in-person meetings, contributing subject matter expertise. They include:

Ray Montgomery, President/CEO, Unity Health, Searcy, Arkansas, and Rural Subcommittee Chairperson, AHA Task Force on Ensuring Access in Vulnerable Communities
Priya Bathija, Senior Associate Director, Policy, AHA
John Supplitt, Senior Director, AHA Constituency Sections
Melissa Hungerford, Senior Vice President, Kansas Hospital Association
Joe Schindler, Vice President of Finance, Minnesota Hospital Association
Matt Anderson, Senior Vice President of Policy and Strategy, Minnesota Hospital Association
David Schuh, Principal, CliftonLarsonAllen
Matthew Borchardt, Principal, CliftonLarsonAllen
Linda Ross, Community HealthCare Association of the Dakotas
Halley Lee, Administrator, South Dakota Office of Rural Health
Marty Link, EMS Director, South Dakota Office of Rural Health
Jason Nordling, BWBR Architects
Scott Holms, BWBR Architects
Carla Dieter, University of South Dakota, South Dakota Interprofessional Practice and Education Collaborative
Ellen Bubak, South Dakota State University Demography Department



3708 W. Brooks Place • Sioux Falls, SD 57106-4211