

# The LRHA Policy Corner

*As you may be aware, some LRHA members and staff will be attending the National Rural Health Association's (NRHA) Policy Institute in Washington, D.C from February 27 – March 1, 2006. During this visit, meetings will take place with Louisiana's Congressional delegation to discuss area sensitive issues with regard to rural health. Listed in this week's policy corner is an agenda for those conversations and detailed explanations of particular initiatives that LRHA will be supporting. If you have any questions or comments, please pass them along.*

*State and Federal Chambers:*

- *The next session of the State Legislature will take place beginning March 27, 2006.*
- *The U.S. Congress was on recess last week for the President's Day holiday and will reconvene come 2:00 p.m. on Monday, February 27<sup>th</sup>.*

## **LRHA U.S. Congressional Agenda**

### **Legislative Issues**

#### ***Appropriations***

- ✓ President Bush has proposed almost \$36 billion in cuts to Medicare in his fiscal year 2007 budget – cuts that could adversely impact patients and caregivers. Included – a reduction in the market basket update for inpatient and outpatient services, a four-year phase out of reimbursement for Medicare bad debt, and “freezing” the payment update for skilled nursing and inpatient rehabilitation facilities and home health care.
- ✓ For the third year in a row, the President's proposed budget seeks to cut rural specific healthcare funding - in order to preserve critical rural health programs and access to care in rural areas, we are urging you to commit to federal funding of rural specific programs including but not limited to: Rural Hospital Flexibility Program, Rural Health Outreach and Network Development Grants and Rural EMS Training.
- ✓ Extend the Hold Harmless Provision (see below.)

#### ***Critical Access Hospitals***

- ✓ Clinical Lab Services (S. 236/H.R. 1016) - No LA Co-sponsors;
- ✓ Payment Under Medicare Advantage (H.R. 800) - No LA Co-sponsors;
- ✓ Expanding 340 B Drug Pricing Program Eligibility (S. 1840/H.R. 3547) - No LA Co-sponsors;

- ✓ Rural Community Hospital Assistance Act ( S. 933/H.R. 2350) – No LA Co-sponsors.

### ***Home Health***

- ✓ Medicare Rural Home Health Payment Fairness Act (S. 300/H.R. 11) - Bipartisan support;
- ✓ S. 300 - Co-sponsored by Senator Landrieu/H.R. 11 - Co-sponsored by Representatives Jindal, Melancon and Alexander.

### ***Prohibition on Physician Self-Referral to Limited Service Hospitals***

- ✓ In order to preserve care in communities, prevent conflict of interest and promote fair competition, the LRHA strongly urges Congress to act quickly to close the loophole in federal law by permanently banning physicians from referring patients to new limited-service hospitals they own.

### **Regulatory Issues**

- ✓ Health Insurance Flexibility and Accountability (HIFA) Waiver (see below);
- ✓ Conrad 30/J-1 Visa Waiver (see below.)

### **On the Radar Screen**

#### ***Rural Health Clinics***

- ✓ Increase the Rural Health Clinic (RHC) encounter cap by 25% to bring reimbursement in line with FQHC services for primary care;
- ✓ Expand Federal Tort Claims Act Coverage (FTCA) to physicians practicing in RHCs;
- ✓ Allow RHCs to participate in the 340 B Drug Pricing Program.

#### ***Federally Qualified Health Centers***

- ✓ Support community efforts to increase access to care by funding Federally Qualified Health Center applications that are currently under review.

#### ***State Office of Rural Health***

- ✓ Support funding for State Offices of Rural Health.

#### **Critical Access Hospital (CAH) Relocation**

- ✓ For CAHs relocating, LRHA requests that CMS issue a formal, written communication detailing that the efforts of the CAH relocation are meeting mandated requirements. Currently, CMS will not make this decision until after a hospital has relocated and is in operation.

## **Hold Harmless Provision Brief**

In August of 2000, the Health Care Financing Administration (HCFA) implemented a prospective payment system (PPS) for outpatient services. The introduction of the outpatient PPS generated concern among rural hospitals because it pays predetermined rates for services provided by all hospitals.

- Existing evidence from previous studies performed by MedPac provided evidence that rural hospitals face some unique circumstances regarding the cost to provide outpatient services,
- Rural hospitals rely more on Medicare and on outpatient services as sources of revenue, increasing their exposure to the financial risks of prospective payment,
- Rural hospitals tend to have limited administrative capacity and financial reserves, crippling their ability to manage financial risk, and
- The available cost data indicates that rural hospitals have higher outpatient unit costs.

For these reasons, the Balanced Budget Refinement Act of 1999 provided transitional financial protection for all small rural hospital with 100 or fewer beds by holding them harmless from losses incurred as a result of the outpatient PPS through 2003. Under this policy, all hospitals must submit claims and be reimbursed PPS rates, however, hospitals that would have received higher payments under the pre-PPS payment rules will receive an additional payment to make up the difference.

The Medicare Modernization Act extended the hold harmless provision until 2005. In the Deficit Reduction Act of 2006, Congress extended the hold harmless for three years.

However, the extension also phases out the hold harmless by reimbursing small rural hospitals at

- 95% of the previous hold harmless amount in 2006,
- 90% of the previous hold harmless amount in 2007, and
- 85% of the previous hold harmless amount for 2008.

This suggests that Congress would like to do away with the hold harmless provision.

Until a long term solution is devised that takes into account the special circumstances encountered by small rural hospitals in providing outpatient services, the hold harmless provision must be extended to ensure that small rural hospitals are able to maintain financial viability and provide access to services in rural areas.

## **Health Insurance Flexibility and Accountability (HIFA) Brief**

Created by the U.S. Department of Health and Human Services in August 2001, a HIFA waiver allows states flexibility under Medicaid and State Children's Health Insurance Plan (SCHIP) in benefits, cost sharing, financing, and populations covered.

By Act 813 of the 2003 Regular Session, the Louisiana Department of Health and Hospitals was directed to develop a HIFA waiver application.

The Purpose of the Louisiana HIFA Waiver is to create a funding pool using the state's Disproportionate Share Hospital (DSH) allotment and use the funds to increase insurance coverage and provide greater access to primary health care services for non-Medicaid individuals with income less than 200% of the federal poverty level (FPL).

The funding pool will:

- Provide UCC payments for inpatient and outpatient hospital services;
- Provide payments for physician services at state owned and operated hospitals;
- Provide funding for *LaChoice* and the *Louisiana Health Plan* (LHP); and
- Provide funding for the *Health Partnership for Access and Coverage* program.

Parishes will have the opportunity to draw down federal DSH dollars for access or coverage programs for low-income adults by providing the state's share of match.

The HealthPAC portion of the funding pool will be allocated among the state's 64 parishes. Each parish will be allocated a capped amount of funds based on level of uninsured, poverty, and other factors. In order to draw down the funds, a parish must:

- Identify an acceptable form of match to be used as the nonfederal share; and
- Present an access or coverage proposal that meets DHH's requirements in terms of benefit package, disease management, maintenance of effort; and other factors.

The Louisiana HIFA was submitted to CMS in July 2005 and is currently pending approval. The state and CMS are engaged in weekly conference calls to review and refine the special terms and conditions that will lead to approval of the waiver.

## **PRIORITIES UNDER THE CONRAD STATE 30 PROGRAM – WHEN BROUGHT UP FOR REAUTHORIZATION**

### ***1. Reauthorization – Permanent Authorization Of The Program***

- The Conrad 30 physician waiver provisions have now been operating for twelve years and have been continuously reauthorized.

- Every state in the country has created a program, which has enabled states to bring physicians to the neediest areas.
- Not a single state has terminated its participation in the program, showing that state health departments view Conrad 30 as a valuable tool in addressing a severe physician shortage
- Initially created on a pilot basis to allow Congress to periodically evaluate the benefit to Americans, the time is now for permanent authorization and the elimination of the statute's sunset provision.

**2. *Increase From Conrad 30 to 40 - Redistribution Of Unused Slots And Flexibility For States That Give Up Unused Slots***

- This provision expands the Conrad program's number of slots by 10 - to 40 per state/per year.
- The national shortage of physicians is expected to triple to 200,000 in the next 14 years and the need to encourage more J-1 physicians to remain in the U.S. to help narrow the gap is clear.
- This provision will help in that effort and it also is tied to the provision below that will allow states to reserve up to ten slots for physicians in academic medical centers.
- The section will more efficiently distribute waiver slots by requiring states to "redeposit" unused slots and for every slot put back into the waiver pool, one of their remaining slots will be eligible for the flexibility provisions of Section 214(l)(1) (D)(ii) of the INA.
- This provision addresses the concerns of heavily populated states that have more demand for waiver slots than the supply available.
- It also protects smaller populated states that have more difficulty recruiting by allowing those states' health departments more leeway in locating physicians in the highest priority locations.

**3. *Hurricane Katrina Provision***

- Hurricane Katrina has had a severely negative impact on health care delivery systems in Alabama, Mississippi and Louisiana and large evacuee populations are burdening health care systems in other states.
- This provision would enable the most severely impacted areas to more effectively attract new physicians, to replace those who have permanently moved away from the region and to assist dozens of health centers in neighboring states that are suddenly dealing with hundreds of thousands of new patients without the needed number of physicians.
- The provision has a five year sunset provision to ensure that once the crisis dissipates, the benefiting states will return to the current limitations.

**4. *10 Academic Waiver Slots Per State***

- This provision expands the Conrad program by allowing states to designate up to ten (10) of their waiver slots for university medical center positions.

- University medical centers provide vital patient care in states across the country and often offer highly advanced - specialty medical services that can only be offered in a university setting.
- In many states, these facilities are the sole location in the state offering the specialized service. Often, state universities are not located in shortage areas and even when they are, academic medical centers are pitted against rural facilities for a very limited supply of waiver slots.
- Many international medical graduates that train in the US – particularly the very top academic performers – are interested only in positions that combine research and patient care.
- This stipulation will also result in retaining physicians that are being recruited to work in top research hospitals in Europe and elsewhere.
- Finally, while HHS has a waiver program available to academic institutions, the waivers are based primarily on research and not on patient care.

#### **5. Relief From Immigrant Visa Retrogression**

- In October 2005, the EB-2 permanent residency category began to retrogress for the first time in five years.
- Currently, Indian and Chinese physicians must wait at least five years for a green card to become available. That backlog in visa availability is expected to extend to doctors of all nationalities this spring and the waits could stretch several years longer based on current projections.
- Retrogression is largely due to the increased issuance of H-1B visas to workers in professions other than medicine who draw permanent residency visas in the same category as medical doctors.
- Part of the bargain of the Conrad program is that in exchange for serving three or more years in an underserved area, a physician will be able to have a path to permanent residency. (Without green card numbers available, the Conrad program's attractiveness diminishes enormously.)
- This backlog is already causing many physicians to reconsider plans to work in underserved communities and instead pursue opportunities in competitor nations like the United Kingdom, Germany and Australia that have similar shortages to the U.S., but physician immigration policies that are very favorable. (This provision would reverse this trend by removing physicians from the EB-2 immigrant visa cap.)
- The most credible shortage studies indicate that the physician supply will be extremely tight for at least two more decades and there is virtually no chance that the U.S. will be able to train enough medical graduates – American or international - to meet the demand.
- Consequently, there is little danger that this provision would have the effect of negatively impacting the ability of American citizen and permanent resident physicians to secure employment. (In turn, lessening the severity of the shortage.)

#### **6. National Interest Waiver (NIW) Petition**

- In 1999, Senators Lott and Daschle – then the minority and majority leaders in the U.S. Senate – co-sponsored legislation to create a permanent residency program to tie in with the Conrad program.
- Hence, offering physicians who work two additional years in an underserved area an easier path to permanent residency than the conventional labor certification program available to professionals in other occupations.
- Unfortunately, various U.S. Citizenship and Immigration Services (USCIS) regulations that do not reflect the intentions of Congress have resulted in the program remaining largely unused. This section clarifies various sections of Public Law 106-95 in order to ensure that the physician National Interest Waiver (NIW) program is able to operate as Congress originally intended.
- First, subparagraph (1) allows specialists to qualify for national interest waivers. The 1999 legislation was clear when it referred to “any” physician and Congress never contemplated limiting the program to primary care physicians. Nevertheless, USCIS issued a regulation limiting NIWs to primary care physicians.
- A number of recent studies indicate that shortages in specialty medical fields are much more severe than in primary care medicine and this change will have the effect of delivering the right kind of medical services to communities in need.
- The original statute was written to allow any federal health agency or any health agency in a state to sponsor an NIW. USCIS regulations limit sponsorship only to statewide health agencies and federal agencies. (Subparagraph (2) clarifies that local health agencies also have the authority to sponsor NIWs.)
- Subparagraphs (1) and (3) address ultra vires USCIS regulations that state that the five year service obligation begins only when an I-140 is approved and gives no credit to H-1B doctors for work performed prior to that point. These sections state that the five-year service time begins when work begins rather than when the I-140 is approved. (Work need not be completed in six years as is arbitrarily required under current USCIS regulations.)
- A new I-140 is not required when a physician changes locations after an original I-140 is approved. The current USCIS requirement to file a new I-140 every time a physician moves to a new underserved area is unnecessary, redundant and burdensome. (USCIS has the ability to address fulfillment of the five-year service requirement in the adjustment of status process.)
- Finally, physicians in Katrina areas covered in the new INA section 214(l)(1)(B)(ii) described above shall only be required to work three years in an underserved area. (This provision will hopefully give hurricane-impacted communities another tool to help replenish the dramatically reduced physician supply.)

#### **7. *H-1 B provisions – Parity For H-1B Physicians***

- An increasing number of physicians are entering the U.S. on H-1B visas instead of J-1 visas.

- Many of these physicians would like to work in underserved communities upon conclusion of their training, but are not able to accept such positions because of the H-1B cap provisions.
- This section is designed to make it possible for physicians to accept such positions and put them into a program that will easily fit into the Conrad 30 programs in each state.

*\*The mission of the Louisiana Rural Health Association is to serve as a unified voice for the promotion of rural health care through advocacy, education, and leadership. The information above was provided in part by the National Rural Health Association and gathered from various publicly released documents of news related sources.*