



## **CRITICAL ACCESS AND SMALL RURAL HOSPITAL 2013 Legislative Agenda**

**Protect Critical Access and Small Rural Hospital Payments** The Arizona Health Care Cost Containment System (AHCCCS) has proposed implementing a new inpatient hospital payment system that will pay hospitals based on case rates, or diagnosis related groups (DRGs). This methodology is similar to the prospective payment system (PPS) methodology that Medicare uses, **and which critical access hospitals are excluded from.**

The PPS is a fixed-price payment system. Hospitals are paid a set price to treat patients with a similar set of medical conditions. Profit or loss is the difference between revenue and expenses. If a patient's expenses exceed the diagnosis-related group (DRG) payment, the hospital suffers a loss on the admission. Alternatively, hospitals whose expenses are below the DRG payment will make a profit on the admission.

In 1997, Congress enacted the Medicare Rural Hospital Flexibility Program, which created the critical access hospital (CAH) designation. In exchange for agreeing to certain limitations, such as geographical restrictions and limited bed size, these rural hospitals (CAHs) were excluded from the PPS/DRG system and paid on a reasonable cost basis for inpatient Medicare services. Congress recognized that the low inpatient volumes of small rural hospitals would put them at grave financial risk if they were paid by DRGs and so paid CAHs on a cost basis to deal with this reality.

The same realities exist for Arizona small rural hospitals for AHCCCS inpatient payments. Less than 1% (\$10,391,935) of the 1.5 billion dollars AHCCCS paid for inpatient care in 2010 went to small rural hospitals. Forcing small rural hospitals into a DRG payment system for AHCCCS inpatient care services will not only continue the less than cost payments that these hospitals receive under the current payment system (CAH hospitals were paid \$1,662,720 less than the cost of care provided to AHCCCS inpatients in 2013), it will open them at the financial risks Congress sought to avoid with the CAH designation.

For this reason, **Arizona's small rural hospitals urge state lawmakers to excuse hospitals with fewer than 50 beds from the detrimental impact of the DRG payment methodology proposed by AHCCCS.**

## **Promote Cost-Effective Telemedicine Treatment**

AZ Senate Bill for health insurance; telemedicine is targeted to be on the Fifty-First legislation first Regular Session docket. This telemedicine reimbursement parity bill will restrict insurers or healthcare service plans from discriminating against telemedicine service coverage. It will require insurers to cover access to tele-healthcare under equivalent terms and conditions as ordinary coverage.

The proposed bill defines telemedicine as “the use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Does not include the use of an audio-only telephone, a facsimile machine or electronic mail.”

This definition includes both synchronous and asynchronous (real-time and store-and-forward) use of interactive audio, video, or electronic media for delivering health care. It would not discriminate by a patient’s geographic location.

Arizona is already a nationally acknowledged leader in the telemedicine field but we can do better. The University of Arizona pioneered the development of teleradiology which is now a national standard-of-care for rural and night-time urban health care. Over one million cases have been handled by telemedicine in Arizona with a high level of provider and patient satisfaction. Lives have been saved. Nevertheless, disparities in reimbursement policies of insurers is a serious bottleneck to further expanding this type of healthcare delivery and is depriving many patients of access to the system.

FYI- Currently 15 states have passed similar parity reimbursement laws: California (1996), Colorado (2001), Georgia (2006), Hawaii (1999), Kentucky (2000), Louisiana (1995), Maine (2009), Maryland (2012), Michigan (2012), New Hampshire (2009), Oklahoma (1997), Oregon (2009), Texas (1997), Vermont (2012), and Virginia (2010). Arizona has pending legislative proposals: (AZ S.B. 705)

National supporters of parity legislation include the American Telemedicine Association, the National Organization of Black Elected Legislative Women, and the National Hispanic Caucus of State Legislators.

### ***Benefits of Telemedicine:***

Reduce disparities in access to care -- For many people access to in-person services is very difficult for a wide variety of reasons, notably their mobility limitations, major distance or time barriers, and transportation limitations (don’t drive, have a car or have transit available).

Improve physician availability -- Many areas of the state already have numerical shortage of needed providers. Another problem is a lack of providers willing to treat the patients of a

particular payer (usually for reimbursement reasons). These problems are only expected to worsen. Telehealth methods can reduce provider's practice costs, improve their productivity, and facilitate triaging for specialty care.

Improve quality of care—Diseases can be identified earlier in their clinical course when treatment may avert the development of more serious disease. Reduction in the fragmentation of care can be a significant benefit to the patient.

Expand patient services offered at rural hospitals—Rural hospitals can retain some potential in-patients in need of specialty consultations that can be handled through telemedicine rather than automatic transfers of the patients to urban hospitals. Lost in-patient revenue is a significant problem for **Arizona's CAHs and small rural hospitals. They are hemorrhaging!!**

Increase range of patient choices -- Wider patient choices will foster provider competition. Today, lack of choices can be especially problematic in rural areas.

Consumer choice -- Patients should be able to choose how they receive covered services, including their urgency, convenience and satisfaction.

Non-discrimination -- Telehealth methods of providing covered services should be on parity with in-person methods. This legislation does not require new coverage.

For these reason, **Arizona's CAHs and small rural hospitals should urge state lawmakers to pass reimbursement parity for telemedicine services legislation in Arizona.**

**Ensure Access to Pediatric Services** Regulations adopted by the Arizona Department of Health Services prohibit hospitals without a separate pediatric unit from admitting pediatric patients except in an emergency. Because of this rule, pediatric patients throughout rural Arizona are flown to the Phoenix metro area or Tucson for inpatient treatment. This is an appropriate protocol for complex medical and surgical cases. But many of these patients can be safely treated in local, community hospitals under the direction of qualified, trained medical personnel.

While smaller hospitals located in rural areas would like to operate separate pediatric units, the combination of regulatory restrictions and uneven patient volume, make this option impractical. **Arizona's CAH and small rural hospitals support legislation that will allow pediatric patients in rural areas to be safely treated in their community hospital.**