2017 Michigan Rural Health Conference
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National Rural Health Association
Leawood, KS

Improving the health of the 62 million who call rural America home.

NRHA is non-profit and non-partisan.
Destination NRHA
Plan now to attend these upcoming events.

- **Annual Conference**—May 9-12, 2017 • San Diego, CA
- **Rural Hospital Innovation Summit**—May 9-12, 2017 • San Diego, CA
- **Quality/Clinical Conference**—July 11-14, 2017 • Nashville, TN
- **RHC/CAH Conference**—September 26-29, 2017 • Kansas City, MO
- **Policy Institute**—February 6-8, 2018 • Washington, DC

Visit RuralHealthWeb.org for details and discounts.
New HRSA Administrator

George Sigounas, MS, Ph.D.
Dept. of Internal Medicine at East Carolina Univ./hematology

MS: Northeastern University, Boston, MS
PhD: Boston University, Boston, MA
Post-Doc Fellowship: National Institutes of Health and Naval Medical Center, Bethesda, MD
Interests: Stem Cells; Cancer Initiating Cells; Stem Cell Microenvironment; DNA Damage and Cancer

A History (short) of Rural Health

• War on Poverty in the 60’s
• Community Health Centers, created in the War on Poverty
• Rural Health Clinics –38 Years Old (1978), 4,100 nationwide
• Result of PPS 1983: 440 hospital closures
• Policy Response 1992-2003:
  – State Office of Rural Health (SORH)
  – Medicare Dependent Hospitals (MDH)
  – Critical Access Hospital (CAH) 1997
  – Medicare Rural Flexibility Program (1997)
  – Low-Volume Hospital (LVH) Adjustment (2003 and 2010)
• Patient Protection and Affordable Care Act (ACA) 2010
• Medicare Access and Chip Reauthorization Act (MACRA) 2015
• ACA Repeal 2017?
We’re not finished yet...

Health Equates to Wealth:

People who live in wealthy areas like San Francisco, Colorado, or the suburbs of Washington, D.C. are likely to be as healthy as their counterparts in Switzerland or Japan, but those who live in Appalachia or the rural South are likely to be as unhealthy as people in Algeria or Bangladesh.

--University of Washington, July, 2013

Rural counties have the highest rates of premature death, lagging far behind other counties, RWJF Report, March, 2016

Rural counties have had the highest rates of premature death for many years, lagging far behind other counties. While urban counties continue to show improvement, premature death rates are worsening in rural counties.

Paradigm Shift


“A paradigm shift is tantamount to what religion often calls a ‘major conversion.’ Any genuine transformation of worldview asks for such a major switch from the track we’re familiar with that often those who hold the old paradigm must actually die off before a new paradigm can gain traction and wide acceptance.

A paradigm shift becomes necessary when the plausibility structure of the previous paradigm becomes so full of holes and patchwork ‘fixes’ that a complete overhaul, which once looked utterly threatening, no appears as a lifeline.”
Rural Populations Suffer many Health Disparities

Rural hospitals care for older, poorer, and sicker populations than non-rural providers:

*Population Health metrics are percentile ranked for all acute care rural and non-rural providers by hospital service area such that lower ranks indicate greater population challenges.

**Lower percentile scores indicate higher density (i.e., providers serving a greater proportion of individuals over 65 receive lower scores).

These rural populations also have less access to primary, dental, and mental healthcare:

Rural America Speaks Loudly…

•  “Hillary lost rural America 3 to 1. If she lost rural America 2 to 1, it would have broken differently.”
  Democrat inside the Clinton campaign. Politico, 11-16-16

• President-Elect Donald Trump never issued any specific rural policy agenda, yet captured high rural voter turnout:
  • 20% of the nation lives in rural America - - according to exit polls, rural voters made up 17 percent of the electorate.
The Rural Vote

- **MICHIGAN**: Trump won rural and small towns 57% to 38% (better than Mitt Romney in 2012, who won 53-46).
- **PENNSYLVANIA**: Trump “blew Clinton out of the water” among rural and small-town voters, 71-26 percent.
- **WISCONSIN**: Rural communities 63-34 (Compare to Romney who pulled 59%.

*The Daily Yonder:*

- Clinton’s support among rural voters down 8% from President Obama’s in 2012.

- “Obama’s support in rural America eroded between 2008 and 2012, from a high of 41 percent to 38 percent. But Clinton took it to a new low: 29 percent.”
#1 The Great Recession.

“The Real Loser in the Recession is Rural America”

Washington Post 2013

Agriculture Secretary Vilsack’s final press release laid out the difficulties in helping rural America rebound:

“At the depths of the Great Recession, rural counties were shedding 200,000 jobs per year, rural unemployment stood at nearly 10 percent, and poverty rates reached heights unseen in decades. Many rural communities were ill-positioned to bounce back quickly.”

“While cities recover, the rural economy still struggles to shake off Great Recession”

Washington Post

No net employment growth in nonmetro counties in 2012 and first half of 2013

Employment index (2008 Q1 = 100)

Year and Quarter

Notes: Local Area Unemployment Statistics (LAUS) estimates cover both wage and salary workers and the self-employed. Metro and nonmetro counties are as identified by the Office of Management and Budget in 2013. New population controls were introduced into the LAUS data following the April 2010 Census, leading to an increase in estimated employment in the second quarter of 2010. The data shown have been corrected to compensate for this change, but caution should be used in comparing levels before and after this date.

Source: USDA-ERS analysis of Bureau of Labor Statistics-LAUS data, seasonally adjusted by ERS.
#2 Rural Mortality Rates.

A Rural Divide in American Death

Center for Disease Control January, 2017 Study:

“The death rate gap between urban and rural America is getting wider”

- Rates of the five leading causes of death — heart disease, cancer, unintentional injuries, chronic respiratory disease, and stroke — are higher among rural Americans.
- Mortality is tied to income and geography.
- Minorities, especially Native Americans die consistently prematurely nation-wide, but more pronounced in rural.
- Startling increase in mortality of white, rural women. Causes:
  - Risky lifestyle (smoking, alcohol abuse, opioid abuse, obesity)
  - Environmental cancer clusters
  - Suicides

Opioid Crisis in Rural American

All states have demonstrated an increase in nonmedical prescription opioid mortality during the past decade, however, the largest areas of abuse are concentrated in states with large rural populations, such as Kentucky, West Virginia, Alaska, and Oklahoma.
“Hospitals, schools, churches. It’s the three-legged stool. If one of those falls down, you don’t have a town.”

JOHN HENDERSON, CHILDRESS REGIONAL CEO
Chris Smiley, Sac-Osage Hospital's last chief executive, stands in the empty emergency room. The Osceola, Missouri, hospital closed after 45 years of serving the rural communities of western (April 2015)

A Catastrophic Crisis

78 Hospitals have closed since 2010.

The VULNERABILITY INDEX™ identifies 673 Rural Hospitals Now Vulnerable or At Risk of Closure

210 hospitals are most vulnerable to closure, while an additional 463 are less vulnerable

At current trajectory, 25% of hospitals will close in less than a decade.

Rural hospitals are closing where health disparities are the greatest.
Rural Hospital Closures and Risk of Closures

Closures Escalating

78 Since 2010

Medicare cuts are causing financial collapse...

36.8% of all rural hospitals have a negative operating margin.

AHA Rural Chartbook, November 2016

According to MedPAC’s March 2016 Report to Congress: “Average Medicare margins are negative and under current law they are expected to decline in 2016.”
The Unending Medicare Cuts...

**Impact of cuts in Bad Debt Reimbursement**

- **$1 billion** lost in bad debt reimbursement (over 10 years)
- **2,000** rural healthcare jobs lost
- **2,600** rural community jobs lost
- **$5.3 billion** loss to GDP (over 10 years)

- **35% cut**
Bad Debt Reductions are Crippling Rural Hospitals

June, 2016 report of the Rural Health Research Program:

- Bad debt is growing for rural hospitals due to high-deductible plans and because of shortfalls care in Medicare and Medicaid were growing.

- Rural hospitals Medicare bad debt levels are almost 50 percent higher than urban hospitals.

What Rural Hospitals are Saying...

“If someone goes from no insurance to a high-deductible plan, they are effectively uninsured.”

“We are experiencing greater charity care. We are finding charity care not only with those who are uninsured but those with large deductible plans as well. They are going to the exchange, getting a high deductible, and then applying for charity care to cover the balance.”
If Congress does not act, history will be repeated...

Rural Hospital Closures: 1983-97

So what do we do???

The Politically Powerful are Listening
THE IMPORTANCE OF TODAY

• No matter your politics, we must join together and capitalize on this opportunity.
• Washington is reaching out to Rural America.
• Policy Institute - - Record attendance from Capitol Hill!

• **Our Message:** rural healthcare is critical for rural patients and the rural economy:
  • You can’t have a healthy rural economy without a healthy rural community.
  • Quality rural healthcare saves lives, provides skilled jobs, attracts businesses, and reinvests millions back into rural communities.

United...Our voice is loud

1. Demand flaws of ACA be fixed;
2. Demand hospital closure crisis be fixed;
3. Demand fair funding for rural health safety net;
4. Demand meaningful regulatory relief.
Deja vu all over again

• Continuing resolution expired April 28, extension for a week
• Omnibus spending bill agreed to Sunday night April 30, 2017
• Government shut-down averted?
• Major features of omnibus spending bill:
  • HHS gets $2.8B increase over FY16 spending bill
  • $2B increase for National Institute of Health (NIH)
  • HRSA to receive $6M increase over FY16 for rural health programs

Rural Health Safety Net Funding—HRSA

• Rural Hospital Flexibility Grant Program—$2M increase from FY16
• Telehealth: Additional $1.5M over FY16
  • Plan to create a “telehealth center of excellence”
  • For the additional new funds for the Telehealth Network Grant Program, HRSA is directed to issue a new funding opportunity announcement, giving preference in grant awards to small hospitals serving communities with high rates of poverty, unemployment, and substance abuse
• National Diabetes Prevention Program (NDPP): increase of $2.5M
  • directs all new funds to support new program providers, including a focus on rural providers.
• First Responder Training: $12M
  • Of this amount, $6,000,000 is set aside for rural communities with high rates of substance abuse.
• AHEC: Level Funding at $30.25M
Rural Health Safety Net Funding—HRSA

- State Offices of Rural Health: $489K over FY16 amount
- Rural Health Outreach
  - $12,514,000 for Outreach Service Grants;
  - $15,000,000 for Rural Network Development Grants;
  - $12,000,000 for Delta States Network Grant Program;
  - $2,200,000 for Network Planning Grants;
  - $6,500,000 for Small Healthcare Provider Quality Improvement Grants.
- Delta States Rural Development Network Grant Program
  - $2,000,000 to support HRSA’s collaboration with the Delta Regional Authority to develop a pilot program to help underserved rural communities identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance.

The AHCA Odyssey

- The American Health Care Act (AHCA), the Republican attempt to repeal/replace ACA
- Signature Republican promise in 2016 election
- Caucus unable to agree on features of the Bill
- Signs of life for “Trumpcare 2.0?”
- Freedom Caucus’ two demands: state determination of pre-existing conditions and repeal Essential Health Benefits
- House R “Tuesday Group” opposes these changes
- Will be a protracted process
Make Affordable Care Act Work in Rural America

Protect positives of ACA

- **Keep Rural Americans Insured.** Health insurance coverage has increased by 8% in rural counties since the implementation of the ACA. Rural Americans are more likely to be uninsured and to have longer periods of uninsurance. The gap between urban and rural rates of insurance have persisted. Rural Americans are less likely to receive health insurance through their employer (51% vs. 57% urban).

- **Keep Medicaid Expansion.** Medicaid is disproportionately important to rural patients as a higher portion of rural residents are covered by Medicaid (21% rural vs. 16% urban). For rural hospitals it accounts for 15% of gross revenues. In implementing Medicaid reform, including approving state plans and waivers, a Rural Impact Study that identifies anticipated impacts on rural areas and contains specific proposals for mitigation of any disproportionate negative impact on rural beneficiaries, health care providers, or health care delivery systems.

- **Protect 340B Drug Program.** Expansion of the 340B program to include rural providers has benefited 1220 rural hospitals. The 340B Drug Pricing Program is a federal program that requires drug manufacturers to provide outpatient drugs to eligible healthcare centers, clinics, and hospitals at a reduced
Change what did not work in rural America

- **Medicaid** - Lack of Medicaid Expansion
- **Exchanges** - Lack of plan competition, exorbitant premium increases, high deductibles
- **Medicare cuts**

Each combines to exacerbate the rural hospital closure crisis.

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1. Medicaid

- Majority of rural residents live in states that have not expanded Medicaid.

- **States with a higher percentage of their rural population living in poverty** are less likely to expand.

- Two-thirds of the uninsured live in a state that hasn’t expanded Medicaid, HHS June 2016.

- **A Kansas example**: one rural hospital would receive about **$1.6 million** more in one year if the state expanded its Medicaid coverage.
2. Exchanges. Are they Working in Rural Areas?

- 58.3% of rural counties only had 1 or 2 plan options
- Over ¾ of urban plans had three or more choices of coverage

“Insurance Options Dwindle in Rural Regions”
Wall Street Journal May, 2016

- Many rural states have just one insurer (Alaska, Alabama, Kentucky, Arizona and Oklahoma).
- Kaiser Family Foundation:
  - 1 in 3 counties have only one plan.
  - Rural regions, counties, and states are more likely to have single-insurer markets than metro areas and have faster-growing premiums.
  - 70% of the counties where insurers pulled out have mostly rural populations.
3. Ending Medicare Cuts...

Critical Rural Medicare Payments Set to Expire Sept. 30

- Medicare Dependent Hospital (MDH) - $100 million
- Low-Volume Hospital (LVH) - $450 million
- Work geographic index floor under the Medicare physician fee schedule (GPCI) - $500 million
- All current ambulance payment rates including rural and super rural - $100 million
- Exceptions process for Medicare therapy caps - $1 billion
- Rural Home Health Add on Payments
Legislation NRHA Supports

- Rural Hospital Regulatory Relief Act of 2017 S. 243/H.R. 741
- Rural Hospital Access Act of 2017 S. 872/H.R. 1955
- Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2017 (S. 967)
- Medicare Access to Rehabilitation Services Act of 2017 S. 253/H.R. 807
- Telehealth Innovation and Improvement Act S. 787

Save Rural Hospitals Act

Rural hospital stabilization (Stop the bleeding)
- Elimination of Medicare Sequestration for rural hospitals;
- Reversal of all “bad debt” reimbursement cuts (Middle Class Tax Relief and Job Creation Act of 2012);
- Permanent extension of current Low-Volume and Medicare Dependent Hospital payment levels;
- Reinstatement of Sole Community Hospital “Hold Harmless” payments;
- Extension of Medicaid primary care payments;
- Elimination of Medicare and Medicaid DSH payment reductions; and
- Establishment of Meaningful Use support payments for rural facilities struggling.
- Permanent extension of the rural ambulance and super-rural ambulance payment.

Rural Medicare beneficiary equity. Eliminate higher out-of-pocket charges for rural patients (total charges vs. allowed Medicare charges.)

Regulatory Relief
- Elimination of the CAH 96-Hour Condition of Payment (See Critical Access Hospital Relief Act of 2014);
- Rebase of supervision requirements for outpatient therapy services at CAHs and rural PPS (PARTS Act);
- Modification to 2-Midnight Rule and RAC audit and appeals process.

Future of rural health care (Bridge to the Future)
Innovation model for rural hospitals who continue to struggle.
Future Model: Community Outpatient Model

• 24/7 emergency Services

• Flexibility to Meet the Needs of Your Community through Outpatient Care:
  • Meet Needs of Your Community through a Community Needs Assessment:
    • Rural Health Clinic
    • FFQHC look-a-like
    • Swing beds
    • No preclusions to home health, skilled nursing, infusions services observation care.

• TELEHEALTH SERVICES AS REASONABLE COSTS.—For purposes of this subsection, with respect to qualified outpatient services, costs reasonably associated with having a backup physician available via a telecommunications system shall be considered reasonable costs.”.

  • “The amount of payment for qualified outpatient services is equal to 105 percent of the reasonable costs of providing such services.”

  • $50 million in wrap-around population health grants.

And, most importantly...
Celebrate the greatness of rural health care

- Higher quality
- Higher patient satisfaction
- Cost-effective
- Doing more with less

An October 2016 study from the Office of the Assistant Secretary for Planning and Evaluation at HHS:

- Rural hospitals outperform their urban counterparts on Medicare’s VBP program and in reducing hospital-acquired infection.
- Rural hospitals provide superior care coordination work on the part of rural providers and “can encourage collaboration across care types and settings.”
- “High levels of trust in providers may facilitate better patient experiences or outcomes both in the inpatient and outpatient setting.”

Emergency Surgery for Medicare Beneficiaries Admitted to Critical Access Hospitals

- Annals of American Surgery published April, 2017
- These findings (in the article) are reassuring that their local hospital (CAH) provides safe care for emergency surgery.
- The data suggest that critical access hospitals are being responsible in triaging and transferring more complex patients to higher levels care.
- For policy makers in the United States Congress considering current legislation to support surgical care in rural communities, this evidence is timely.
NRHA Policy Concerns/Updates

- Regulatory Relief
- MACRA Final Rule
- Sleep Study Accreditation Requirements
- Emergency Preparedness Requirements
- CMS Re-certification of CAHs
- Exclusive Use/Co-location of Visiting Specialists
- Star Ratings
- Veteran’s Choice Act (VCA)
- 340B Drug Discount Pricing Program
- CJR/Cardiac Bundled Payments of Care
- Implementing Comprehensive Addiction and Recovery Act (CARA) to address Opioid Crisis

Demand for Regulatory Relief

1. Non-enforcement of 96-Hour Rule Condition of Payment requirement.
2. Common-sense approach needed for “exclusive use” standard.
3. Prohibit the direct supervision requirements for outpatient therapy services.
4. CMS should make full use of flexibility already given by Congress regarding rural Graduate Medical Education (GME).
5. Sole Community Hospitals (SCH) and CAHs should be eligible for Indirect GME
6. Expand Medicare coverage of telehealth services.
8. Adjust rural readmission measures to reflect differences in sociodemographic factors.
10. Hold Medicare Recovery Audit Contractors (RACs) accountable.
11. More accurate price standardization of CAH swing bed claims is needed.
12. Performance comparisons should occur between equivalent cohorts in MIPS.
13. Implement appropriate validation survey rotations for CMS Validation Surveys.
14. Create a culture of consultation/education as part of CMS mandated surveys.
15. Improper MAC denial of Low-Volume Hospital Adjustment
New HPSA Designation Could Have Significant Impact

Overview: HRSA to use new system – Shortage Designation Management System

• Goal - utilize more standardized provider data - - based on NPI (National Provider Identifier)
• HRSA is working on various impact analysis on changes in Shortage Designation.
  – By May 2017, PCOs are to finish submitting provider data.
  – In June 2017, Second impact analysis, including Auto-HPSAs, provided to stakeholders by HRSA.
  – By July 2017, National update of all designations, including Auto-HPSAs.
• HRSA promising to fully review the impact on HPSAs and offer opportunities for stakeholders to review the impact.

• NRHA forming a coalition of stakeholders -- we must be vigilant!
• Much more to come!

CMS Rural Council and White House Rural Task Force

• CMS Rural Council continues into the Trump Administration as an Intra-agency council stood up by CMS Administrator Andy Slavitt, February, 2016
• Cara James, CMS Office Minority Affairs and John Hammarlund, CMS Seattle Region Administrator are Co-Chairs
• Designed to be an internal working group to assess prior to regulations being promulgated the impact on rural providers and to mitigate negative effects on same
• Presentation of findings and next steps at NRHA Rural Hospital Innovation Summit May 9-12, San Diego
• White House Rural Task Force announced Monday, April 24, 2017 to largely address rural economic development
NRHA Advocacy Agenda

• Fix the ACA
• Reduce Regulatory Burden
• Solve the rural hospital closure crisis
• Reverse cuts to rural providers
• Permanent extension of rural payment programs set to expire Sept. 30
• Rural sensitive innovation

Summary

• Rural Can Lead
• Population Health
• Patient Centered Medical Homes
• Collaborative Care Models
  • Care Management Programs
  • High Risk Populations
  • Chronic Disease Management
  • Care Transitions/Post-acute Care
  • Episodes of Care
• Health Information Technology
• Leadership/Cultural Transformation
Questions?

THANK YOU

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