The Rural Health Landscape: Current Trends and Policy

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Senior Vice President for Member Services
National Rural Health Association
Improving the health of the 62 million who call rural America home.

NRHA is non-profit and non-partisan.
National Rural Health Association Membership

One Dot Represents One Member
(Map shows only members residing in the United States & Puerto Rico)
Our Grassroots Effort

- NRHA doesn’t have a PAC
- Website: ruralhealthweb.org
- Depends solely on grassroots advocacy
- Members have access to:
  - ✓ Rural Health Blog
    http://blog.ruralhealthweb.org
- Join NRHA today at ruralhealthweb.org
Destination NRHA
Plan now to attend these upcoming events.

Rural Health Clinic Conference - Sept. 30-Oct. 1 • Kansas City, Mo.

Critical Access Hospital Conference - Oct. 1-3 • Kansas City, Mo.

Rural Health Policy Institute - Feb. 3-5, 2015 • Washington, D.C.

Visit RuralHealthWeb.org for details and discounts.
Plan now to attend NRHA’s
38th Annual Rural Health Conference
April 14 - 17, 2015
Philadelphia
Rural disparities/challenges

- War on Poverty in the 60’s
- Rural Health Clinics – just turned 36 (1978), >4,500 RHC’s nationwide
- Community Health Centers, created in the War on Poverty
- Advent of PPS 1983: 400 hospital closures
- Policy Response: SORH, Flex, MDH, CAH and LVH
- Rural serves more challenging populations:
  - “Rural Americans are older, poorer and sicker than their urban counterparts… Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider.” (HHS, 2011)
- Disparities are compounded if you are a senior or minority in rural America.
Problems still exist…

- *Health equates to wealth* according to Univ. of Washington Study, July 2013

- **Key Finding:**

- The study found that 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.
Medicare cuts enacted so far:

- Sequestration cuts – 2% for nine years
- Bad Debt Reimbursement cuts
- Documentation & Coding cuts
- Readmission cuts
- Multiple therapy procedure cuts
- ESRD reimbursement cuts
- Super rural laboratory extender – expired
- Outpatient hold harmless payments (TOPS) – expired
- 508 reclassifications – expired
Impact of Sequestration

- Loss of over $1 billion in rural revenue.
- Tens of millions of dollars lost for rural PPS hospitals.
- 41% of rural hospitals operate at a financial loss; sequestration will force many more into the red.
- SGR Patch – pay-for; extends non-discretionary sequestration years.

**Result:**

- Rural Job losses;
- Rural revenue lost
- Rural patient services cut
- Possible rural hospital closures
## Rural and Urban Comparison of Operating Margin

<table>
<thead>
<tr>
<th></th>
<th>Profitable</th>
<th>Switch</th>
<th>Unprofitable</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Rural</td>
<td>739</td>
<td>44</td>
<td>1,540</td>
<td>2,323</td>
</tr>
<tr>
<td>CAH</td>
<td>363</td>
<td>26</td>
<td>927</td>
<td>1,316</td>
</tr>
<tr>
<td>Medicare Dependent</td>
<td>62</td>
<td>8</td>
<td>147</td>
<td>217</td>
</tr>
<tr>
<td>Sole Community</td>
<td>173</td>
<td>7</td>
<td>262</td>
<td>442</td>
</tr>
<tr>
<td>Standard Rural PPS</td>
<td>141</td>
<td>3</td>
<td>204</td>
<td>348</td>
</tr>
<tr>
<td>Urban</td>
<td>1,166</td>
<td>42</td>
<td>1,157</td>
<td>2,365</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1905</td>
<td>86</td>
<td>2,697</td>
<td>4,688</td>
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UNC Sheps Center Series of Reports on CAH Financial Distress

• Important series of reports by Sheps Center for Health Research analyzing proposed cuts to rural providers.

**Overall:**
• Urban hospitals paid under PPS had consistently the highest profitability.
• Rural hospitals paid under PPS and Critical Access Hospitals generally had the lowest profitability.
Rural Hospital Closures: 1983-97

Location of Closed Rural Hospital
(N = 315)
The History of Rural

- 1986  46% of ALL community hospitals were located in rural, non-MSA, counties
- During the 80’s nearly 10% of all U.S. rural hospitals closed [Hart et. al, 1991]
- 1992-1999 -- 122 Rural Hospitals Closed
- Nearly 60% of rural hospitals gross revenue come from Medicare and Medicaid

Approximately 439 Rural Hospitals in 20 years!

Moscovice, I.: Rural hospitals: a literature synthesis and health services research agenda. Dec. 13-15, 1987 (a) p. 4
Deja’ vu all over again

Rural Hospital Closures:
24 in 2013-14

State breakdown:

Alabama 3
Georgia 5
Kentucky 1
Nebraska 1
Tennessee 3
Texas 4
Ohio 1

Nebraska 1
Pennsylvania 1
Mississippi 1
North Carolina 1
Virginia 1
Missouri 1
Current Status of State Medicaid Expansion Decisions

NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.
Medicaid Expansion and Rural Populations

• A majority of the states with the largest percentage of population living in rural areas are not expanding, while nearly all of the least rural states are expanding.

• Rural, poor states are the least likely to expand Medicaid.

• The majority of rural residents in the U.S. live in states that are not expanding. Only 3 of the 11 states with the largest rural population have expanded (IA, KY, MI)

• There is a wider rural-urban insurance coverage that existed pre-ACA.

Source: NC Rural Health Research Program, July 2014
BRANXTON LIONS CLUB

Welcomes Careful Drivers

We have two cemeteries
no hospital
Federal Deficit Trends

- FY 2009 Deficit: $1.4 Trillion
- FY 2014 Deficit: $514 Billion
- 2014 Debt Level is 3% of GDP
- This 3% is the average for the last 40 years
- Anticipated debt in FY 2015: $478 Billion

Source: CBO
Slowdown In Health Cost Growth

Annual Change in Spending Growth

Source: CMS OACT National Health Statistics Group; Historical Tables.
Monthly Medicare 30-Day, All-Condition Hospital Readmission Rate
January 2007 - August 2013

Source: Centers for Medicare and Medicaid Services, Offices of Enterprise Management
Legislative Success

- **Protecting Access to Medicare Act of 2014 (PAMA)**
  - Signed into law on April 1, 2014
  - SGR Fix preventing 24% to Medicare FFS payments
  - MDH and LVH
  - GPCI Rural Floor
  - These provisions extended for only 1 year or March 31, 2015…déjà vu all over again
  - ICD-10 Delay, now Oct. 1, 2015
  - Delay Medicaid DSH Cuts for 1 year (2017)
Key Issues

• Protection from burdensome and excessive policies
  --Physician Supervision
  --96 Hour Certification Rule in CAH’s
  --Two-midnight Policy
  --Recovery Audit Contractors:
• Protect 340B Program
• Trends in Hospital Affiliations: RUPRI Policy Brief
• Narrow Networks and ACA
• CMS’ 68% Solution
• Public Health—Ebola, Enterovirus D68
Key Issues

• Protect/Enhance Provider Payments
  --CAH’s
  --PPS Hospitals
  --Physicians
  --Offsets to pay for other programs
  --Veteran’s access to rural providers
  --Meaningful Use Stage 2
  --Medicaid Expansion
  --Rural Health Clinic (RHC) Program
  --Federally Qualified Health Center (FQHC)
  --Population Health
Why is there an assault on rural health care?

• Loss of champions;
• New members who don’t know why certain rural payments exist;
• Strong fiscal conservative movement;
• CMS negative attitude toward CAHs;
• Confusing rural payment system - - many see payments as “bonuses”
Rural champions exit Congress

Many other rural champions are also leaving or have left – Sen. Harkin (D-IA), Sen. Rockefeller (D-WV), Sen. Inouye (D-HI), Sen. Conrad (D-ND), Sen. Bingaman (D-NM), Sen. Lugar (R-IN), Sen. Snowe (R-ME)

Senator Max Baucus (D-MT) – Staunch rural health advocate, now Ambassador to China
  - CAH program
  - Rural primary care programs
  - Rural demonstration projects

NOTE: Sen. Ron Wyden (D-OR) is now
  - Finance Committee Chairman.
Congress Gets In 12 Solid Hours Of Gridlocking Before Calling It A Day
Legislators Proudly Call Gridlocking Session A ‘Team Effort’

WASHINGTON—Exhausted but satisfied leaders from both parties came together Tuesday night to announce that Congress had successfully completed 12 solid hours of nonstop gridlocking, once again going above and beyond to needlessly prevent the nation from moving forward.

In a marathon session that lawmakers proudly called “one of [their] least productive ever,” each of the 535 members of the House and Senate gridlocked deep into the night to ensure that no bipartisan compromise could be reached, no laws intended to aid the American people could be passed, and no sense of national unity or progress could possibly be achieved.

For more, visit theonion.com

YOUR HOROSCOPE: You shall drink from the fountain of wisdom this week, repeatedly missing your big dumb mouth, and completely soaking your ridiculous shirt.

MONDAY
MARCH 31
Opportunities for Kentucky Communities

• Optimize fee-for-service (transition)
  – Market share, Revenue Cycle, Payer Contracts (skinny networks), GPO Contracts, Inventory control, appropriate volume

• Attend to performance and innovation
  – Telehealth, mobile clinics, expanded primary care, health risk assessments, care coordination, community health assessments, population health, EHR, post-acute care, outpatient infusion

• Drive in efficiency
  – Eradicate waste (lean), Reduce variation (6 Sigma), Flatten the organization, Aggressively review “bricks and mortar budgets

Source: RUPRI
Opportunities for Kentucky Communities

- Drive out variation
  - Best evidence to practice medicine, Care should vary by unique patient needs, not by doctor, nurse, time of day or day of week. Diagnostic accuracy, care plan implementation, Guideline compliance, drug choice, procedural skill and efficient resource use

- Develop medical homes (Pop Health)

- Engage the medical staff
  - Involve at every organizational level and function: strategic planning, governance, operations and evaluation. Invest in physician leaders, develop salary system based on “how would peers identify a great physician?” Continued recognition of accomplishment.

  Source: RUPRI
Health Care Critical to Rural Economy

- Health care is the fastest growing segment of rural economy.
- Each rural physician generates 23 jobs in the local rural economy.
- Health care often represent up to 20 percent of a rural community's employment and income.
Delivering Value
Study Area B - Shared Savings (Medicare beneficiaries)

Rural vs. Urban Spending

$1.5 BILLION
Less spending per beneficiary

$5.2 BILLION
Apply the rural rate of spend to urban beneficiaries

Total savings if all beneficiaries were treated at the rural equivalent?

$6.8 BILLION *

Medicare spends less on rural beneficiaries than on urban beneficiaries

* Approximate Totals
Source: Rural Relevance Under Healthcare Reform 2014, Study Area B.
## Legislation to Support

<table>
<thead>
<tr>
<th>Rural Hospital Access Act</th>
<th>S. 842 and H.R. 1787</th>
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<tr>
<td>Rural Hospital and Provider Equity Act R-HoPE</td>
<td>S 2359</td>
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<td>Strengthening Rural Access to Emergency Services Act</td>
<td>S. 328</td>
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<tr>
<td>Extension of FESC Demonstration</td>
<td>S. 239</td>
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<tr>
<td>Senate Resolution on importance of rural health providers</td>
<td>S.R. 26</td>
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<tr>
<td>Rural Hospitals are Essential Act</td>
<td>H.R. 356</td>
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<td>The DSH Reduction Relief Act</td>
<td>S. 1555 and H.R. 1920</td>
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<td>S. 1012 and H.R. 1250</td>
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<td>The Two-Midnight Rule Delay Act</td>
<td>H.R. 6398</td>
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<tr>
<td>Protecting Access to Rural Therapy Services Act</td>
<td>S. 1143 and H.R. 2801</td>
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<tr>
<td>Critical Access Hospital Relief Act</td>
<td>HR 3991 and S. 2037</td>
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<tr>
<td>Two-Midnight Rule Coordination and Improvement Act of 2014</td>
<td>S 2082</td>
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<tr>
<td>Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)</td>
<td>S 2553 and HR 4994</td>
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Questions?

THANK YOU

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