Thursday, March 5, 2015

Alan Morgan
Chief Executive Officer
National Rural Health Association

Rural Health Care Policy
and your Community

Improving the health of the 62 million who call rural America home.
NRHA is working to help members take advantage of ACA programs.
Disclaimers:

- NRHA did **NOT** take a position on the ACA
- NRHA sought for inclusion of rural-relevant funding and programs in the ACA
- Since passage, NRHA’s Rural Health Congress has passed policy encouraging states to expand Medicaid

Rural Health Disparities

- More likely to report fair to poor health
  - Rural counties 19.5%
  - Urban counties 15.6%
- More obesity
  - Rural counties 27.4% VS urban counties 23.9%
  - Less likely to engage in moderate to vigorous exercise: rural 44% VS urban 45.4%
- More chronic disease (heart, diabetes, cancer)
  - Diabetes in rural adults 9.6% VS urban adults 8.4%
**Workforce Shortages**

- Only 9% of physicians practice in rural America.
- 77% of the 2,050 rural counties are primary care HPSAs.
- More than 50% of rural patients have to drive 60+ miles to receive specialty care.

**Rural is Different**

- Strong sense of community responsibility, propensity toward collaboration (unique ways to develop and provide services needed.)

- Creation of regional networks to provide greater access to state-of-the-art health care.

- IOM 2005
Rural hospitals have lower risk-adjusted rates of potential safety-related events.
– Jolliffe 2003

Rural hospitals have significantly lower adverse event rates than urban counterparts.
– Whitener and McGranahan, 2003
Rural is Different

- Rural hospitals have significantly lower rates of postop hip fracture, hemorrhage, and hematoma.
  – Cromartie, 2002

Rural is Different

- Rural areas score higher than urban on appropriate provision of preventative services related to breast exams/family history of cancer, influenza immunization...
  – Pol et al., 2001
Rural is Different

- Hospitals in rural areas have significantly higher ratings on HCAHPS measures than those located in urban areas.
  – Casey and Davidson, 2010

Rural is Different

- Rural critical access hospitals performed as well as or better than urban hospitals in four of the five pneumonia-related indicators.
Delivering Value
Study Area C – Hospital Performance

Who has the edge?

- Quality
- Patient Safety
- Patient Outcomes
- Patient Satisfaction
- Price
- Time in the ED

Rural hospitals match Urban hospitals on performance at a lower price

Source: Rural Relevance Under Healthcare Reform 2014, Study Area C.
A Crisis in Rural America

- 47 rural hospitals have closed since 2010;
- Since 2013, more rural hospitals have closed than in the previous 10-years – COMBINED.
- 283 more rural hospitals are on the brink of closure.
Financial Crisis for CAHs

- 41% of operate at a financial loss.
- Average operating margin 0.7% (Flex Monitoring Team)
- Cuts in Effect:
  - Medicare Sequestration cuts
  - Medicare Bad Debt Reductions
  - Coding
  - Uncompensated care provided in states that have not expanded Medicaid
- Many for cuts threatened
  - 79% of CAHs will be in financial distress if Congress acts on current proposals for Medicare cuts.
## Rural Hospital Mergers, 2005-12

- Number of Mergers and Acquisitions

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<th>Year</th>
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### 2010-14 rural hospital closures:
When did they close?

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<th>Year</th>
<th>Number of Closures</th>
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<td>2010</td>
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<td>2014</td>
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In each year from FY11 to FY13, rural hospitals posted a median operating profit margin that was at least 1.66 percentage points lower than that of urban hospitals, and the gap is widening.

Source: Rural Relevance Under Healthcare Reform (2014 HCRIS)

Rural Hospital Closures

iVantage identifies 283 rural hospitals that match the performance of the 26 forced to close already this decade.

Source: Hospital Strength Index - Vulnerability Index
Impact of 283 Hospital Closures

- 700,000 Patient Encounters
- 36,000 Healthcare Jobs Lost
- 50,000 Community Jobs Lost
- $10.6 Billion Loss to GDP

Source: Hospital Strength Index - Vulnerability Index

Rural Hospital Closures: 1980-90

Location of Closed Rural Hospital (N = 315)
Vulnerability Index: Rural Closures and Risk of Closures

The Vulnerability Index™ identifies 283 rural hospitals statistically clustered in the bottom tier of performance.

Rural Hospital Closures

State breakdown:
- Alabama - 2
- California - 1
- Georgia - 4
- Kentucky - 1
- Maine - 1
- Massachusetts - 1
- Mississippi - 1
- Missouri - 1
- Nebraska - 1
- North Carolina - 2
- Ohio - 1
- Pennsylvania - 1
- Tennessee - 3
- Texas - 7
- Virginia - 1
The headlines are already here…

“Another Rural Hospital Closes”
   - Georgia Health News Feb. 13, 2014

“Rural Hospitals are on Life Support”
   - Insurance News Net April 1, 2014

“More Rural Hospitals Face Closure”
   - Fierce Health News April 3, 2014

“Rural Hospital Closure Creates Challenges”
   - Deerfield Valley News April 10, 2014

“Rural America is Losing its Hospitals”
   - Newser July 12, 2014

“Rural Hospital Closures Strand Many in Need”
   - News and Observer July 28, 2014

“Rural Hospitals Pressured to Close as Healthcare System Changes”
   - Reuters Sept. 3, 2014

“More Critical-Access Hospital Closings Likely”
   - Modern Healthcare Sept. 30, 2014
“When rural hospitals close, towns struggle to stay open.”

What Happens When a Town's Only Hospital Shuts Down?

• “It was a tragedy that stunned a small Texas town: 18-month-old Edith Gonzales, a grape lodged in her tiny throat, died in her desperate parents’ arms because the county’s only hospital and emergency room had closed for good a few months earlier.” US News and World Report, Nov. 2013

• “The toddler’s Aug. 12 death has starkly exposed the vulnerabilities of a rural community suddenly left without its longtime safety net.” Dallas News, Nov. 2013
It’s about the patients…

“Only four days after the Pungo District Hospital in Belhaven closed its doors for good on July 1, Portia Gibbs, 48, suffered a heart attack and died just as the chopper arrived to airlift her to a hospital. “In that hour that she lived, she would have received 35 minutes of emergency room care, and she very well could have survived” Belhaven Mayor Adam O’Neil.

(The nearest hospital is now 75 miles away.)

“It ends up with rural communities, such as Hancock County (Georgia), where 39 percent of the folks who have a stroke or have a heart attack die. That’s a lot higher than in counties with hospitals close by.”

David Lucas, Georgia State Senator.

It’s about access to care…

• 5,700 hospitals in the country; only 35 percent are located in rural areas.

• 640 counties across the country without quick access to an acute-care hospital. - UNC Sheps Center

• “Access to care remains the number one concern in rural health care.” - Rural Healthy People

• [The closings] “are a growing problem of ‘medical deserts’…it is much like the movement of a glacier: nearly invisible day-to-day, but over time, you can see big changes.”

- Alan Sager, Boston Univ. professor of health policy
Four hundred ninety rural communities that had one or more retail pharmacy (including independent, chain, or franchise pharmacy) in March 2003 had no retail pharmacy in December 2013.

* A loss of 924 independently owned rural pharmacies in the United States.

Why are Rural Hospitals Closing?
Greatest challenges to CAHs since program established

- ACA – challenges in Health Exchanges; Challenges in Medicaid expansion
- Continued cuts in Medicare
- Continued threats of cuts in Medicare


Chart 2: $1.9 trillion

Chart 3: $1.4 trillion

Chart 4: $1.9 trillion
Sequestration – mandated 2% cuts to Medicare providers extended AGAIN.

- Loss of over $1 billion in CAH revenue.
- SGR Patch – pay-for; extends non-discretionary sequestration years.

**Result:**
- Rural Job losses;
- Rural revenue lost (more CAHs operating in the red)
- Rural patient services cut
- Possible rural hospital closures

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**Medicare Cuts Enacted**

- 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
And wave after wave of cuts for rural PPS hospitals…

- MDH expiration – 12% inpatient cut to 200 rural hospitals
- LVH expiration – 13% inpatient cut to 650 rural hospitals
- 25% cut in DSH payments to rural hospitals (non-CAH)
- Hold harmless – 4% cut in outpatient payments
- 5% cut uncompensated care to rural hospitals (non-CAH)

Critical Access Hospitals are not immune…

- CAH reimbursement cuts – (President’s budget)
- Elimination of CAH status for nearly 50 hospitals (President’s budget)
- Proposed cuts in flex and outreach grants proposal to eliminate all CAHs (CBO budget proposal)
- 35% cut uncompensated care
- Provider tax cuts

41% of CAHs operate at a financial loss.
Medicare cuts will mean reductions in services, job loss, or worse, hospital closures - - jeopardizing rural seniors’ access to care.
If proposed cuts occur

- If Congress acts on any of the proposed cuts to CAHs, there will likely be a reduction of 20-30% in Medicare payments (depending upon proposal).
- With a 30% reduction, 80% of CAHs would operate in negative financial margin; 45% would be a high or mid-high risk of financial distress.
- CAHs in the south see the sharpest increase in risk.

“Such a substantial reduction in financial viability could lead to an increase in the number of CAHs experiencing insolvency, bankruptcy or closure, with deleterious effects on the health and economic well-being of these communities.”

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Slowdown In Health Cost Growth

![Graph showing annual change in spending growth with 3.9% and 4.3% markers](chart.png)

**Annual Change in Spending Growth**

- Hospitals
- National Health Expenditures

Source: CMS OACT National Health Statistics Group, Historical Tables.
Last year, cuts were slated, but your voice was heard…

*Political wins are possible even in this tough environment.*

“Rural hospitals get relief in fiscal cliff deal”
- Kaiser Health News

“Fiscal bill extends a Medicare lifeline to small, rural hospitals”
- The Washington

Despite climate, rural victories were achieved

- Rural providers were to lose hundreds of millions in Medicare payments if Congress did not act by March 31.
- What was at stake?
  - **For Rural Doctors**: 27-32% cut in Medicare reimbursement rates
  - SGR expiration
  - GPCI expiration
  - **For Rural Hospitals**:
    - Medicare Dependent Hospital – 12% loss of Medicare revenue; need to make up 18% from private insurer.
    - Low Volume Hospital -- approx. $500,000 per hospital and can mean well over $1 million.
  - **For Rural Ambulance Providers** – 22.6% reductions
  - All on top of Sequestration – 2% across the board cut.
Affordable Care Act
1. Rural implications in Medicaid Expansion
2. Rural implications in Federal and State Exchanges

Is ACA Working?

Percentage Uninsured in the U.S., by Quarter
Do you have health insurance coverage?
Among adults aged 18 and older

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Quarter 1, 2008-Quarter 1, 2014
Gallup-Healthways Well-Being Index
GALLUP
Are Health Exchanges Working in Rural Areas?

- 58.3% of rural counties only had 1 or 2 plan options
- 23.7% of rural counties vs. 5.5% of urban counties had only 1 plan option
- Over ¾ of urban plans had three or more choices of coverage

Rural areas appear to have lower rates of plan selection, suggesting that improving outreach and enrollment efforts in these communities may be particularly warranted. Sept. 2014

Medicaid

- Disproportionately important to rural America (rural patients and rural economies).

- Supreme Court decision: Allowed states to “opt-out” or seeking waivers

- 21 states are opting out - - creating a new gap in coverage.
The Path Forward
Headway made with Press and Congress

• “NRHA, AHA Slam OIG Report Urging Cuts To Critical Access Hospitals”
  *Inside Health Policy*

• “Deep cuts to Medicare funding ‘would effectively kill rural healthcare’.”
  *Modern Healthcare*

How NRHA is Fighting Back

Our Campaign:

1. **Stop the bleeding.** Halt additional proposed cuts to rural hospitals from the Administration and Congress immediately. Support pro-rural provisions such as Medicaid expansion, elimination of the 2% sequestration cuts and 101% reimbursement for CAHs to stabilize the rural safety net.

2. **Build bridge to the future.** Promote new provider payment models to create a new rural reality.
(Community Access and Rural health Equity 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 See 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.

Important Rural Hospital Legislation
Already/Soon-to-be Introduced

- HR 169, Critical Access Hospital Relief Act, Rep. Adrian Smith (one year)
- S. 257, Protecting Access to Therapy Services Act, Senators Moran and Tester
- Veterans Access to Community Care Act of 2015, Sen. Moran
- HR 170, Rural Health Care Provider Relief Act – Direct Supervision
- S. 332, Rural Hospital Access Act – MDH/LVH
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

The Future

- Mandatory quality reporting for CAHs and RHCs.
- Development of an NQF Measures Application Partnership (MAP) for small-volume providers.
- Transition time and technical assistance money for these providers to make the transition.
- Feature bonuses for good performance in CAH and RHCs (say 103% of cost) versus a cut in reimbursement for bad performance (97% of cost, e.g.).
Go Rural!

Alan Morgan
Chief Executive Officer
National Rural Health Association