



Your voice. Louder.

Minnesota Rural Health Conference: Federal Rural Health Policy Update June 20, 2017

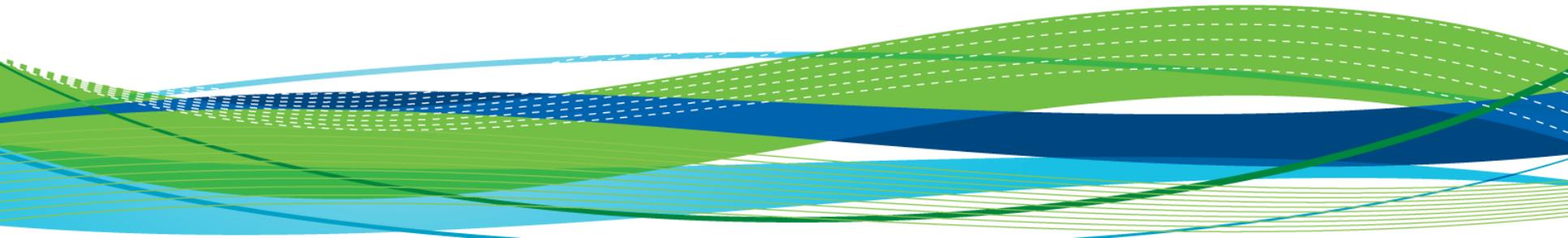
**Brock Slabach, MPH, FACHE
Sr. Vice-President
National Rural Health Association
Leawood, KS**



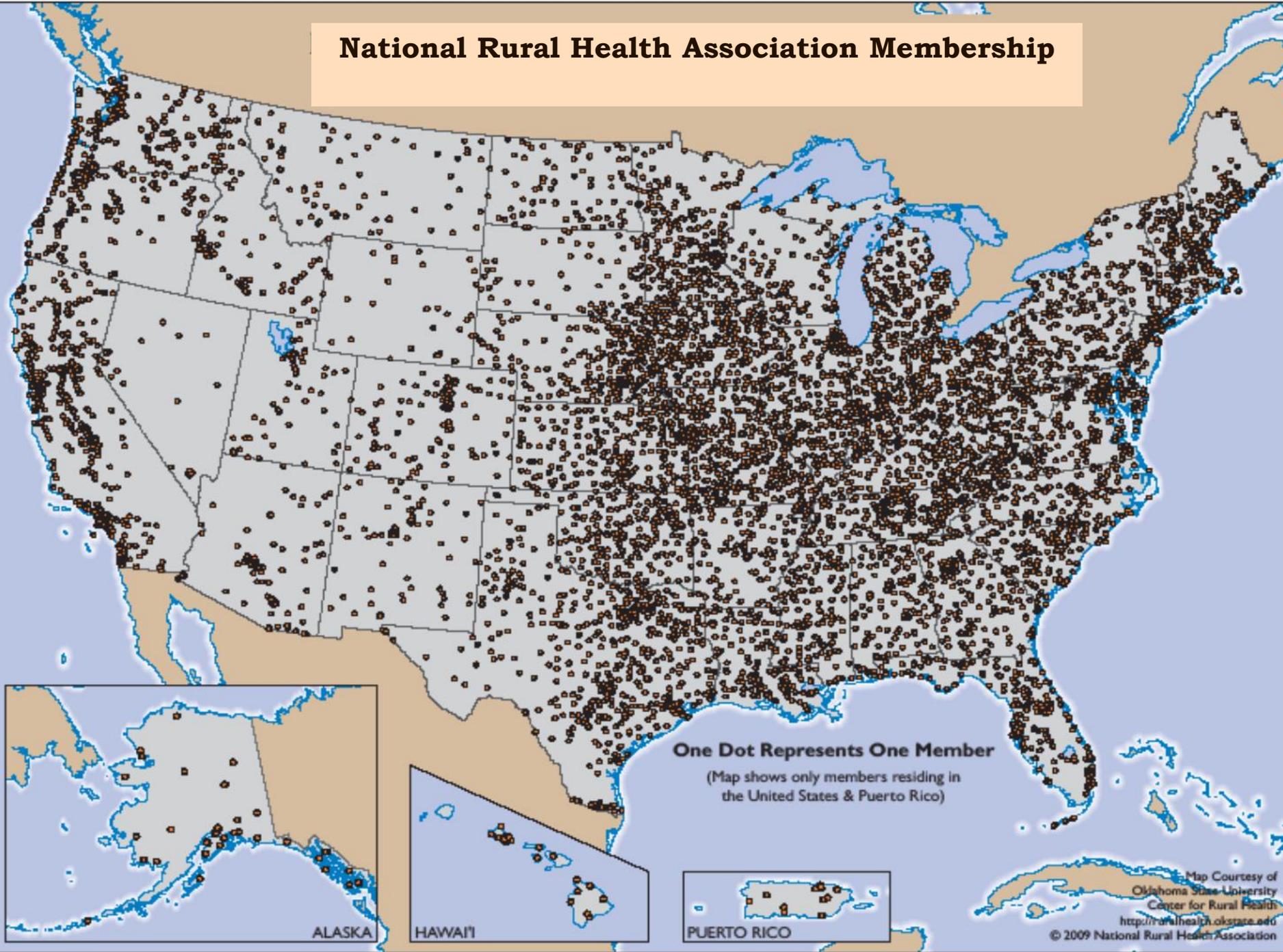
Your voice. Louder.

**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)

ALASKA

HAWAII

PUERTO RICO

Destination NRHA



Plan now to attend these upcoming events.

Quality/Clinical Conference—July 11-14, 2017 • Nashville, TN

RHC/CAH Conference—September 26-29, 2017 • Kansas City, MO

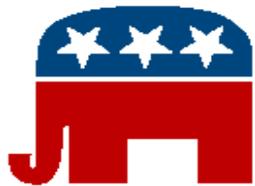
Policy Institute—February 6-8, 2018 • Washington, DC

Annual Conference—May 8-11, 2018 • New Orleans, LA

Rural Hospital Innovation Summit—May 8-11, 2018 • New Orleans, LA

**Visit RuralHealthWeb.org
for details and discounts.**

Non-Profit and Non-Partisan



REPUBLICAN



DEMOCRAT

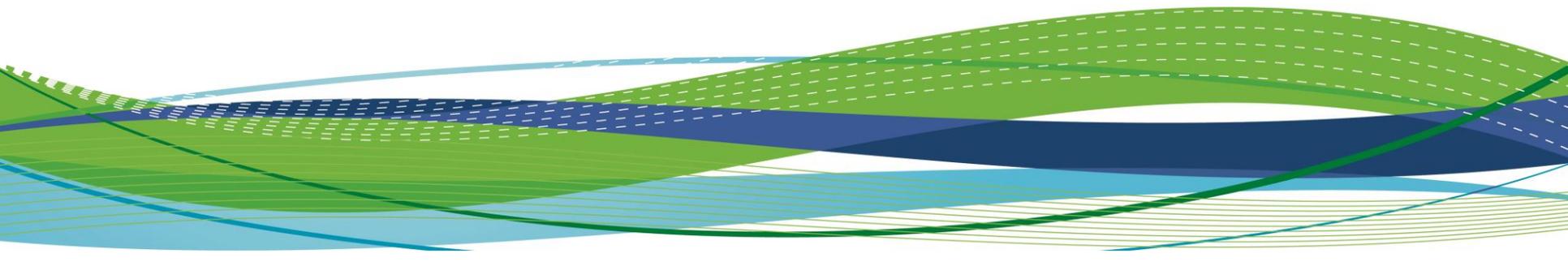


**RURAL
ADVOCATE**



Much to cover

- House passed health care bill;
- Our advocacy fight for rural health care in the Senate's secret proceedings;
- Federal funding for rural health care safety net;
- First, how do we shape our advocacy based on the politics of today?

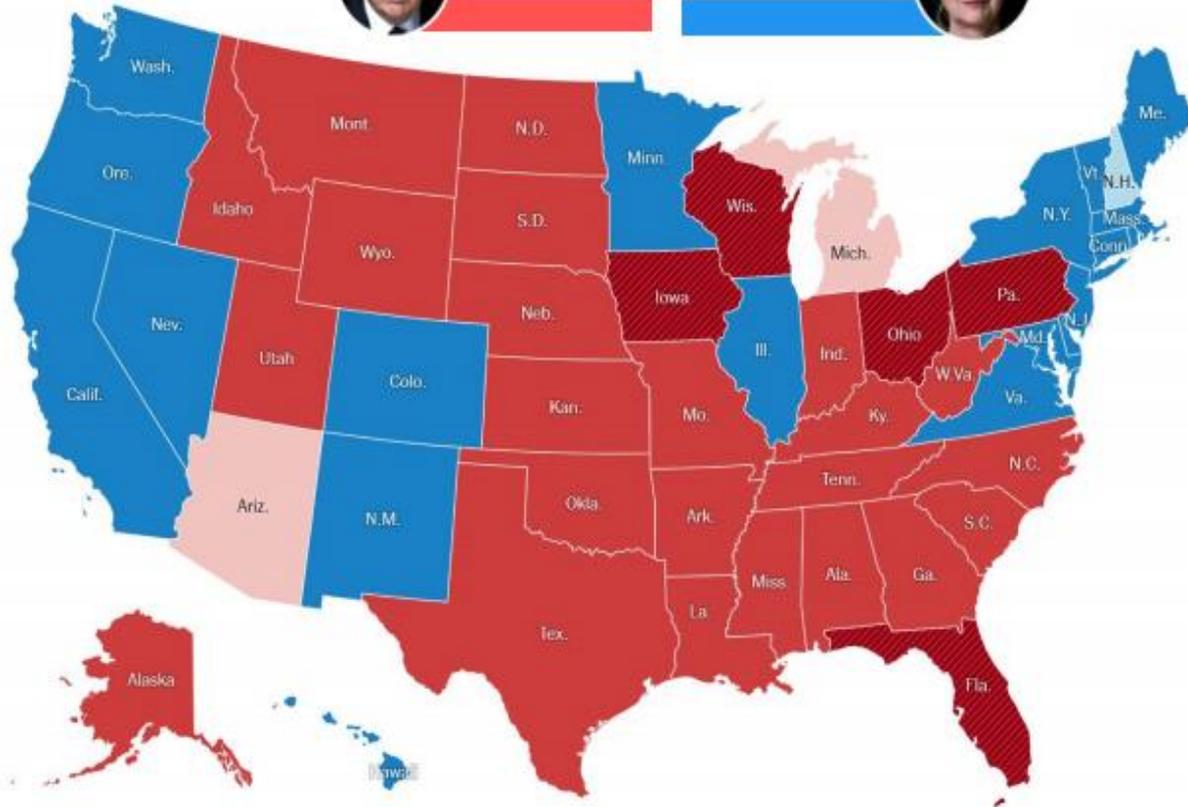


RESULTS: Big Night for the GOP



306 trump

clinton **232**



ELECTION RESULTS

HOUSE: D+7*

	114 th	115 th
GOP	247	240
DEM	188	195

SENATE: D+2

	114 th	115 th
GOP	54	52
DEM / IND	46	48

GOVERNORS: R+2

	2016	2017
GOP	31	33
DEM	18	16

The Political Force of Rural...

- ***“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

- Clinton received less than 30% of the vote in counties with less than 20,000 people.



CRACKER BARREL VS. WHOLE FOODS

DONALD TRUMP WON:

76% OF COUNTIES WITH
A CRACKER BARREL

22% OF COUNTIES WITH
A WHOLE FOODS

SOURCE: DAVE WASSERMAN, COOK POLITICAL REPORT



TEXAS

38 ELECTORAL VOTES **99%** IN



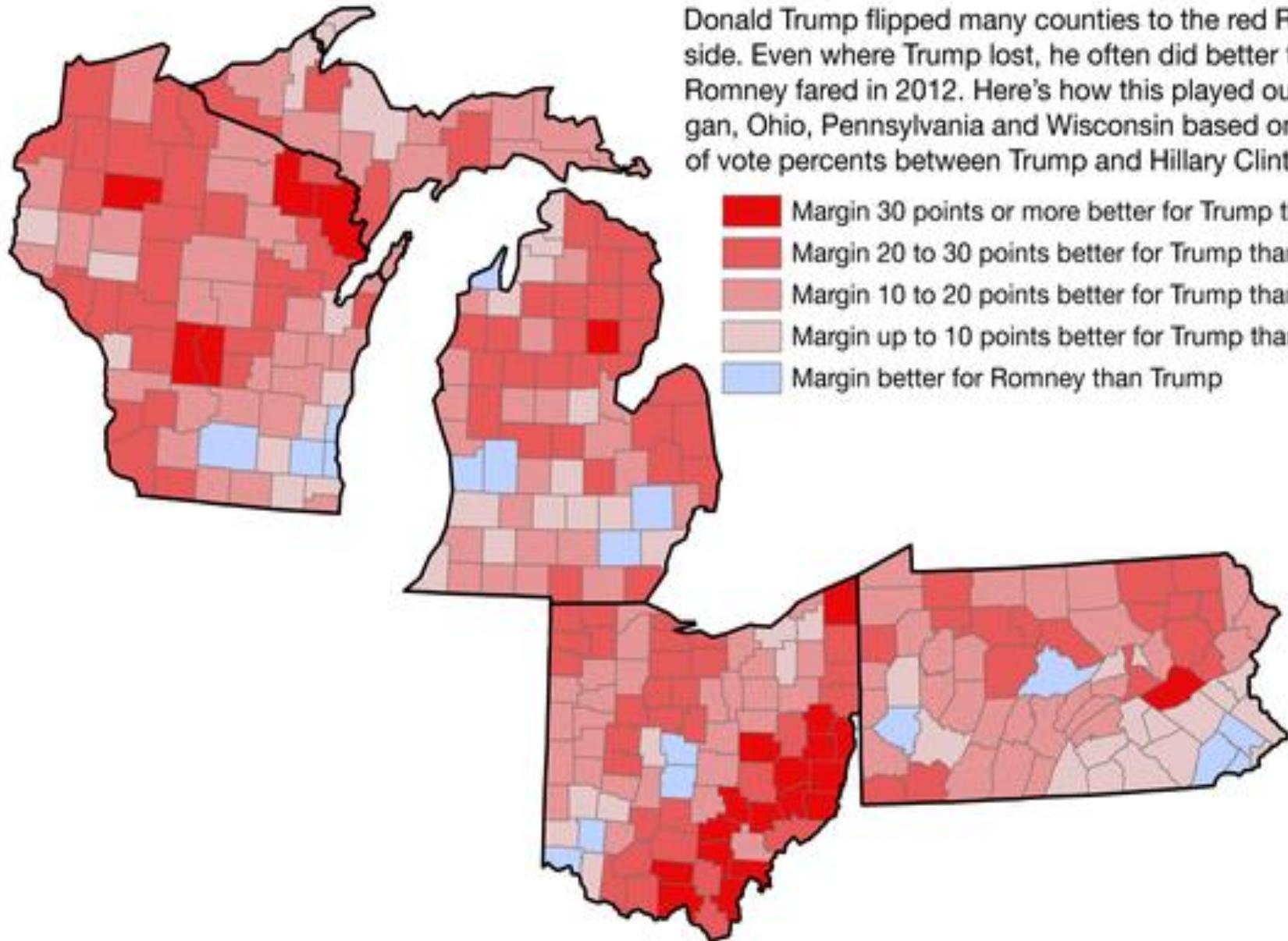
✓ **PROJECTED WINNER**

DONALD TRUMP

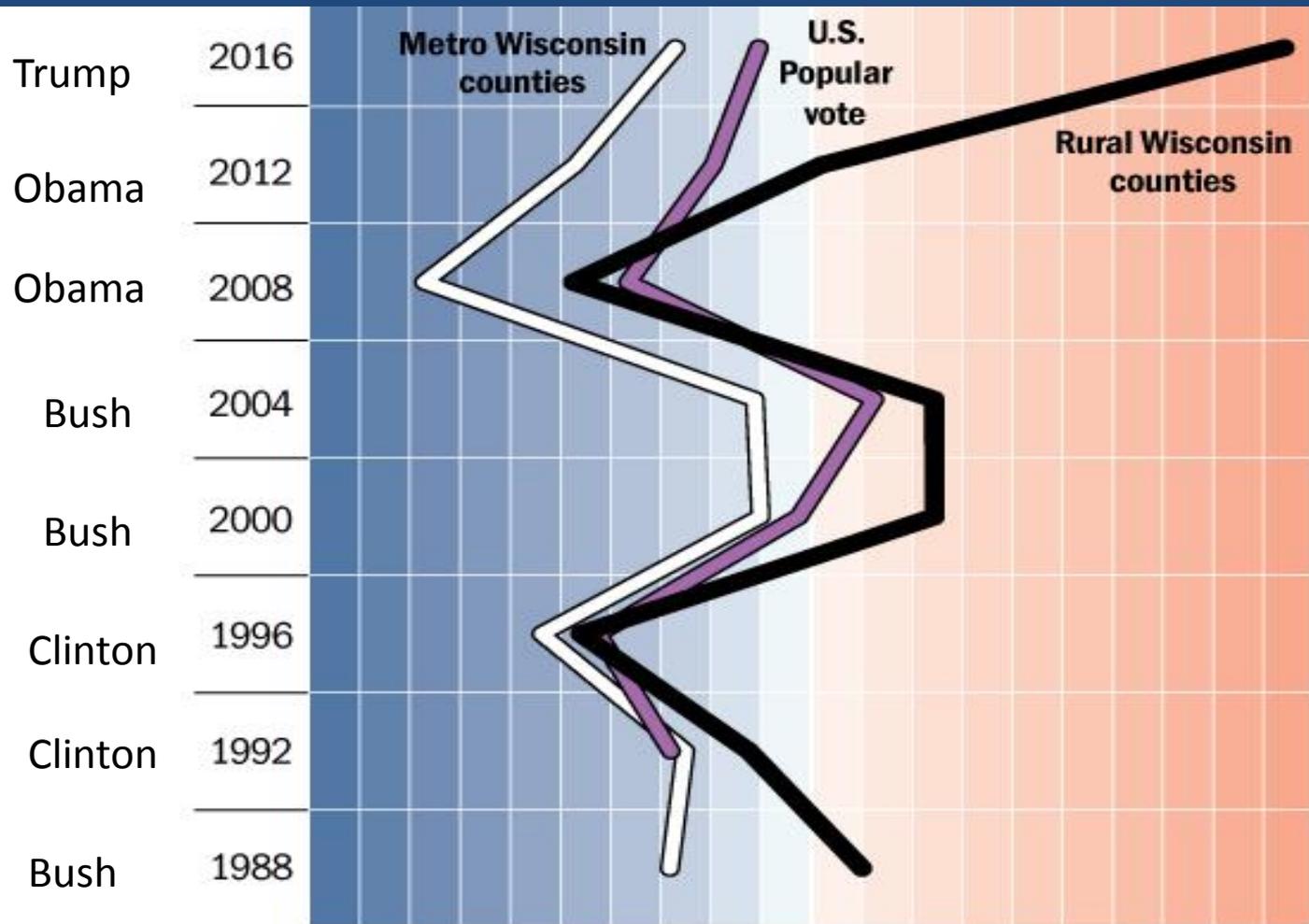
LIVE

Turning the Rust Belt red

Donald Trump flipped many counties to the red Republican side. Even where Trump lost, he often did better than Mitt Romney fared in 2012. Here's how this played out in Michigan, Ohio, Pennsylvania and Wisconsin based on the margin of vote percents between Trump and Hillary Clinton.



Wisconsin





#1 The Great Recession.



“The Real Loser in the Recession is Rural America”

Washington Post 2013

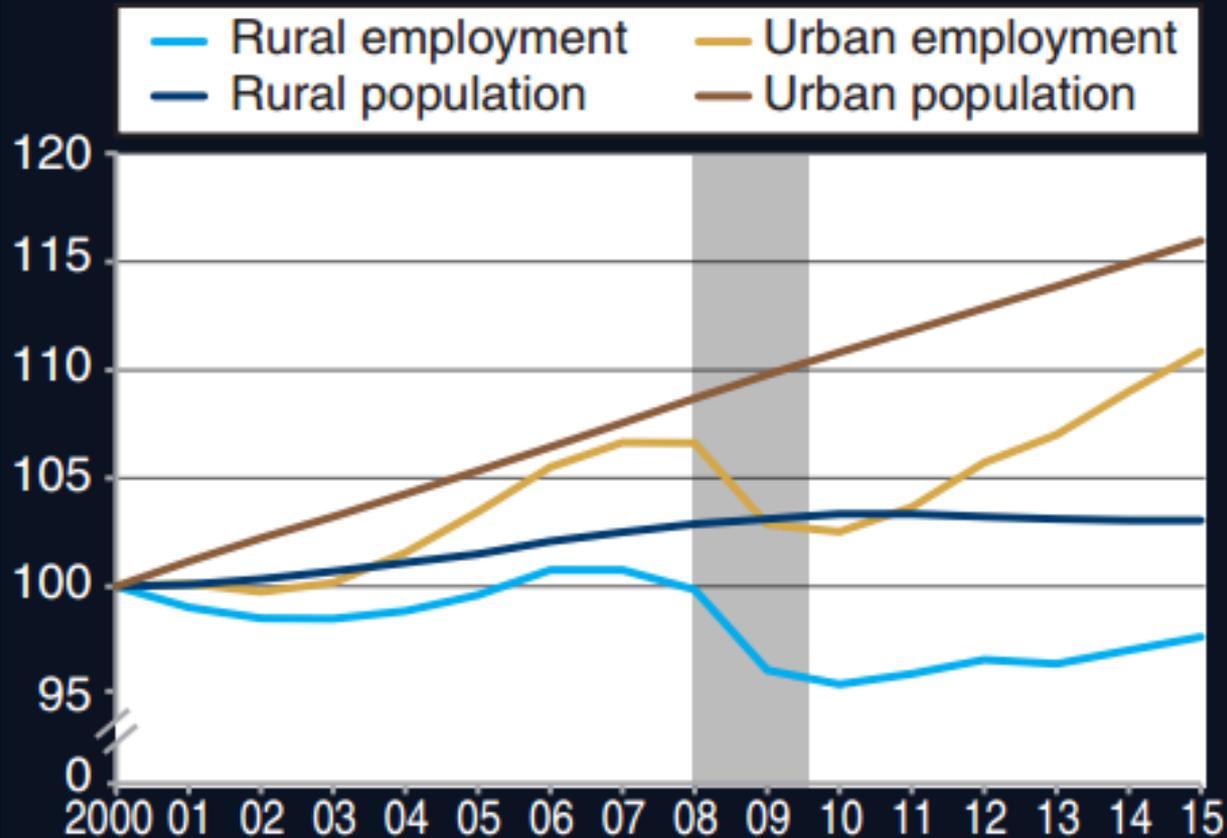
Agriculture Secretary Vilsack’s final press release described the difficulties in helping rural America rebound:

"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."



Rural employment has grown slowly in recent years while rural population has declined slightly

Indices (Level in 2000=100)



Note: Shaded area indicates Great Recession.

Source: Population data reflect July 1 estimates from the U.S. Census Bureau. Employment data are USDA, Economic Research Service estimates based on data from the Current Population Survey and the Bureau of Labor Statistics, Local Area Unemployment Statistics.

#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

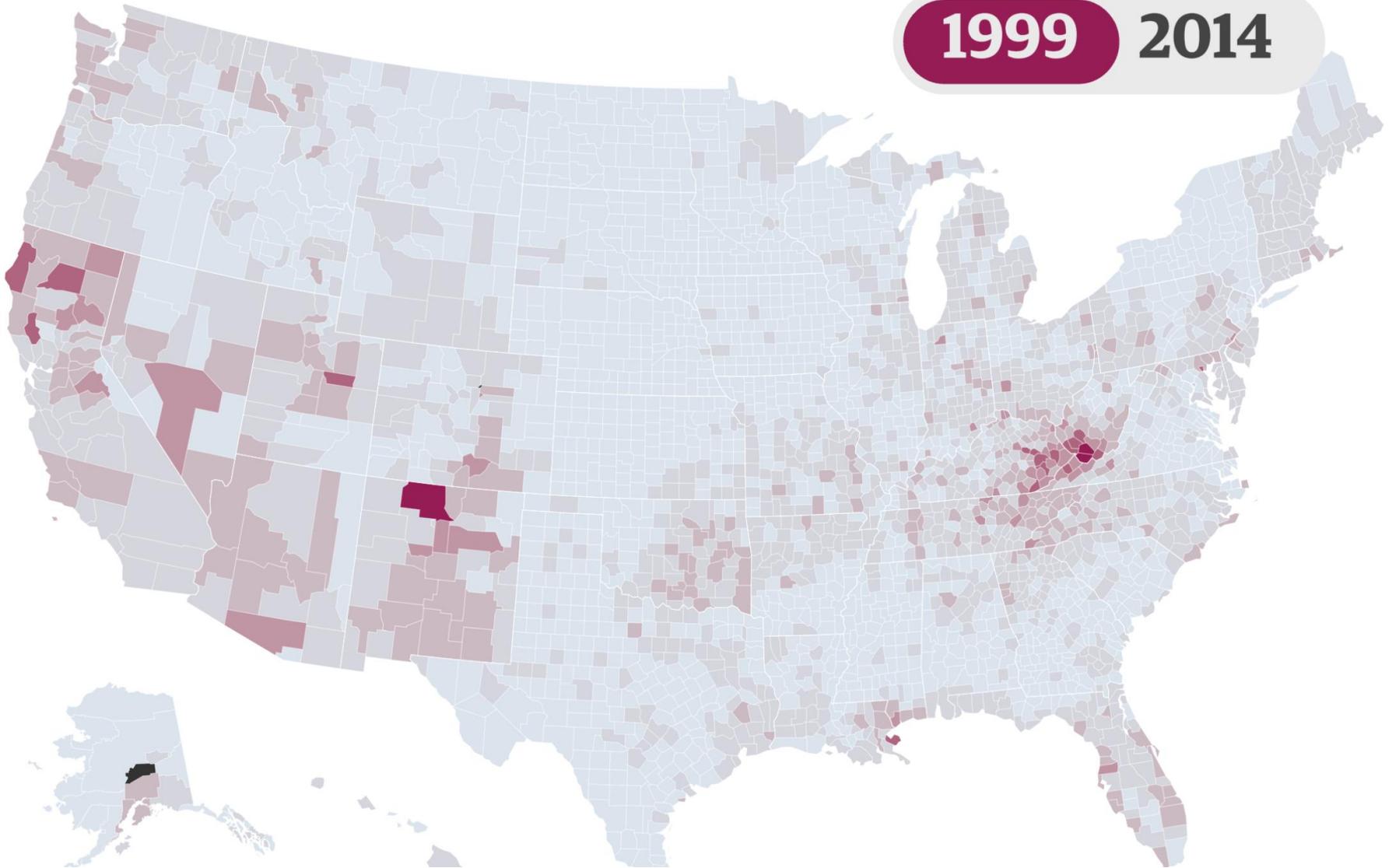


Mapping the Opioid Crisis

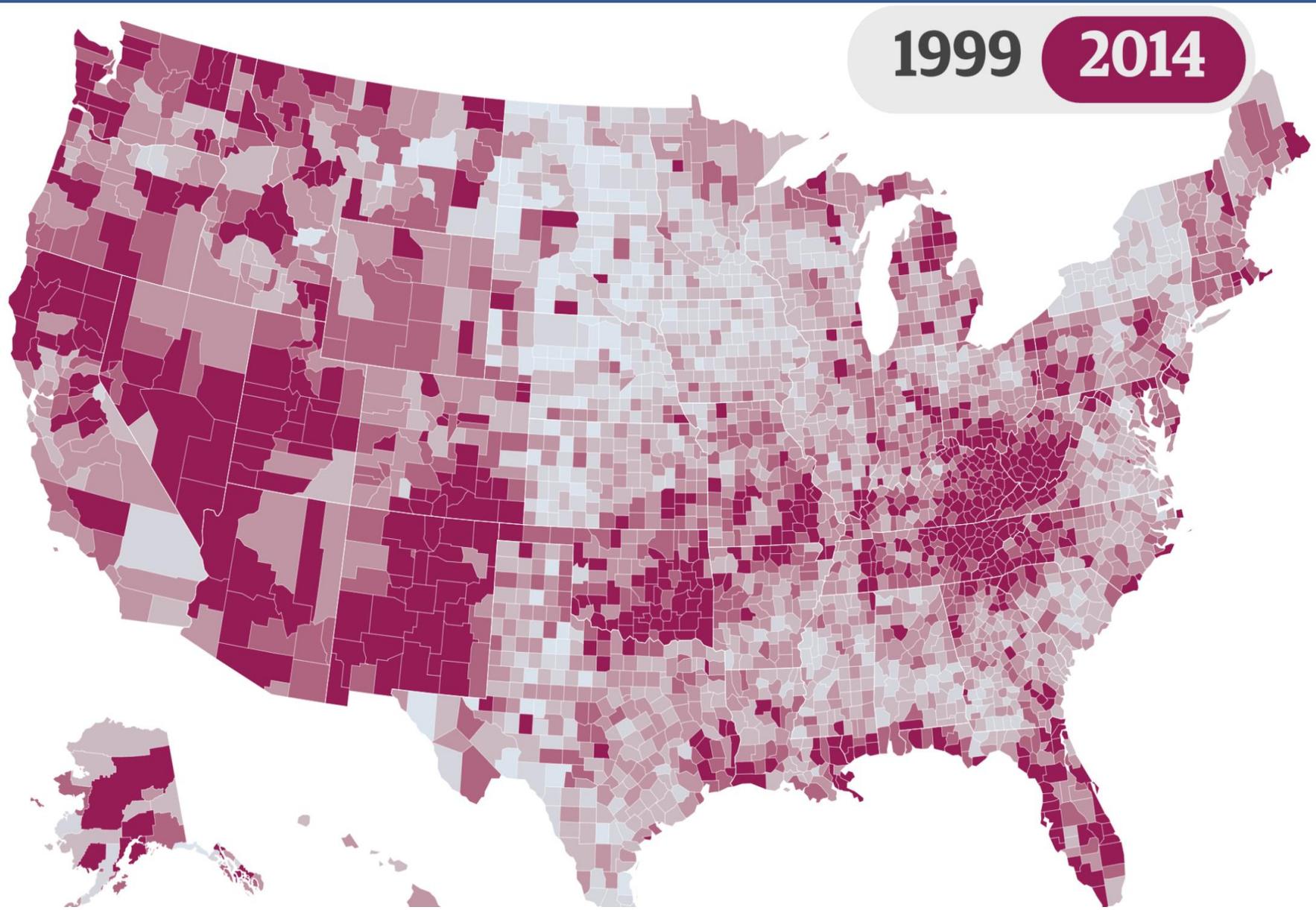


1999

2014

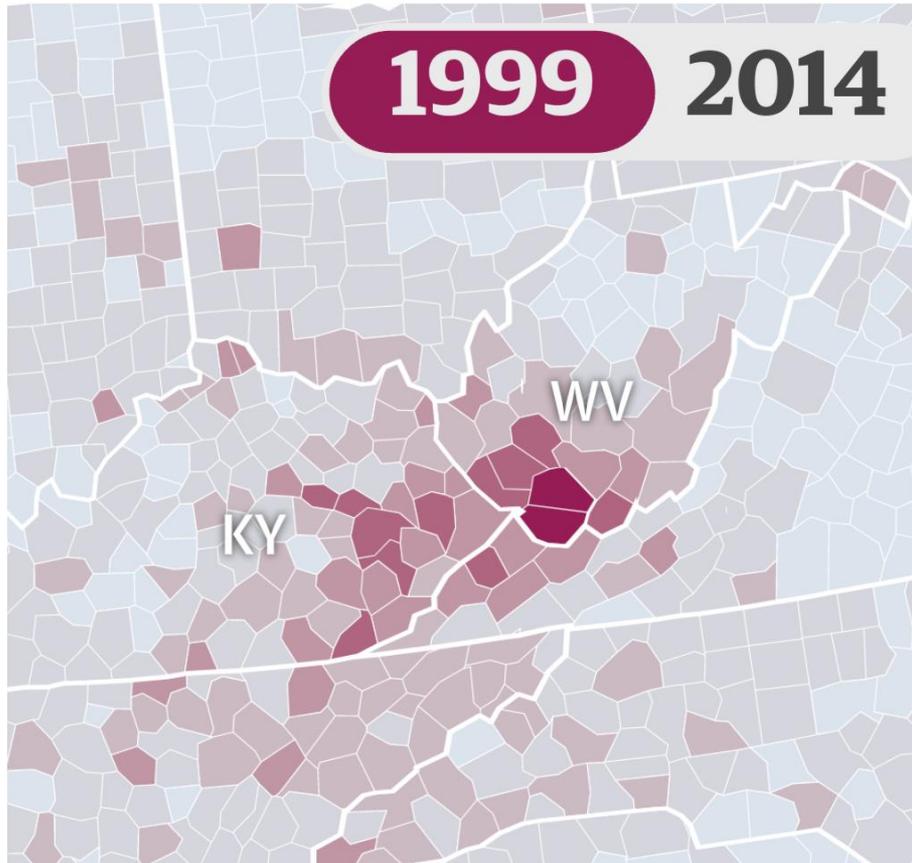


Deaths per 100,000 residents



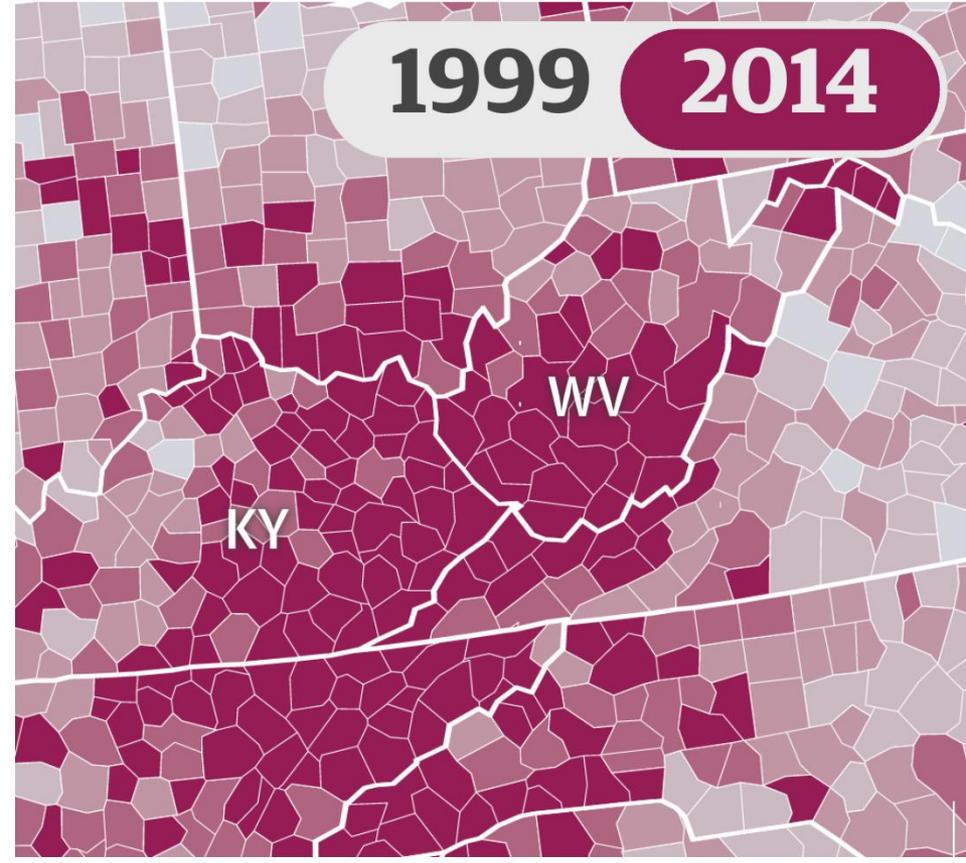
Deaths per 100,000 residents

Central Appalachia



Deaths per 100,000 residents - by state

Central Appalachia



Deaths per 100,000 residents - by state

“Follow the pills and you will find overdose deaths...” Charleston Gazette

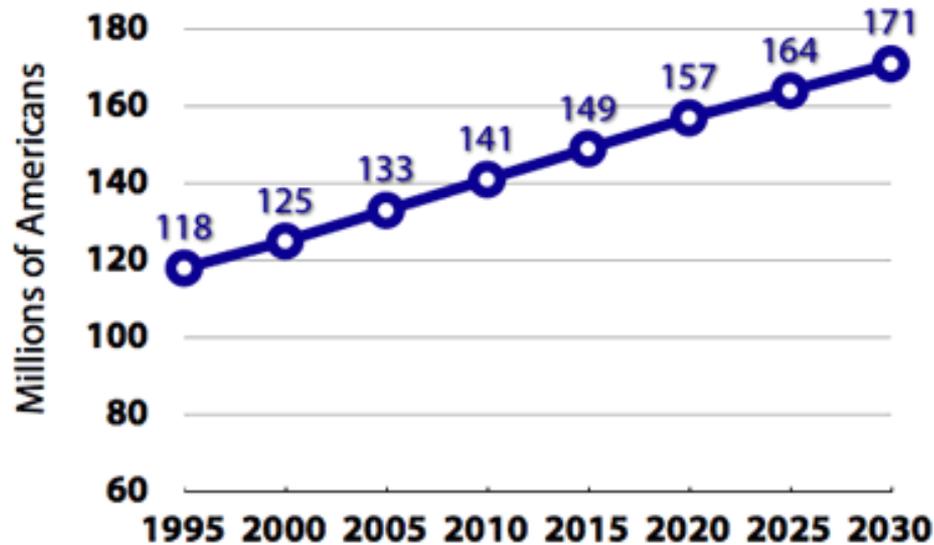
- *“The trail of painkillers in West Virginia leads to southern coalfields, to places like Kermit, population 392. There, out-of-state drug companies shipped nearly 9 million highly addictive — and potentially lethal — hydrocodone pills over two years to a single pharmacy in the Mingo County town.”*
- Rural and poor, Mingo County has the fourth-highest prescription opioid death rate of any county in the United States.



Chronic Disease Growth Projections



Prevalence of Chronic Disease in the U.S.



Source: Wu, Shin-Yi et al. 2000. Projection of Chronic Illness Prevalence and Cost Inflation. RAND Corporation.

#3 Hospital Closure Crisis

Rural Hospital Closures: 2005 – 2016

Press play or drag the timeline handle to see the locations of rural hospital closures over the last decade. The size of the bubble represents the number of hospital beds.

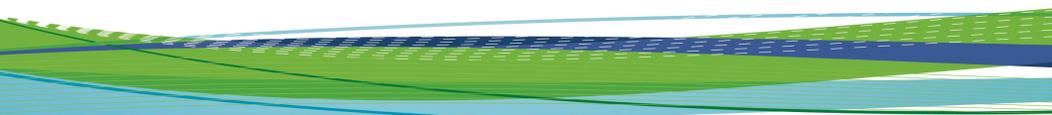
Total for [ANY 2005 -

MAY 2006



***“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



So are the politicians listening?

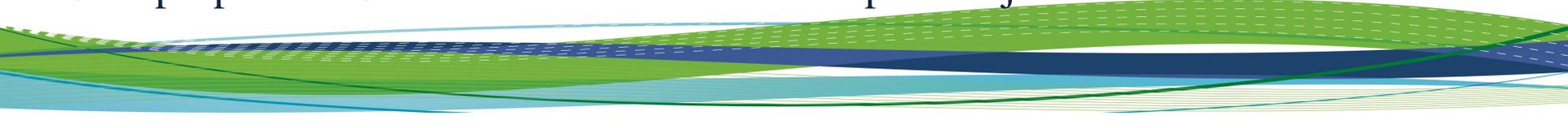


CMS Rural Council and White House Rural Task Force

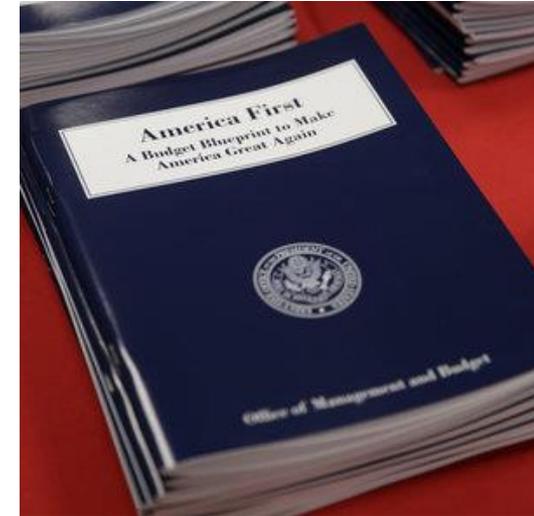


- CMS Rural Council continues into the Trump Administration as an Intra-agency council stood up by CMS Administrator Andy Slavitt, February, 2016
- Cara James, CMS Office Minority Affairs and John Hammarlund, CMS Seattle Region Administrator are Co-Chairs
- Designed to be an internal working group to 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

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.
 7. Implement the National Quality Forum (NQF) Rural Metrics Report Recommendations.
 8. Adjust rural readmission measures to reflect differences in sociodemographic factors.
 9. Suspend hospital star ratings.
 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
- 

President's FY 18 Budget— Catastrophic to Rural Health Safety Net



- Elimination Rural Hospital Flex Grants;
- Drastic cuts in Rural Hospital Outreach Grants;
- Elimination of State Offices of Rural Health;
- Drastic cuts in Rural Telehealth funding;
- Drastic cuts in Rural Health Policy Development;
- Devastating \$1.4 trillion in cuts to Medicaid over 10 years;
- Drastic cuts in mental health funding; and
- *Drastic cuts to core public health programs that focus on disease surveillance, health research, emergency preparedness, and chronic disease prevention.*

dys·func·tion *noun* \(\,dis-'fən(k)-shən\

: the condition of having poor and unhealthy behaviors and attitudes within a group of people



Congressional Spending Bill



Positives:

- Rural Hospital Flexibility Grant Program receives an additional \$2 million; directs HRSA to preference grant awards to CAHs serving communities with high poverty, unemployment and substance abuse.
- The bill also provides additional funding for telehealth and the State Offices of Rural Health.
- The Rural Health Outreach programs are funded at \$65.5 million.
- Opioid abuse funding - of \$181 million -- CARA authorizes federal grants to state and local governments from DOJ and HHS to test new approaches to preventing and treating opioid addiction.
- Conrad 30 reauthorization

However:

“Lawmakers found themselves in the awkward position of having to formally appropriate money for fiscal 2017 that was mostly already spent, since the bill came seven months late. Only five months remain before fiscal 2018 begins on Oct. 1.”

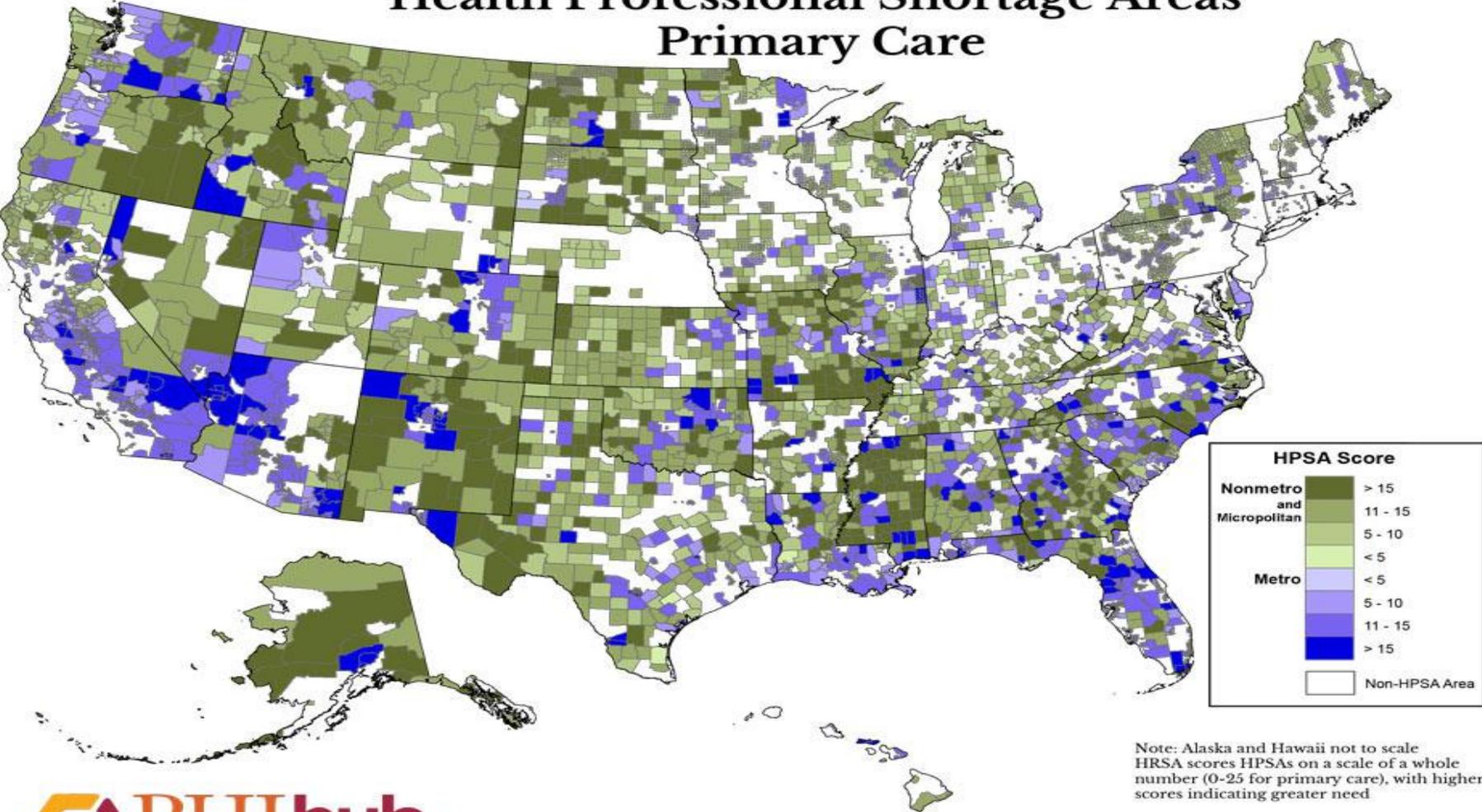
And, does nothing to stop this...



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)

Or this...

Health Professional Shortage Areas Primary Care



Note: Alaska and Hawaii not to scale
HPSA scores on a scale of a whole number (0-25 for primary care), with higher scores indicating greater need

Source(s): HRSA Data Warehouse, U.S. Department of Health and Human Services, November 2016



- 6,000 areas in the U.S. are primary care health shortage areas;
- 4,300 areas are dental health shortage areas; and
- 3,500 areas are short of mental health shortage areas.

And What Have Republicans Done?

- American Health Care Act - passes House 217-213
- NRHA in strong opposition - - Did nothing to:
 - Stop closure crisis
 - Improve broken market system
 - Improve Medicaid



Big Takeaways...



March CBO Report concluded that over 10 years, 24 million fewer people would be covered under the bill who otherwise would have had insurance under current law. Still unknown how modifications made by House Republicans will impact a new CBO score.



Insurance

- Employer Mandate is effectively eliminated - (penalty goes to zero).
- Individual Mandate is effectively eliminated – (penalty is eliminated).
- No longer required to buy insurance through the ACA marketplaces - - can use federal tax credits to buy coverage anywhere.
- In place of that mandate, people are encouraged to maintain coverage; Insurance companies can't deny coverage or charge more for pre-existing conditions (some exceptions) ***as long as their insurance doesn't lapse.***
- If coverage is interrupted for more than 63 days, however, insurers can charge people a 30 percent penalty over their premium for one year.



Subsidies eliminated

- ACA subsidies are eliminated.
- Income-based tax credits are replaced with age-based tax credits. (ranging from \$2,000 a year for people in their 20s to \$4,000 a year for those older than 60).
- Depending on age and where you live - - some people will see their costs go up while others would pay less.
- How does rural fair? Kaiser's interactive map The map shows that a 27-year-old who makes \$30,000 a year would see costs rise about \$2,000 in Nebraska but fall by about the same amount in Washington state. A 60-year-old, however, would see costs rise almost everywhere, with increases of almost \$20,000 a year in Nebraska.
- *Both Kaiser and the Congressional Budget Office found that, on average, older people with lower incomes would be worse off under the Republican plan than under the Affordable Care Act.*

Does Republican plan help?

ACHA replacement for Obamacare offers lost subsidy, higher health costs for rural and older lowans



Loss from reduction in credit: 60-year old rural Iowa couple

Loss from reduction in credit: overall Iowa average

Average gain from tax cut for top 1% of lowans





Tax Cuts

- The bill eliminates nearly all the taxes that were included in the ACA to pay for the subsidies that help people buy insurance.
- Cuts add up to \$592 billion, include:
 - tax on incomes over \$200,000 (or \$250,000 for a married couple);
 - tax on health insurers and a limit on how much insurance companies can deduct for executive pay; and
 - tax on medical-device manufacturers.



BIG CHANGES IN MEDICAID

- No longer open-ended entitlement program. Now a grant program based on per capita caps.
- Rolls rolls back expansion starting in 2019 by cutting the federal reimbursement to states for anyone who leaves the Medicaid program.
(People often cycle in and out of the program as their income fluctuates, so the result would likely be an ever-dwindling number of people covered.)
- The federal government would give states either a set amount of money for each Medicaid enrollee or let them choose to receive a fixed-dollar block grant.



State Waivers

- Optional, state-level full repeal of Obamacare. It would give states the ability, through a waiver, to opt out of most of the regulations and consumer protections that were included in the Affordable Care Act.
- States could apply for waivers that would allow insurance companies in their states to do three things:
 - Charge older people more than five times what they charge young people for the same policy;
 - Eliminate Health Benefits required coverage, including maternity care, mental health and prescription drugs, that were required under the Affordable Care Act; and
 - Charge more for or deny coverage to people who have pre-existing health conditions.
- **High Risk Pools**: States with a waiver must create some other way to ensure that people with expensive illnesses are able to get health care, and the law provides up to \$138 billion over 10 years for such programs, typically called high-risk pools.
- **High-Risk Puddle?** An analysis last week concludes that that amount would be inadequate for providing full health coverage for the number of people who now buy insurance in the individual market and have medical problems.

Updated CBO Score of AHCA v. 2

- 23 Million people will lose health insurance from those currently covered over 10 years
 - Reduce the deficit by \$119 Billion over ten years
 - AHCA V1 scored 24M people losing insurance and save \$337B
 - So, through losing \$218B in deficit reduction, only 1 Million fewer people will lose their insurance between V1 and V2.
 - Largest savings come from cutting Medicaid (\$800B) and reducing tax credits for middle-income insurance buyers
 - Most expensive provision: elimination of \$600B in taxes imposed under ACA
 - Cost of insurance could rise more than 9-fold for older people with lower incomes
 - Premiums could go down through flexibility to offer “skinnier” plans with possible higher coinsurances and deductibles
- 

NRHA to Congress: Vote NO on the American Health Care Act



- ***Less health coverage:*** According to the Congressional Budget Office, about 2.9 million rural Americans would lose their coverage by 2020.
- ***More hospital closures.*** The AHCA also fails to restore hundreds of billions of dollars in reductions to Medicare's hospital payments under Obamacare that offset the cost of increased coverage. Since the AHCA would also eliminate coverage for 24 million Americans by 2026, hospitals would be stuck dealing with the Medicare cuts along with the loss of revenue from people with coverage.
- ***Unaffordable premiums for older, rural Americans.*** Could charge older Americans who buy their own coverage up to 5 times the cost for younger individuals.
- ***Worsens rural economy.*** The combination of higher insurance premiums and fewer rural hospitals would put rural areas at a disadvantage in attracting jobs to their area. In addition, health care is, by itself, a big part of rural economies.
- ***Less treatment for opioid addiction.*** Loosens requirements for health plans to cover a minimum level of health care costs will make the treatment less accessible; and cuts to Medicaid will have an outsized impact on substance abuse treatment because Medicaid covers 25% of this treatment throughout the country.



Senate Plan

- Gang of 13 writing “secret” plan behind closed doors
- Details are leaking out, for example, phase in over a longer period of time the reductions in Medicaid coverage
- President Trump’s directive: “make it less mean” than the House Bill.
- Rule 14 procedure...could pass with 20 hours of debate

What it didn't do: Fix any for the Affordable Care Act Concerns in Rural America





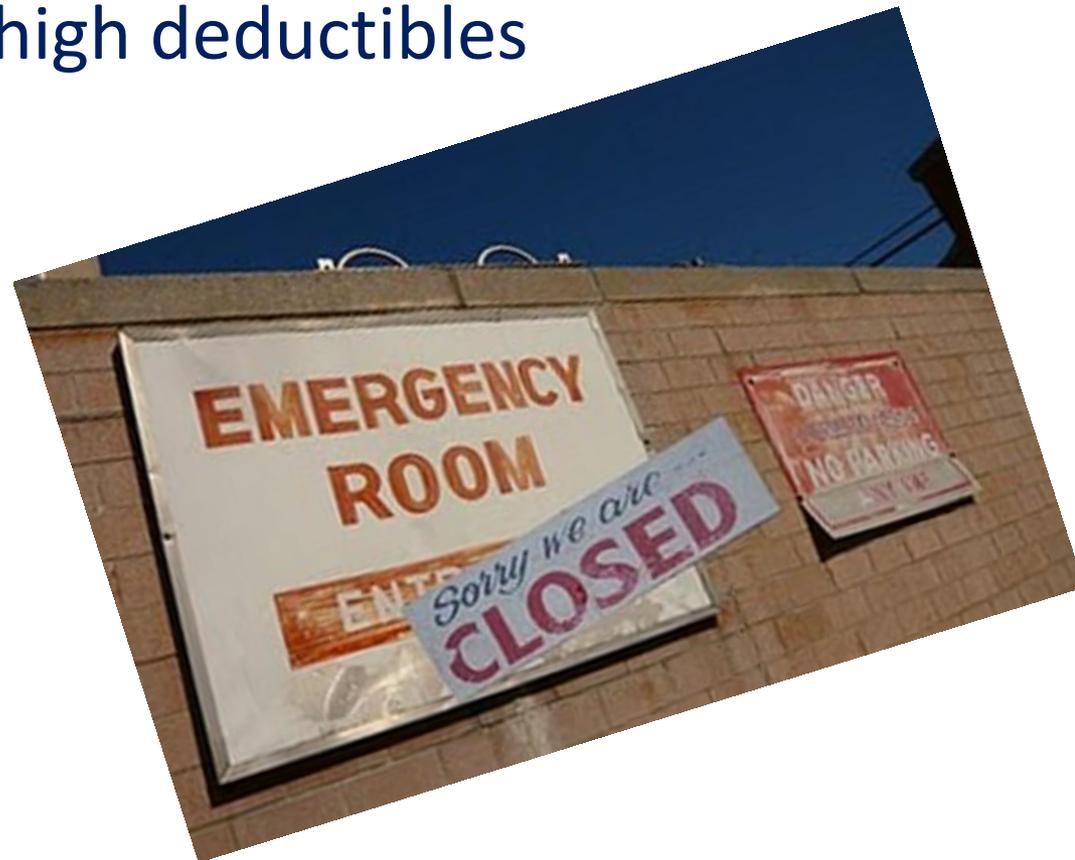
Protect positives of ACA

- **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.



NRHA Solution: Cost – Based Medicaid Reimbursement



PROTECT THE RURAL HEALTH SAFETY NET:

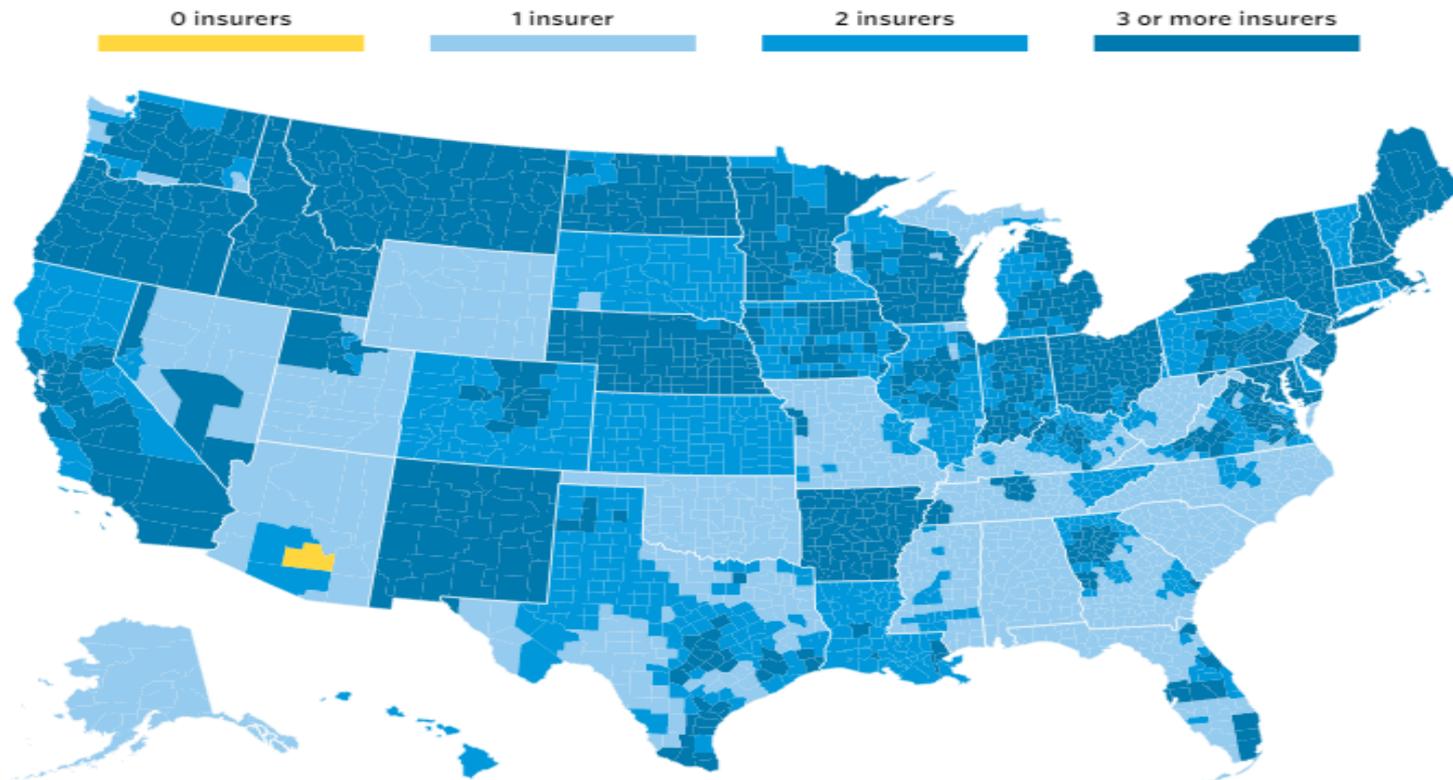
- Twenty-eight states provide Medicaid reimbursement based on cost for either inpatient or outpatient services or both
 - Just over one-half of CAHs are located in states which use a cost-based reimbursement methodology for Medicaid inpatient services
 - Two-thirds of CAHs are located in states which provide cost-based reimbursement for outpatient services
- *Provide state the option of receiving an enhanced FMAP (or per capita cap) to continue to provided cost based reimbursement.*
- *Will encourage other states to follow.*
- *Must include entire rural health care safety net: “Rural safety net providers include, but not limited to, Critical Access Hospitals, Rural Prospective Payment Hospitals, Rural Health Clinics, Indian Health Service providers, and individual rural providers. “*

2017 Market-place penetration

THINNING FIELD

Kaiser August, 2016

“Most of the counties with just one insurer in 2017 would be predominantly rural.”



Note: Net changes represent insurer entries and exits disclosed through Aug. 26, 2016. If exact county footprints were not available, estimates were used.

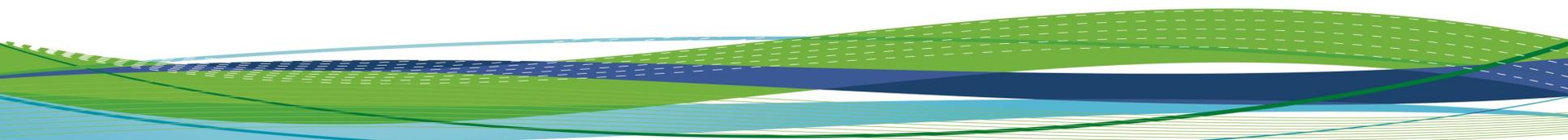
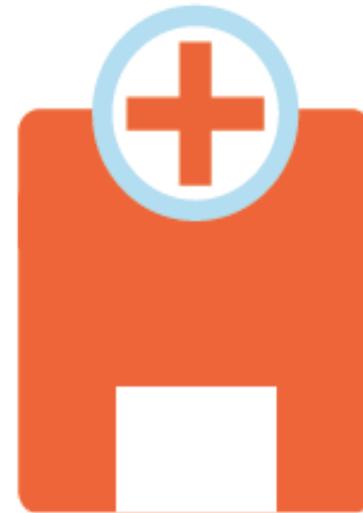
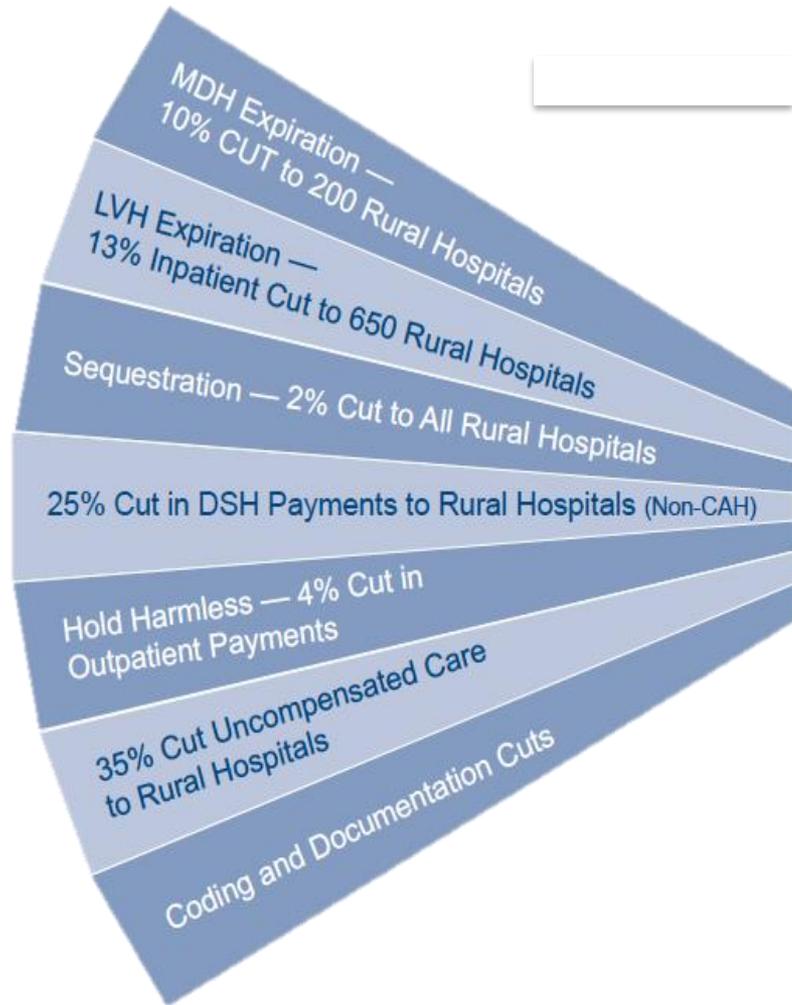
Source: Kaiser Family Foundation

NRHA Solution: Market Reform

- Any federal health reform proposal must address the fact that insurance providers are vacating rural markets.
- Support requirements similar to those passed by Congress in the Community Reinvestment Act.
 - CRA encourages financial institutions to meet the credit needs of underserved communities. To enforce the statute, federal regulatory agencies examine banking compliance, and take this information into consideration when approving new bank branches or mergers and acquisitions.
- Nevada efforts



3. Ending Medicare Cuts...



NRHA Solution

- Stop Bad Debt Cuts
- Reverse sequestration
- Save Rural Hospital Act

#SaveRuralHospitals

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 (See *PARTS Act*);
- Modification to 2-Midnight Rule and RAC audit and appeals process.

Future of rural health care (Bridge to the Future)

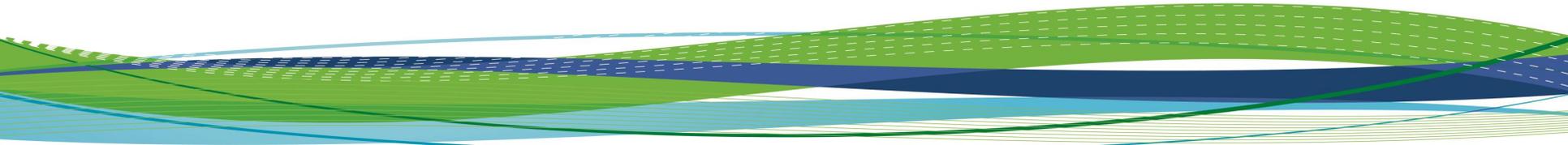
Innovation model for rural hospitals who continue to struggle.

Future Model: Community Outpatient Model

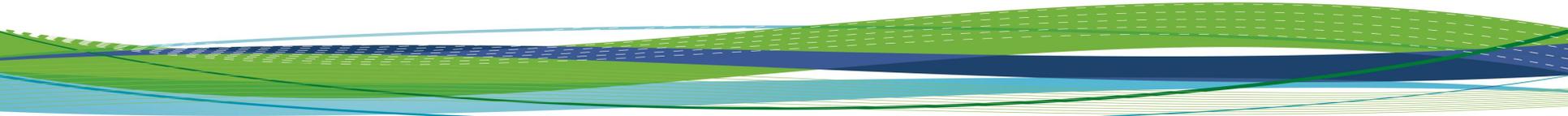
- 24/7 emergency Services
- Flexibility to Meet the Needs of Your Community through Outpatient Care:
 - Meet Needs of Your Community through a Community Needs Assessment:
 - Rural Health Clinic
 - FFQHC look-a-like
 - Swing beds
 - No preclusions to home health, skilled nursing, infusions services observation 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.***



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



- Extending and Expanding J1-Visas. The Conrad State 30 and Physician Access Act S. 898/H.R. 2141 (Expands to 35 slots)
- 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

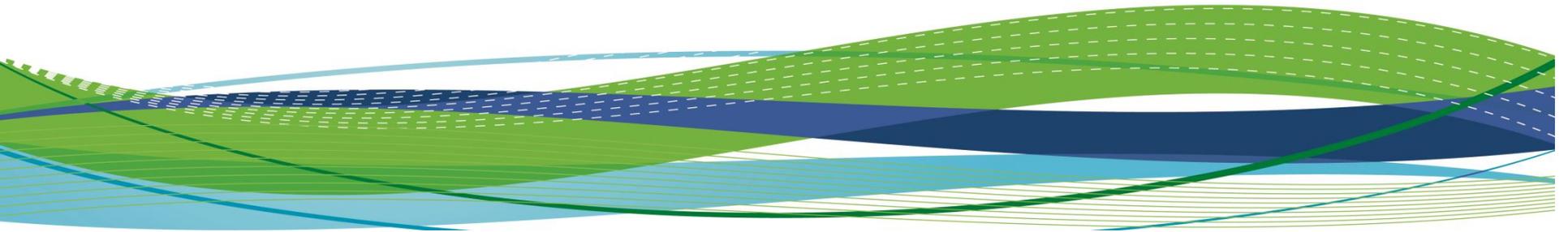
NRHA Policy Concerns/Updates



- 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

United...Our voice is loud

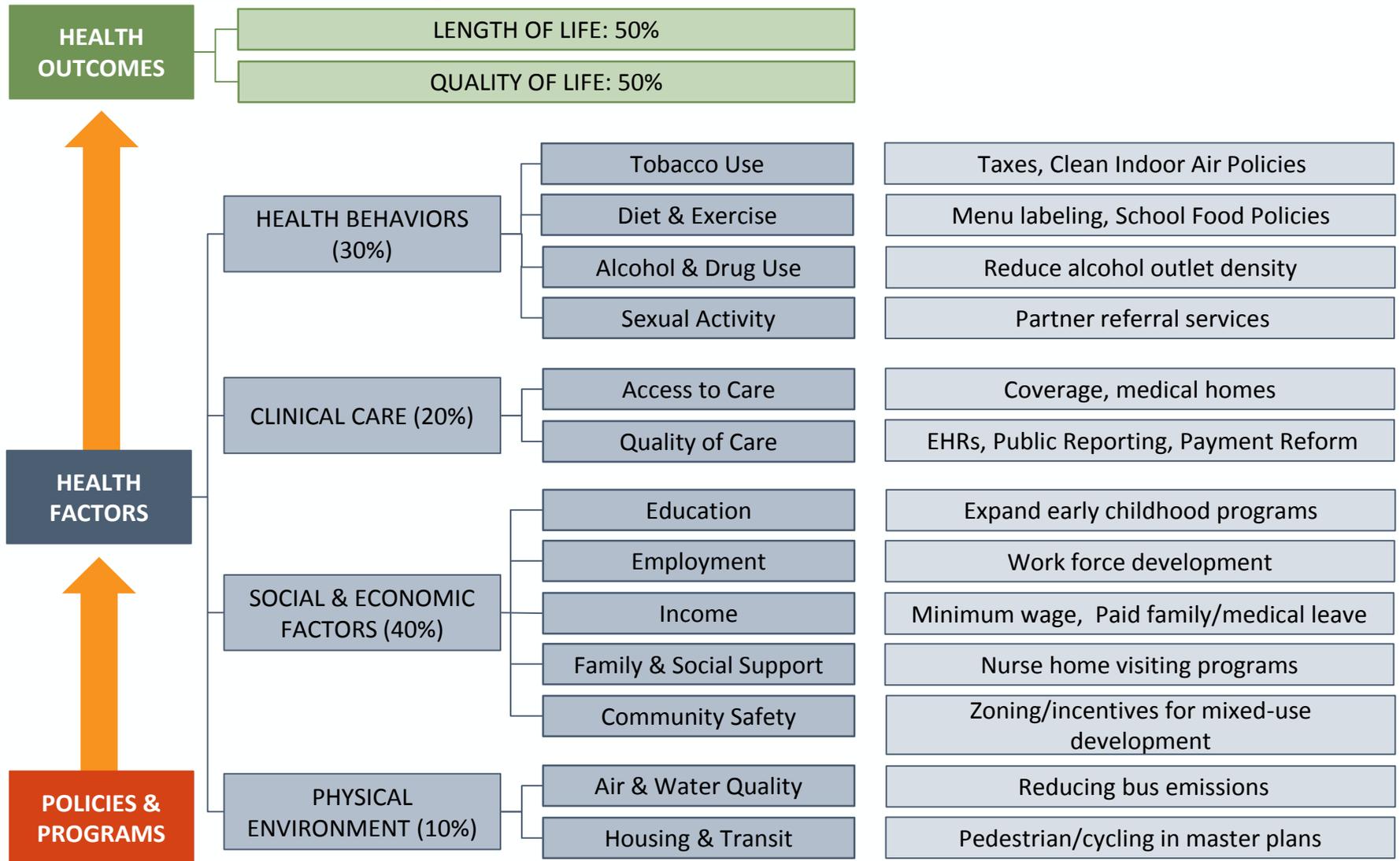
1. Demand flaws of ACA be fixed;
2. Demand hospital closure crisis be fixed;
3. Demand fair funding for rural health safety net;
4. Demand meaningful regulatory relief.



County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program



Four Stages to Population Health



Your voice. Louder.



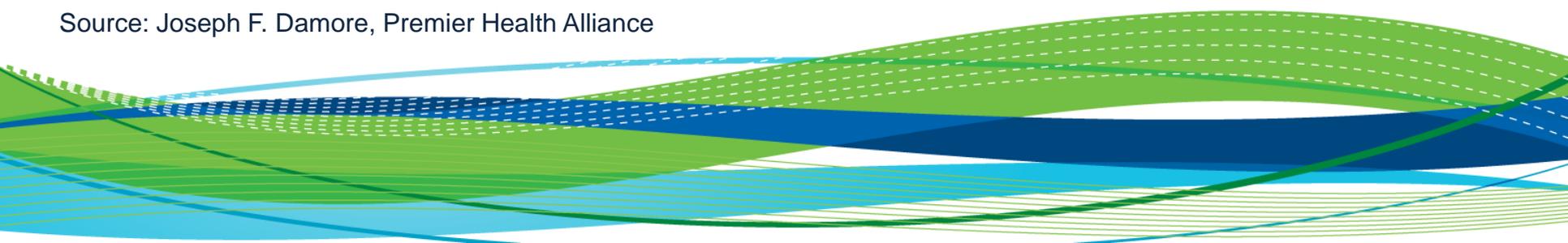
- Education
- Assessment
- Gap Analysis
- Operational Plan

- Primary Care
- PCMH
- Clinical Integration
- Care management network
- Network development
- Health informatics

- Defined population
- Payor partner
- Post-acute

- Employee health plan
- Commercial arrangement
- Medicare
- Medicaid
- Employer contracting
- Uninsured

Source: Joseph F. Damore, Premier Health Alliance

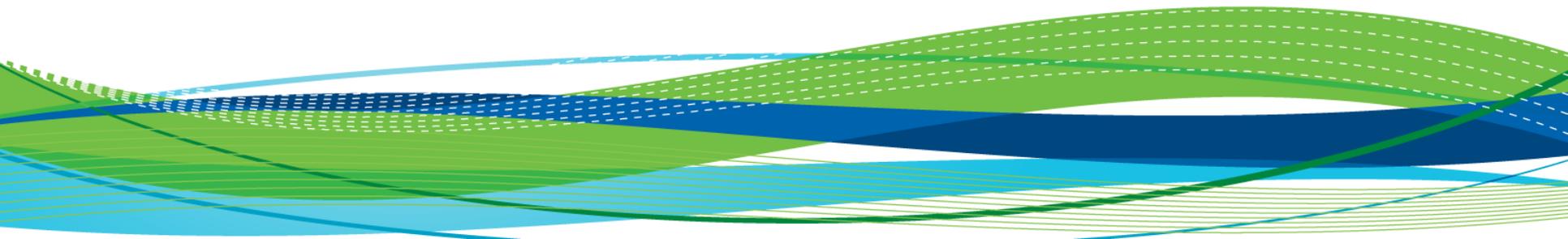


Summary



Your voice. Louder.

- Advocacy: more important than ever
 - Demand that AHCA fixes flaws of ACA and protects vulnerable;
 - Demand hospital closure crisis be fixed;
 - Demand fair funding for rural health safety net;
 - Demand meaningful regulatory relief.
- Rural Can Lead
- Population Health
- 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





Your voice. Louder.

Questions?

THANK YOU

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