November 10, 2016

Alan Morgan
Chief Executive Officer
National Rural Health Association

New Approaches
To Health Care Delivery
Improving the health of millions who call rural America home.
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.
Opening Remarks

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Declining Rural Life Expectancy

‘We don’t know why it came to this’

As white women between 25 and 55 die at spiking rates, a close look at one tragedy

The Rich Live Longer Everywhere. For the Poor, Geography Matters.

Life expectancy of 40-year-olds with household incomes below $35,000, adjusted for race*
Metro/Non Metro Life Expectancy

![Graph showing life expectancy trends for Metro and Non-Metro areas for both males and females from 1969-1971 to 2005-2009.](image-url)
Findings from 2016 RWJ County Health Rankings

Years lost increased in 1 of every 5 rural counties
A Rural Divide in American Death

• Mortality is tied to income and geography.

• Minorities, especially Native Americans die consistently prematurely nationwide, but more pronounced in rural.

• New study shows startling increase in mortality of white, rural women.
  – For every 100,000 women in their late 40s, 228 died at the turn of this century. Today, 296 are dying.

• Since 1990 death rates for rural white women have risen by nearly 50%

• Causes:
  – Risky lifestyle (smoking, alcohol abuse, opioid abuse, obesity)
  – Environmental cancer clusters
  – Suicides

• In major cities life expectancies continue to expand.
Rural Communities
Disproportionately Impacted

- Drug-related deaths 45% higher in rural
- Rural communities have a history of substance abuse
- Rural residents are most likely to be prescribed opioid painkillers

- Rural has greater prevalence of risk factors and fewer options for treatment.
Suicide Rates: Metro/Non-Metro

NOTES: Rates are age adjusted. See Technical Notes for description of age-adjustment method and urbanization levels. See Data Table 19 for data points graphed.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.
Rural Behavioral Health

- 65% of non-metro counties have no psychiatrists (80% of remote counties)

- 65% of non-metro counties have no psychologists (61% of remote counties)

- Non-metro counties with these providers have about 50% fewer per 10,000 population than metro counties
Nineteen closed in 2015:
Already 15 closed in 2016
Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. "AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/2016. LA's Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as "adoption under discussion."

Where are the uninsured today?

Is ACA Working?
U.S. Uninsured Rate is 8.6%
Health Insurers Quit Rural Exchanges

By Anna Wilde Mathews
And Stephanie Armour

Health-insurance customers in a growing number of mostly rural regions will have just one insurer’s plans to choose from on the Affordable Care Act’s exchanges next year, as some companies pull out of unprofitable markets.

The entire states of Alaska and Alabama are expected to have only one insurer on the health law’s signature online marketplaces next year, according to state regulators. The same is expected to be true in parts of several other states, including Kentucky, Tennessee, Mississippi, Arizona and Oklahoma, regulators said. So...
Does an access issue remain?

1. Exchanges
   a. Premium increase
   b. Lack of choice
   c. High deductible

Rural residents tend to be poorer

- On the average, per capita income is $7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. The disparity in incomes is even greater for minorities living in rural areas. Nearly 24% of rural children live in poverty.
CLOSED
“Rural hospitals and the rural economy rise and fall together”

“Three years after a rural hospital community closes, it costs about $1000 in per capita income.”

Mark Holmes, professor, University of North Carolina

- On average, 14% of total employment in rural areas is attributed to the health sector. Natl. Center for Rural Health Works. (RHW)
- The average rural hospital creates 107 jobs and generates $4.8 million in payroll annually. (RHW)
- Health care often represent up to 20 percent of a rural community's employment and income. (RHW)
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
The Path Forward – New Approaches
For immediate release Feb. 2016

New report indicates 1 in 3 rural hospitals at risk

New research indicates that sustained Medicare cuts threaten the financial viability of more than one-third of rural hospitals in America. As rural hospital closures continue to escalate, the…
Rural Hospital Closures on the Rise

The rate of closure is six times higher in 2015 than in 2010

At this rate, 25% of rural hospitals will shut down in less than 10 years.
The unconscionable abandonment of rural America

Jeff Spross

mericans who can barely keep their heads above water
New estimates from the U.S. Census show that after a modest four-year decline, the population in nonmetropolitan counties remained stable from 2014 to 2015 at about 46 million.
Although some rural areas are indeed declining in population, this figure obscures the larger overall trend: **The number of students in rural school districts is steadily growing**, according to data compiled by the National Center for Education Statistics (NCES).
A Diversifying Rural America

Minorities Grow In Many Areas

BY JANET ADAMY
AND PAUL OVBBERG

White Americans no longer count for the majority in hundreds of counties across the U.S., a trend transforming America’s social and political landscape, according to a new analysis by the Pew Research Center.

The analysis, released Thursday, found that in 2015, seven counties in the District of Columbia, 36 others in the U.S. and 90 counties across 38 states and the District of Columbia, non-Hispanic whites made up a majority of the population. Nearly a third of Americans live in these counties.

The analysis found that whites and older Americans are helping to drive the trend, with whites increasing by an average of 1.3 percentage points in each of the 100 counties analyzed.

The analysis also found that in some counties, whites are becoming a majority of the population, while in others, whites are becoming a minority of the population.

The analysis is based on data from the U.S. Census Bureau’s 2016 County Business Patterns and the 2016 American Community Survey.

The analysis is part of a series of reports that examine how the U.S. is changing.
A Diversifying Rural America

America’s Heartland Becomes More Diverse
Rural counties in the Great Plains and Appalachia have become more racially and ethnically diverse in the past 15 years. Southern and coastal areas have higher levels of overall diversity.

Change in diversity from 2000-15, based on percentage change in an indexed measure of racial and ethnic diversity.

Unemployment rates. 12-month average ending in Aug. 2016:
- 0% 1% 2% 3% 4% 5% 6%
- Overall

Annual growth in average wages per worker, 2000-15, adjusted for inflation:
- 0% 0.2% 0.4% 0.6% 0.8% 1.0%
- Overall

Adults without any college education, as a share of the over-25 population, 2014:
- 0% 10% 20% 30% 40% 50%
Delivering Value

Study Area C – Hospital Performance

Who has the edge?

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Rural hospitals match Urban hospitals on performance at a lower price

Data sources include CMS Process of Care, AHRQ PSI Indicators, CMS Outcomes, HCAHPS Inpatient/Patient Experience, MedPAR, HCRIS

Source: Rural Relevance Under Healthcare Reform 2014, Study Area C.
CMS Star Ratings

• July 27\textsuperscript{th} CMS released Overall Hospital Quality Star Ratings

• 20\% of hospitals (937 facilities) do not meet the minimum data requirements to have a star rating calculated.

• The majority (671) of the facilities with no star rating are CAHs.
The Results

Star Rating Results
» One Star 133 (4%)
» Two Star 723 (20 %)
» Three Star 1770 (48%)
» Four Star 934 (25%)
» Five Star 102 (3%)

Of the 540 CAHs that did have a Star Rating calculated, CMS found a higher average Star Rating among CAHs - The range was generally from 2 to 4 stars.
Delivery System Reform (DSR)

January 2015 Announcement

- HHS Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program towards paying providers based on the quality, rather than the quantity of care.

Goals

1. **Alternative Payment Models:**
   1. 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016
   2. 50% by the end of 2018

2. **Linking FFS Payments to Quality/Value:**
   1. 85% of all Medicare fee-for-service payments are tied to quality or value by 2016
   2. 90% by the end of 2018
System Redesign

County Medicare ACO Presence
Continental United States

Counties have an ACO presence if they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of December 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.
UnitedHealth Group recently announced it will launch a national accountable care organization (ACO), called NexusACO, in order to connect more self-funded employers with the resources necessary to participate in value-based care.
Care Management: Target Populations

- 2-3% of Population
- 5-7% of Population
- 20-25% of Population
- 100% of Population

- Disease Management—Virtual/Telephonic
- Wellness/Prevention

- Complex Individual Case Management (40% of costs)
- Complex Disease Management Embedded/Primary Care
Transition to Transformation/
Huge Impact of MACRA

- Sweeping changes to Medicare reimbursement for physicians - moving away from fee-for-service.
- Goal: tie increased reimbursements to merit-based system or APMs.
- Hospitals’ impact: hospitals that employ physicians directly will be impacted. Hospitals may also be called upon to participate in APMs.
Rural Telehealth Challenges: The Big Four -

-Reimbursement
-Licensure
-Clinical Adoption
-Community Acceptance
A slow transition forward

- Radiology and Psychiatry

- Tele-ICU services, and remote support from critical care specialists.

- Direct patient engagement
How to Fix the Rural Workforce Problem

Talley, 1990, “Graduate medical education and rural health care”
- Rural docs come from rural places
- Rural residency training leads to rural practice
- Family medicine is key to rural health
- Residents practice close to where they live

Goodfellow et al. 2016, “Predictors of primary care physician practice location…Systematic review”
- Rural docs come from rural places
- Rural residency training leads to rural practice
- Family medicine is key to rural health
- Residents practice close to where they live
Muddy Creek Family Clinic
200 White Way
785-933-2000
Current Workforce Solutions

AHECs
NHSC
Loan repayment programs
Reimbursement incentives
Rural Residency Programs
Scope of practice flexibility
Emerging Workforce Solutions

• New professions:
  – Community Paramedicine
  – Community Health Workers
  – Patient Navigators
  – Dental Therapists (DHATs)
Future Models for Rural Providers

• Kansas Model
• Grassley Proposal, S 1648
• Save Rural Hospital Act, HB 3225
• MedPAC Proposal
• Global Budgeting
Analysis of Rural Hospitals

Target solutions for three cohorts of rural hospitals:

- At high-risk of closure (n=210)
- Stable with strategically sound fundamentals (n=1,437)
- High-performers or first movers (n=208)
Primary (core) Elements for Rural Design

- Primary Care
- Ambulatory Services
- Emergent Care (EMS/non-emergent transportation/ER)
- Rehabilitative Services
- Behavioral Health
- Transitional Care (observation/swing bed, etc.)
- Pharmacy (community?)
- Oral Health
- Prevention/Wellness
New Provider Type?

- Primary Health Center (PHC):
  - Traditional ambulatory/clinic services
  - Emergency Care (tele-emergency allowed/required)
  - Care Coordination and Disease Management
  - Transitional care (e.g., observation, extended stay) capacity
  - EMS/Non-emergent Medical Transportation may be provided through PHC
Kansas Model

Primary Health Center 1: 24 Hour Model
Primary Health Center 2: 12 Hour Model

Services:
• Traditional ambulatory, clinic services
• Urgent, emergency, transport services
• Local/regional ancillary and other services
• Strong care coordination and disease management
• Niche or regional services – depending on community need (behavioral, social)

Staff:
• RN(s) on site during hours of operation
• Physician, APRN, PA on call
• Active telemedicine
Rural Emergency Acute Care Hospital (REACH) Act

• S. 1648, Introduced by Sen. Chuck Grassley, June 23, 2015
• Freestanding Emergency Department Model
  • 24/7 ED and Observation
  • No inpatient beds
  • Designated as a Rural Emergency Hospital (REH)
  • 110% of reasonable cost, including telehealth and ambulance
MedPAC Rural Proposals

- MedPAC enters the rural proposal space in January, 2016
- MedPAC proposed two models:
  - Model 1: Freestanding Emergency Department
  - Model 2: Clinic with Ambulance
MedPAC Rural Proposals

Model 1: Freestanding ED

• 24/7 ED

• Reimbursement scheme
  • Fixed grant for standby costs
  • Hospital outpatient PPS (OPPS)

• No inpatient acute care services
• Swing Bed SNF services reimbursed based on PPS rates
• CAH or PPS may elect this reimbursement model
MedPAC Rural Proposals

Model 2: Clinic with Ambulance

- 8 or 12 hour clinic days
- 24/7 ambulance
- Reimbursement scheme
  - Fixed grant for ambulance standby costs and uncompensated care
  - PPS rates for clinic services (example—FQHC rate)
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.
Save Rural Hospital Act:

**Community Outpatient Hospital**

- 24/7 emergency Services
- Observation up to 48 hours
- Community Health Needs Assessment
- Rural Health Clinic or FQHC (or look-a-like)
- Swing beds
- No preclusions to home health, skilled nursing, infusions services or observation care
- Telehealth services included as reasonable costs
- 105% of reasonable costs
- Wrap-around grant for transition into this model

- “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.
Request for Information (RFI) from the Centers for Medicare and Medicaid Services Innovation (CMMI) Center:

- Population Health
- Next Generation Rural Payments: What’s after ACOs?
- Focused on Global Budgeting
- NRHAs APM/DSR SIG Leadership Team submitted response
Global Budgeting

- CMMI published White Paper on Global Budgeting and rural providers
- Maryland All-Payer Model
  - Fixed global budgets based on historical cost trends
- Pennsylvania initiated Global Budgeting demonstration
  - Approximately 8 rural hospitals participating
  - Hope to start January 1, 2018
  - Karen Murphy, Secretary of Health in PA a former CMMI leader
  - Rural providers and SORH so far enthusiastic
  - Featured at 2017 Rural Hospital Innovation Summit, San Diego
- Concerns:
  - Variations in cost due to seasons and epidemics
  - Services covered under budget and for what populations/payers?
CMS Rural Council

- 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
- Desire to lay foundation for next Administration
Rural Oral Health Initiative

Purpose: provide leadership on rural oral health care with the intent to establish oral health care as part of primary care, thereby increasing health care access for all rural Americans.

Year-long initiative in collaboration with the DentaQuest Foundation with a focus on:

- **Policy**: Development of a Special Rural Oral Health Interest Group to provide policy recommendations/analysis that target legislative and regulatory barriers.
- **Communications**: Disseminate rural oral health information and a compendium of best practices via NRHA avenues.
- **Education**: Integrate rural oral health related tracks within NRHA conferences, Rural Community Health Worker Training, and within strategies utilized by State Rural Health Associations.
- **Research**: Advance rural oral health related research and policy.
Rural Veterans Initiative

Purpose: *provide leadership to address access to health care needs of rural veterans.*

- 5 year initiative that began in 2014 with support from the Federal Office of Rural Health Policy

- Annual meetings to assess current issues impacting rural veterans’ care.

- Collaboration on placement of transitioning military personnel into health care positions.

- Dissemination of best practices

- Additional collaboration with the VA Office of Rural Health to highlight rural veterans’ research and communication of models of care
Rural Community Health Worker Network

Brief History:

• Clinton Global Initiative - Commitment to action to train 60 CHWs along the US./Mexico Border
• 8 trainings since 2012
• Trained over 350 CHWs
• Curriculum - Leadership, Cancer survivorship, Diabetes & Eye care, Obesity, Nutrition, HPV, and ACA enrollment
• Verizon Global Corporate Citizenship Partnership
  • To demonstrate how the use of handheld technology and access to education and CHWs can improve Type 2 Diabetes disease management and outcomes in patients living in rural Murray County, Georgia.
Rural Philanthropy

**Purpose:** provide forum to foster public-private partnerships to enhance continued investment and opportunities in rural health innovation.

- Collaboration with the Federal Office of Rural Health Policy and Grantmakers In Health
- Host annual meetings of foundations investing in rural health to focus on current issues and collaborations
- NRHA led foundations meeting during the Annual Conference
- Foundation representation in the Rural Health Fellows Program
Go Rural!

Alan Morgan
Chief Executive Officer
National Rural Health Association