The Evolving Landscape of Rural Health
Preserving Access to Rural Care (PARC) of NMHA

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National Rural Health Association

September 28, 2016
Improving the health of the 62 million who call rural America home.

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

Policy Institute—February 6-9, 2017 • Washington, DC

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

Visit RuralHealthWeb.org for details and discounts.
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
Rural Hospital Closures: 1983-97

Location of Closed Rural Hospital
(N = 315)
We’re not finished yet…

Rural differentiation:

“Our 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
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.
18 have closed in 2015, Already thirteen closed in 2016
Rural Hospital Closures and Risk of Closures

Closures Escalating

76
Since 2010

Map of the United States highlighting the closure of hospitals in rural areas.
RURAL Hospital Closures Escalating

76 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

Rural hospitals closing where health disparities are the greatest.
The Impact of Rural Hospital Closures

The Vulnerability Index™ identifies 673 rural hospitals statistically clustered in the bottom 2 tiers of performance.

The loss of these Hospitals would mean...

- 11.7M Patient Encounters
- 99,000 Healthcare Jobs Lost
- 137,000 Community Jobs Lost
- $277B Loss to GDP (10 years)

Powered by iVantage Health Analytics
Impact of Sequestration

- 7,200 jobs lost in rural hospitals and communities (sustained over 10 years)
- 30 rural hospitals shifting from profitable to unprofitable
- $2.8 billion lost in rural Medicare reimbursement (over 10 years)
- 2% cut
- 0.6% off the bottom line

20% cut
Impact of cuts in Bad Debt Reimbursement

35% cut

$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)

2,000 rural healthcare jobs lost

$1 billion lost in bad debt reimbursement (over 10 years)
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)
Future Models for Rural Providers

• Grassley Proposal, S 1648
• MedPAC Proposal
• Kansas Model
• Save Rural Hospital Act, HB 3225
• Global Budgeting
Rural Emergency Acute Care Hospital (REACH) Act

- 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
    -- Covers ambulance cost from REH to a CAH or PPS Hospital
    -- Not clear on coverage TO a REH
Rural Emergency Acute Care Hospital (REACH) Act

• Comments
  • Telehealth costs only for ED services
  • On-call ED providers cost reimbursed, or Part B?
  • Clinic services
    • RHC considered provider-based with no UPL?
  • Ambulance costs TO the REH
  • Ability to attract/retain providers
  • Targeted specifically to “at-risk” facilities
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 1: Freestanding ED Concerns

- Grant size adequate?
  - ED call alone can exceed $1M
  - Ancillary availability/costs
- Facilities with new physical plants would be harmed
- Clinic services reimbursed
  - RHCs at cost or FFS? UPL?
- Swing Bed services using MDS and RUG (not cost-based)
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)
MedPAC Rural Proposals

Model 2: Clinic with Ambulance Concerns

• Grant size adequate to cover standby and fixed costs?
  • Ambulance costs can be significant compared to fee schedule
• Access to ancillary services and reimbursement?
• Access to care after clinic hours? Strong network arrangement?
• Newer facilities and high debt load would not fare well
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
• Transitional care (24 hour model only)
• 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
Paper Test: Clinical Findings

946 Cases Reviewed

70% ER

Patient Age - All Cases

Patient Transportation (All Sites)

70-75% of patients could be served in Primary Health Center – more?
Kansas Model (recent findings)

Paper Test Findings:

- PHC Base Costs
  - 12 Hour: $4.7m
  - 24 Hour: $6.1m
- Includes
  - Primary Care ($1.1m – 8 FTEs all staff)
  - EMS/Transportation ($550,000 – 6 FTEs all staff)
  - Telehealth/Telemedicine ($100,000 – no staff)
  - Care Management ($150,000 – 2 FTEs)
  - Capital/Debt Service ($500,000)
Save Rural Hospitals Act, HR 3225

**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)*;

**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.
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
• CMS Rural Health Solutions Summit, October 19, 2016 from 9:00 to 4:00, Baltimore, MD in CMS Grand Auditorium. Open invitation to attend
• Today’s listening session with CMS Dallas Office Administrator an advanced session designed to inform the national agenda
• Desire to lay foundation for next Administration
Sen. Franken Bills

- **Connecting Rural Americans to Care Act of 2016**: Focus: the lack of transportation options and the need for more health information technology infrastructure.

- **Strengthening Our Rural Health Workforce Act of 2016**: reforms to strengthen our rural health workforce, including efforts to assess our health care workforce needs, expand the number of primary care providers, support emerging professions, and grow the mental health workforce in rural areas.

- **Rural Health Care Quality Improvement Act of 2016**: calls for a core set of measures that are tailored to rural health care delivery – focus is care quality
Where do we go from here?
Issue to be addressed by new Congress

• Changes in ACA
  – Premiums
  – Provider payments
  – Lack of insurance competition

• Chronic Disease
• Opioid Abuse
• Hospital Closure Crisis
NRHA Strategy in January

• Engage with Transition Team to update on NRHA priorities
• Analyze unfolding healthcare agenda and inform members
• Meet appointees to cabinet level positions and engage on rural health priorities, particularly HHS: CMS and HRSA
• Work with Congress on NRHA priorities
• Attend NRHA Policy Institute February 4-6, 2017 to hear from new Executive branch appointees and Congressional leaders
Regulatory Environment: Due by December 31, 2016

- Part B Drug Payment Model Final Rule
- Outpatient Final Rule
- Physician Final Rule
- Home Health Final Rule
- MACRA Final Rule
- Cardiac Bundling Final Rule
- Emergency Preparedness CoP Final Rule
- Discharge Planning CoP Final Rule
- Medicare Appeals Final Rule
- 340B Mega-Guidance Final Rule
NRHA Policy Concerns/Updates

- MACRA Physician Payment
- Physician Fee Schedule Rule (2017)
- Rural Health Clinics
- Emergency Preparedness Requirements
- CMS Certification of Necessary Providers
- Exclusive Use/Co-location of Visiting Specialists
- Star Ratings
- 340B Drug Discount Pricing Program
- CJR/Cardiac Bundled Payments of Care
- Rural Health Clinic Qualified Visits
- Reducing Rx Drug Prices and Implementing CARA (Opioid Crisis)
- Comprehensive Primary Care +
- Insurance Marketplace Stability
2017 Physician Fee Schedule Rule

Telehealth coverage expansion:
• End-stage renal disease
• Advanced care planning
• Critical care consultations
• Point of Service Code

Changes to Chronic Care Management (CCM) physician supervision requirements: direct to general supervision
Rural Health Clinics (RHC)

- HCPCS Codes on RHC Claims April 1, 2016
- Revenue Opportunities:
  - Annual Wellness Visits
  - Chronic Care Management
  - Annual Depression Screening (Patient Health Questionnaire PHQ-9)
- Physician salary limitations in RHCs
- Essential Community Provider Petition (ECP) due Oct. 15
- Transforming Clinical Practice Initiative (TCPI)
Conditions of Participation: CAH and Hospital

Released July 11, 2016 requires:

• Antibiotic stewardship
• Infection control and prevention
• Hospital Medical Records content changes
• Dieticians/nutrition professionals to order patient diets
• Explicit and expanded prohibitions against discrimination
CMS Star Rating Program

- CMS released Star Rating Program July 27, 2016. Click [here](#) for link to see your hospital’s Star Rating.

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>Number of hospitals (percent of hospitals rated)</th>
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<tbody>
<tr>
<td>One Star</td>
<td>133 (4%)</td>
</tr>
<tr>
<td>Two Star</td>
<td>723 (20%)</td>
</tr>
<tr>
<td>Three Star</td>
<td>1,771 (48%)</td>
</tr>
<tr>
<td>Four Star</td>
<td>934 (25%)</td>
</tr>
<tr>
<td>Five Star</td>
<td>102 (3%)</td>
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Total Hospitals in *Hospital Compare* Data Set July, 2016: 4,599
Met Reporting Threshold: 3,658 (80%)
Did not meet reporting threshold: 941 (20%) *

*These are too few measures or measure groups to calculate a Star Rating or measure group score.*
## CMS Star Rating System

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Process of Care Measures</th>
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<tbody>
<tr>
<td>• Mortality (N=7, 22% weight)</td>
<td>• Effectiveness of Care (N= 18, 4% weight)</td>
</tr>
<tr>
<td>• Safety of Care (N=8, 22% weight)</td>
<td>• Timeliness of Care (N=7 , 4% weight)</td>
</tr>
<tr>
<td>• Readmissions (N=8, 22% weight)</td>
<td>• Patient Experience (N=11, 22% weight)</td>
</tr>
<tr>
<td></td>
<td>• Efficient Use of Medical Imaging (N=5, 4% weight)</td>
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To meet the minimum threshold to have a star rating calculated hospitals must have at least three measures, in at least three groups, with at least one outcome group.
Star Rating Reports

Star Rating Hospital Specific Report (HSR)
“The idea that dying and being readmitted to the hospital are equally important to patients seems funny to me,”

Ashish Jha, M.D.
Harvard Medical School
CCJR Program and Swing Beds

Comprehensive Care for Joint Replacement Program:
• Bundled payment demonstration
• Swing Bed (SB) costs included in bundle at per diem rates (cost)
• SB costs are demonstrably higher than SNF rates
• Referral patterns shifting away from SBs
• No Nursing Home Compare Star Rating in SBs
• 72 hour PAC qualifying stay waived for participating CCJR facilities as long as referred to a SNF with 3 Star Rating or above
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.
Opioid Abuse Legislation/Rural Victories

S. 524 -- Comprehensive Addiction and Recovery Act (CARA), passed and signed by President

- Rural findings
- Federal Office of Rural Health Policy
- Ensure grants go to rural communities

Summary:

- Launch a medication assisted treatment (MAT) and intervention demonstration program. Expand MAT authority to APRNs and PAs.
- Expand prevention and educational efforts—particularly aimed at teens, parents and other caretakers, and aging populations—to prevent the abuse of opioids and heroin and to promote treatment and recovery.
- Expand the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives.
- Expand resources to identify and treat incarcerated individuals suffering from addiction disorders promptly by collaborating with criminal justice stakeholders and by providing evidence-based treatment.
- Expand disposal sites for unwanted prescription medications to keep them out of the hands of our children and adolescents.
- Launch an evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country.
- Strengthen prescription drug monitoring programs to help states monitor and track prescription drug diversion and to help at-risk individuals access services.
MACRA of 2015: Quality Payment Program

Overview

• Repeals the SGR flawed payment.
• Creates a new framework for Medicare providers based on quality. Establishes two tracks for payment:
  o Merit-based Incentive Payment System (MIPS), and
  o Alternative Payment Models (APMs)
• Consolidates three existing quality reporting programs, plus adds a new program, into a single system through MIPS:
  o Physician Quality Reporting System (PQRS)
  o Value-based Payment Modifier (VBPM)
  o Meaningful use (MU)
  o Clinical practice improvement activities (CPIA)
• Proposed MACRA regulation – impact on small practice addressed
• RHC and FQHCs are exempted
  o Except Method II CAH billing
  o Except Professional Part B billings from RHC or FQHC (i.e., physician rounding on inpatients)
• CMS Administrator Andy Slavitt announces “pick your pace” program
MACRA Pick your Pace Plan

Overview:

- Allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017.
- Physicians would choose one of 3 options which would ensure not receiving a negative payment adjustment in 2019.
- These 3 options will be described fully in the MACRA Final Rule due out later this year.
First option:
Test the QPP

As long as a physician submits some data to the QPP, including data from after January 1, 2017, they will avoid a negative payment adjustment. This first option is designed to ensure that systems are working and that they are prepared for broader participation in 2018 and 2019.
Second option:
Participate for part of the calendar year

A physician may choose to submit QPP information for a reduced number of days. This means their first performance period could begin later than January 1, 2017 and their practice could still qualify for a small positive payment adjustment.
MACRA Pick your Pace Plan

Third Option:
Participate for the full calendar year

For practices that are ready to go on January 1, 2017, they may choose to submit QPP information for a full calendar year.
MACRA Pick your Pace Plan

Fourth Option:
Participate in an Advanced Alternative Payment Model (APM) in 2017

Instead of reporting quality data and other information, the law allows practices to participate in the QPP by joining an APM Model, such as Medicare Shared Savings Track 2 or 3 in 2017 or Patient Centered Medical Homes (PCMH)
How much can MIPS adjust payments?

Starting in 2019, physicians’ reimbursement from Medicare will be increased or cut by a certain percentage based on the quality of care they deliver.

- **2019**: -4%
- **2020**: -5%
- **2021**: -7%
- **2022 and onward**: -9%

Adjustment to provider’s base rate of Medicare Part B payment.

Source: CMS
THANK YOU

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