Oregon Rural Health Conference
2016

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Vice President of Government Affairs
Change is coming... again

• Election 2016 - -
• What can we expect from a new Administration and Congress?
• What will it mean for Oregon rural health care?
We know some change is needed...

- Hospital closures increase.
- Profits plummet for MANY rural hospitals.
- Rural/Urban divide continues to grow.
What impact will these two have?
Or these guys?

- Rural America: Disproportionately dependent on Federal Government.
- Medicare/Medicaid/regulatory impact
And what about Oregon’s delegation
Issues to be addressed by new Congress

Not Election Dependent
• Chronic Disease
• Opioid Abuse
• Hospital Closure Crisis

Election Dependent
• Degree of Changes to ACA
  – Premiums
  – Provider payments
  – Lack of insurance competition
Today

• Affordable Care Act - - What is it doing to/for rural America? What changes will the election bring?

• What can we expect from a Republican Congress? A Democratic Congress?
Issues where we need vigilance
Critical Rural Payments Set to Expire Next Year

- 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
New HPSA Designation Could Have Significant Impact

Overview: HRSA to use new system – Shortage Designation Management System

• Goal - utilize more standardized provider data - - based on NPI (National Provider Identifier)
• HRSA is working on various impact analysis on changes in Shortage Designation.
  – By May 2017, PCOs are to finish submitting provider data.
  – In June 2017, Second impact analysis, including Auto-HPSAs, provided to stakeholders by HRSA.
  – By July 2017, National update of all designations, including Auto-HPSAs.
• HRSA promising to fully review the impact on HPSAs and offer opportunities for stakeholders to review the impact.
• NRHA forming a coalition of stakeholders -- we must be vigilant!
• Much more to come!
CMS Star Rating

• July 27th 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.
  – “Not available” with a note that indicates “there are too few measures or measure groups reported to calculate a star rating or measure group score.”
The Results

- 64 measures used in calculation.

  **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 (mean = 3.31) compared to non-CAHs (mean = 2.99). The range was generally from 2 to 4 stars.

- Legislative response: legislation to delay implementation.

- **NRHA Fight**: Rural relevant measures meaningful in rural settings.
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.
Slavitt message to doctors: “Let’s be flexible!”

*September 8 letter, Slavitt specifically cites “the unique issues facing small and rural non-hospital-based physicians” as one of the reasons for creating flexibility.*

**Offers Four different Options:**

1. **Test the Quality Payment Program.**
   As long as you submit some data you will avoid a negative payment adjustment..

2. **Participate for part of the calendar year.**
   You may choose to submit data for a reduced number of days. Allows you to still qualify for a small positive payment adjustment.

3. **Participate for the full calendar year.**
   For practices that are ready to go on January 1, 2017, -- allows a modest positive payment adjustment.

4. **Participate in an Advanced Alternative Payment Model in 2017.**
   Instead of reporting quality data you can participate in an Advanced APM. Possible to qualify for a 5 percent incentive payment in 2019.
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%

- Distances to access care are vast: 20% of population scattered over 90% of landmass
• 46% of the land area of the United States as frontier, and over 5.6 million people lived in these areas in 2010.
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.
6th Anniversary of the Affordable Care Act

• The good, bad and not so pretty...
Is ACA Working?

September Numbers: Lowest uninsured rates in half a century. Latest numbers - - **U.S. Uninsured Rate is 8.6%**

**Percentage Uninsured in the U.S., by Quarter**

Do you have health insurance coverage? Among adults aged 18 and older

% Uninsured

- **Q1 2008**: 14.6%
- **Q1 2016**: 11.0%

**SOURCE:** GALLUP-HEALTHWAYS WELL-BEING INDEX
Does an access issue remain?

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

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
Unanticipated...

- “Millions are now being covered through the law, but they're older, sicker and more expensive to insure than anyone anticipated. To compensate, health plans are raising premiums, in some cases by a lot—the largest insurer in Texas wants to jack up rates for individual plans by an eye-popping 60 percent next year.”
  - Politico, July 2016

- Most insurers lost money the first year of operations (2014); insurers underestimated medical claims by 5.7%.
Insurance companies drop out, spike rates...

• “Largest Insurer Pulls out of ObamaCare Exchanges”
  • “UnitedHealth Group – No longer participates in a majority of exchanges; limits plans to just a “handful” of states in 2017 and is “evaluating the viability” in the future.” U.S. News and World Report April, 2016

• “Aetna, Coventry Back out of State Exchanges” - - 834,000 will lose coverage from Aetna alone. Blames higher than expected medical claims.
  
  *Atlanta Constitution, July 2016*

• “Another Major Insurer May Leave Obamacare’s Exchanges”
  
  *Health Care News, March 2016*

• “Humana Seeks 50% ObamaCare Premium Hike in Michigan”
  
  *Investors Business Daily, March, 2016*
One insurer...UnitedHealth Group

• Largest health insurer in nation will exit 34 exchanges;
• Expects to lose $650 million this year on its Obamacare business;
• HOWEVER: The individual insurance market is a small piece of UnitedHealth's overall business. The company had profits of $3.2 billion on $46.5 billion in revenues during the second quarter, beating expectations.
ALASKA, ALABAMA, KENTUCKY, ARIZONA AND OKLAHOMA MAY HAVE JUST ONE INSURER IN ACA EXCHANGE.

The Kaiser Family Foundation estimates that one in three counties have only one plane. Rural regions, counties, and states are more likely to have single-insurer markets than metro areas and have faster-growing premiums.

In fact: 70 percent of the counties that insurers have pulled out have populations that are mostly rural.
Co-Op Collapse

• 23 co-ops received significant federal money to offer health care plans in the exchanges.
• Nine. That's how many co-ops are still in business.
Affordable Care Act Health Insurance Co-ops Lose $1.2 billion of $2.4 billion in Federal Funding

[Map of the United States showing states with red and green colors indicating closed and functioning co-ops, respectively.]

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The Oregon Plan and Oregon Exchanges

**Exchanges Struggle**
- Oregon lost two health care providers from the exchanges last year including Health Republic, a failed co-op that went belly up after $20 million in losses.

- Oregon’s BCBS plan reported a loss of $12.7 million in just the first quarter of this year. In fact, there’s only one insurer in Oregon operating in the black.

**Oregon Plan** - Medicaid Waiver and Coordinated Care Organizations
Expansion approved. CCOs show innovation and potential

**DENTAL COVERAGE:** More innovation is needed - must better integrate in primary care.
Oregon gubernatorial debate: urban/rural divide focus
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.”

Medicaid and Rural Impact

• Fewer rural states have expanded Medicaid.
• 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.
• **States with a higher percentage of their rural population living in poverty are less likely to expand.** The majority of rural residents live in a state without plans to expand Medicaid.
• Only three of the 11 states with the largest rural population have expanded their Medicaid programs (IA, KY, MI).
Rural Health Clinics Advocacy

- Rural Health Clinic across rural America face long-standing challenges of inadequate reimbursement rates, workforce shortages and technology challenges.
RHCs - Sequestration cuts continue

- Amount allowed: $79.17
- 80% Medicare Payment of All-inclusive Rate: $63.84
- 2% Sequestration on Medicare share: $1.28
- Net payment from Medicare: $62.56

Net Payment decrease from Medicare is 1.62% of capitated rate.
Reimbursement under new reporting requirement troubling

2015 Physician Fee Schedule Final Rule:

• April 1, RHCs required to report Healthcare Common Procedure Coding System (HCPCs)
• Included RHCs exempt from electronic reporting.
• When it was rolled out -- it was unnecessarily complex and disruptive to RHC billing processes
• MACs were not prepared.
• Significant payment delays - - cause significant harm to RHCs.

• October 1, more billing phases set to begin - - Will CMS be ready?
RURAL HOSPITAL CLOSURES
Closed July 1, 2016. The hospital is the only one in Scott County, Tennessee. The facility sees around 25 to 30 patients in the emergency room each day and 30 outpatients.
Rural Hospital Closures and Risk of Closures

Closures Escalating

76 Since 2010
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.

Of the 673 hospitals identified as vulnerable to closure, 355 are in markets with great health disparities. In other words, many of the hospitals most at risk of closure are located in communities that can least afford to lose access to care.
Rural Hospital Closures: 1983-97

Location of Closed Rural Hospital
(N = 315)
72 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.
Rural Hospital Closures on the Rise

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

*Even if legislative action is taken today, if it takes as long to implement the Community Outpatient Hospital as it took from the implementation of the CAH from a demo to the first certified CAH (10 years), 485 hospitals will be closed.
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)
The Impact of 76 Closures

- 10,000 rural jobs lost.
- 1.2 million rural patients who have lost access to their nearest hospital.
“When rural hospitals close, towns struggle to stay open.”

Marketplace, April 2014
“Rural hospitals and the rural economy rise and fall together”

- On average, 14% of total employment in rural areas is attributed to the health sector. Natl. Center for Rural Health Works. (RHW)

- The average CAH 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)

- Medical deserts form in rural communities where hospitals close.

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

Mark Holmes, professor, University of North Carolina
Policy Consequences Impact Rural Hospitals

69% of Rural Hospitals have a negative OPERATING profit margin.

THE BOTTOM LINE: 35%* of RURAL HOSPITALS OPERATING AT LOSS
Rural Hospitals Losing Money

MedPAC March 2016 report:
Medicare Margins: NEGATIVE 9%
New Study: ACA and the Financial Performance of Rural Hospitals

Health Research Center, July 19, 2016

• “…the ultimate financial impact of the ACA on rural hospital providers is still unknown.”

• “The ACA’s expansion of insurance coverage has affected uncompensated care, unreimbursed cost, and financial performance in rural hospitals.”

• Despite expanded insurance coverage “few (rural hospitals) reported a positive net financial impact as a result of the ACA’s expanded insurance coverage — primarily because respondents felt that bad debt from high-deductible health plans and shortfalls between payments and costs of care in Medicare and Medicaid were growing.”
Impact of Sequestration

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

$2.8 billion

30
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)
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.
New Grants Available to CAHs and Rural PPS Hospitals

• $12 million appropriated annually for Quality Improvement and Compliance Grants.
• $15 million appropriated annually for rural population health needs.
• $2 MILLION EMS GRANT FUNDING — to develop EMS programs to meet community needs, address workforce and funding problems.

• For COHs - $50 million in grant funding.
The Save Rural Hospitals Act – Join NRHA efforts.

• SRHA is not a bill just for rural hospitals that struggle.
• SRHA will mean millions of dollars to your facility.
• SRHA will offer key regulatory relief.

Current Status
• Senate: Not yet introduced.

• We need you grassroots efforts. We need your hospital boards and your community to be involved.
Even MedPAC recognizes that rural hospitals are struggling...

- June 2016 Report “Improving Efficiency and Preserving Emergency Access to Emergency Care in Rural Communities.

- “Average Medicare margins are negative, and under current law they are expected to decline in 2016.”

- When CAHs face a decline in the number of private insurers, they face financial difficulties despite receiving cost-based Medicare reimbursement.

- Medicare may achieve greater efficiency and financial stability at some rural hospital by subsidizing emergency services rather than inpatient care.

- New HRSA report backs up the need for supplemental payments for emergency care.
A Rural Divide in American Death

- Mortality is tied to income and geography.

- Minorities, especially Native Americans die consistently prematurely nation-wide, but more pronounced in rural.

- New study: startling increase in mortality of white, rural women. Causes:
  - Risky lifestyle (smoking, alcohol abuse, opioid abuse, obesity)
  - Environmental cancer clusters
  - Suicides

- Since 1999, 650,000 rural individuals have died prematurely – that’s equivalent to the death toll of the Civil War.

- In major cities life expectancies continue to expand.
Opioid Crisis in Rural American

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.
Last Week: National Opioid Epidemic Week

• Ag Secretary Tom Vilsack yesterday announced $4.7 million to 18 different distance learning and telemedicine projects, intending to expand opioid treatment in rural areas.

• Hundreds of millions in grant dollars in recently passed CARA.
  - NRHA fought for language to prioritize rural areas.

• **Oregon**: More drug overdose deaths involve prescription opioids than any other type of drug.
The Seinfeld Congress

• Congress setting new bar for doing nothing.
• Election year usually means little gets done on Capitol Hill but “Congress seems to be setting a new bar for unproductiveness.”
Some appropriations bill completed but most not; battle over a continuing resolution which will ultimately mean level spending.
## Funding for the Rural Health Safety Net

NRHA FY 2017 Request (dollars in millions)

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*Title VII and VIII Programs of Particular Interest to Fund*

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*Source: National Rural Health Association*
Battle for the Senate

- The current U.S. Senate has 54 Republicans and 45 Democrats (including one independent).
- There are 34 Senate seats up in 2016, of which 24 are held by Republicans. Democrats will need to gain 4 or 5 seats to take control.
Senate Races to Watch

ARIZONA – LEANS R
COLORADO – LIKELY D
FLORIDA – LEANS R
ILLINOIS - LEANS D – (SWITCH) – SEN. KIRK IN TIGHT RACE.
INDIANA – LEANS D (SWITCH) – OPEN SEAT/COATS RETIREMENT
MISSOURI – LEANS R
NEVADA – TOSS UP – OPEN SEAT/REID’S RETIREMENT
NEW HAMPSHIRE – TOSS UP
NORTH CAROLINA – LEANS R
OHIO – LEANS R
PENNSYLVANIA - TOSS UP
WISCONSIN – LEANS D (SWITCH) – SEN. JOHNSON IN TIGHT RACE
But does it *really* matter?

Democrats - Build and expand Affordable Care Act
Republican Overview – “A Better Way”
What we do now!

- Meet with key committees - - Oregon is important!
- Meet with Senate Rural Caucus
- Meet with transition teams of both possible new administrations

- Activate grassroots during Congressional recess!
- Election year to best time to get involved.
THANK YOU!

GO DUCKS!

GO BEAVS!