November 18th, 2016

Alan Morgan
Chief Executive Officer
National Rural Health Association

Rural Health Policy and Telehealth
Improving the health of the 62 million 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.
Declining Rural Life Expectancy

‘We don’t know why it came to this’
As white women between 25 and 55 die at spikes rates, a close look at one tragedy

The Rich Live Longer Everywhere. For the Poor, Geography Matters.
Life expectancy at age 40, by race and income, adjusted for race

Alone on the Range, Seniors Often Lack Access to Health Care

Get your free woman card
Life expectancy declines with rurality

Life expectancy at birth, in years, 2005-2009

Source: Singh, Siapush 2014
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.
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

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

• In major cities life expectancies continue to expand.
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
Behavioral Health – Suicide Rates

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.
“In rural health care, broadband technologies are proving to be cost-saving and opportunity-expanding tools for delivering services...Telemedicine provides virtual access to better staffed and equipped urban health centers, and can reduce costs for rural patients (by reducing driving time or time lost from work) and hospitals (by lessening the need for full-time on-site specialists, for example).

Rural Telehealth Challenges: The Big Four -

- Reimbursement
- Licensure
- Clinical Adoption
- Community Acceptance
Challenges Abound

“Telemedicine infrastructure is lagging on two fronts. First, many rural clinics have Internet access that is still too slow and unreliable. Second, telemedicine is increasingly moving from the clinic into the home, with at-home monitoring and mobile apps. Here, the facts on the ground are even worse: According to the FCC’s 2015 Broadband Progress Report, 55 million Americans still do not have access to broadband speed Internet access, which includes more than half of rural Americans.”

- Wired 2015
Can Rural Overcome Barriers?
The unconscionable abandonment of rural America

Jeff Spross

Americans 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).
Rural is Different

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

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

  - Institute Of Medicine “Quality through Collaboration”
Delivering Value
Study Area C – Hospital Performance

Who has the edge?

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

Rural hospitals match Urban hospitals on performance at a lower price

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.
A slow transition forward

- Radiology and Psychiatry

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

- Direct patient engagement
Relevance of Telehealth Today
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 and Risk of Closures

Closures Escalating

68
Since 2010

[Map showing the risk of hospital closures across the United States, with states in red indicating higher risk areas.]
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.
Research indicates…

• **Most closures in South**
• Annual number of closures increasing
• Most are CAHs and PPS hospitals (vs MDH and SCH)
• Most are in states that have not expanded Medicaid
• Patients in affected communities are probably traveling between 5 and 25 more miles to access inpatient care
• Most hospitals closed because of financial problems
“When rural hospitals close, towns struggle to stay open.”

Marketplace, April 2014
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*
Tele-Pharmacy?
Four hundred ninety rural communities that had one or more retail pharmacy (including independent, chain, or franchise pharmacy) in March 2003 had no retail pharmacy in December 2013.

* A loss of 924 independently owned rural pharmacies in the United States.
Why are Rural Hospitals Closing and Relevance for Telehealth?
Federal Budget Faces Annual Trillion-Dollar Deficits Through 2021

Federal Deficits, in Billions of Nominal Dollars

<table>
<thead>
<tr>
<th>Year</th>
<th>Deficit</th>
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<tbody>
<tr>
<td>2008</td>
<td>$0</td>
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<tr>
<td>2009</td>
<td>$-500</td>
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<td>2010</td>
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<tr>
<td>2013</td>
<td>$-1.48 trillion</td>
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<tr>
<td>2014</td>
<td>$-1.9 trillion</td>
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Sequestration – mandated 2% cuts to Medicare providers extended AGAIN.

• Result:
  * Rural Job losses;
  * Rural revenue lost
  * Rural patient services cut
  * Possible rural hospital closures
Medicare Cuts Enacted

- Sequestration cuts – 2% for nine years
- Bad debt reimbursement cuts
- Documentation & coding cuts
- Readmission cuts
- Multiple therapy procedure cuts
- ESRD reimbursement cuts
- Super rural laboratory extender – expired
- Outpatient hold harmless payments (TOPS) – expired
- 508 reclassifications – expired
Affordable Care Act

1. Rural implications in Medicaid Expansion
2. Rural implications in Federal and State Exchanges
Is ACA Working?
April Gallop Poll: U.S. Uninsured Rate at 11.0%, Lowest in Eight-Year Trend

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

SOURCE: GALLUP-HEALTHWAYS WELL-BEING INDEX
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.
Current Status of State Medicaid Expansion Decisions

NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.
The Path Forward
How NRHA is Fighting Back

Our Campaign:

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

2. **Build bridge to the future.** Promote new provider payment models to create a new rural reality.
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.
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:
   - 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016
   - 50% by the end of 2018

2. Linking FFS Payments to Quality/Value:
   - 85% of all Medicare fee-for-service payments are tied to quality or value by 2016
   - 90% by the end of 2018
# Delivery System Reform (DSR)

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
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<tbody>
<tr>
<td>Payment Taxonomy Framework</td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)</td>
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<tr>
<td>Medicare FFS</td>
<td>• Limited in Medicare fee-for-service</td>
<td>• Hospital value-based purchasing</td>
<td>• Accountable care organizations</td>
<td>• Eligible Pioneer accountable care organizations in years 3-5</td>
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<td></td>
<td>• Majority of Medicare payments now are linked to quality</td>
<td>• Physician Value-Based Modifier</td>
<td>• Medical homes</td>
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<td></td>
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<td>• Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>• Bundled payments</td>
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<td>• Comprehensive primary care initiative</td>
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<td>• Comprehensive ESRD</td>
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<td>• Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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Transformation to Population Health Management

Fad 2010

Trend 2012

Reality 2016
Care Management: Target Populations

- **2-3% of Population**: Complex Individual Case Management (40% of costs)
- **5-7% of Population**: Complex Disease Management Embedded/Primary Care
- **20-25% of Population**: Disease Management—Virtual/Telephonic
- **100% of Population**: Wellness/Prevention

Source: Joseph F. Damore, Premier Health Alliance, March, 2015
2016

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2018

- 50%
- 90%

85%
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
Our Grassroots Effort

- NRHA doesn’t have a PAC
- Website: ruralhealthweb.org
- Depends solely on grassroots advocacy
- Members have access to:
  - Rural Health Blog
    - http://blog.ruralhealthweb.org
- Join NRHA today at ruralhealthweb.org
Go Rural!

Alan Morgan
Chief Executive Officer
National Rural Health Association