Minnesota Rural Health Association
Federal Legislative Update
February 21, 2017
RESULTS: Big Night for the GOP

ELECTION RESULTS

HOUSE: D+7*

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SENATE: D+2

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GOVERNORS: R+2

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Rural America Speaks Loudly...

- “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*

- President-Elect Donald Trump never issued any specific rural policy agenda, yet captured high rural voter turnout:
  - 20% of the nation lives in rural America - - according to exit polls, rural voters made up 17 percent of the electorate.
The Rural Vote

- **MICHIGAN**: Trump won rural and small towns 57% to 38% (better than Mitt Romney in 2012, who won 53-46).
- **PENNSYLVANIA**: Trump “blew Clinton out of the water” among rural and small-town voters, 71-26 percent.
- **WISCONSIN**: Rural communities 63-34 (Compare to Romney who pulled 59%.

**The Daily Yonder**:  
- Clinton’s support among rural voters down 8% from President Obama’s in 2012.
- “Obama's support in rural America eroded between 2008 and 2012, from a high of 41 percent to 38 percent. But Clinton took it to a new low: 29 percent.”
but why?
Agriculture Secretary Vilsack’s final press release laid out 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."
“While cities recover, the rural economy still struggles to shake off Great Recession”

Washington Post

Notes: Local Area Unemployment Statistics (LAUS) estimates cover both wage and salary workers and the self-employed. Metro and nonmetro counties are as identified by the Office of Management and Budget in 2013. New population controls were introduced into the LAUS data following the April 2010 Census, leading to an increase in estimated employment in the second quarter of 2010. The data shown have been corrected to compensate for this change, but caution should be used in comparing levels before and after this date.

Source: USDA-ERS analysis of Bureau of Labor Statistics-LAUS data, seasonally adjusted by ERS.
# 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
“Deaths of Despair”

New California Study (The California Endowment)

• Death rates from stress-related conditions in rural areas up dramatically.

• **Fresno County**: rate of 40-64 year olds death by drug poisoning increased 212%

• **Tulare County**: death rate from viral hepatitis increase 166% and suicides increased by 121%

• **Kern County**: white women are most impacted. Accidental drug overdoses have increased over 250%

“We cannot blame these deaths simply on the opioid epidemic. These are deaths of despair”
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.
#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.
“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
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 Missouri (April 2015).
A Catastrophic Crisis

80 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

At current trajectory, 25% of hospitals will close in less than a decade.

Rural hospitals are closing where health disparities are the greatest.
Rural Hospital Closures and Risk of Closures

Closures Escalating

80
Since 2010

[Map showing rural hospital closures across the United States]
Medicare cuts are causing financial collapse...

36.8% of all rural hospitals have a negative operating margin.

AHA Rural Chartbook, November 2016

According to MedPAC’s March 2016 Report to Congress: “Average Medicare margins are negative and under current law they are expected to decline in 2016.”
In each year from FY11 to FY13, rural hospitals posted a median operating profit margin that was at least 1.66 percentage points lower than that of urban hospitals, and the gap is widening.
The Unending Medicare Cuts...

- MDH Expiration — 10% CUT to 200 Rural Hospitals
- LVH Expiration — 13% Inpatient Cut to 650 Rural Hospitals
- Sequestration — 2% Cut to All Rural Hospitals
- 25% Cut in DSH Payments to Rural Hospitals (Non-CAH)
- Hold Harmless — 4% Cut in Outpatient Payments
- 35% Cut Uncompensated Care to Rural Hospitals
- Coding and Documentation Cuts
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)
Bad Debt Reductions are Crippling Rural Hospitals

June, 2016 report of the Rural Health Research Program:

• Bad debt is growing for rural hospitals due to high-deductible plans and because of shortfalls care in Medicare and Medicaid were growing.

• Rural hospitals Medicare bad debt levels are **almost 50 percent higher than urban hospitals.**
What Rural Hospitals are Saying...

“If someone goes from no insurance to a high-deductible plan, they are effectively uninsured.”

“We are experiencing greater charity care. We are finding charity care not only with those who are uninsured but those with large deductible plans as well. They are going to the exchange, getting a high deductible, and then applying for charity care to cover the balance.”
If Congress does not act, history will be repeated...

Rural Hospital Closures: 1983-97
So what do we do???

The Politically Powerful are Listening
THE IMPORTANCE OF ADVOCACY

• No matter your politics, we must join together and capitalize on this opportunity.
• Washington is reaching out to Rural America.
• Policy Institute - - Record attendance from Capitol Hill!

• **Our Message**: rural healthcare is critical for rural patients and the rural economy:
  • You can’t have a healthy rural economy without a healthy rural community.
  • Quality rural healthcare saves lives, provides skilled jobs, attracts businesses, and reinvests millions back into rural communities.
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 meaning regulatory relief.
Demand for Regulatory Relief

• Common-sense approach needed for “exclusive use” standard.

• Critical Access Hospitals (CAHs) and many Sole Community Hospitals (SCH) should be Eligible for Indirect GME (IME).

• Performance Comparisons Should Occur Between Equivalent Cohorts in MIPS

• Implementation of the Section 603 Site Neutral payment for new off-campus provider based department (PBD) harms rural providers.

• Hospital Star Rating treats Rural Hospitals Unfairly. Rural Relevant Measurements Needed.

• Elimination of the 96 hour Condition of Payment requirement reduces unnecessary red tape in line with the congressional intent in the creation of the CAH.

• Changing the supervision requirements for outpatient therapy services to general supervision from direct supervision protects patient safety and access.

• Improper MAC denial of Low-Volume Hospital Adjustment
Make Affordable Care Act Work 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.
1. Medicaid

- Majority of rural residents live in states that have not expanded Medicaid.

- **States with a higher percentage of their rural population living in poverty are less likely to expand.**

- Two-thirds of the uninsured live in a state that hasn’t expanded Medicaid, HHS June 2016.

- **A Kansas example:** one rural hospital would receive about **$1.6 million** more in one year if the state expanded its Medicaid coverage.
2. Exchanges.
Are they Working in Rural Areas?

- 58.3% of rural counties only had 1 or 2 plan options
- Over ¾ of urban plans had three or more choices of coverage
• Many rural states have just one insurer (Alaska, Alabama, Kentucky, Arizona and Oklahoma).

• Kaiser Family Foundation:
  • 1 in 3 counties have only one plan.
  • Rural regions, counties, and states are more likely to have single-insurer markets than metro areas and have faster-growing premiums.
  • 70% of the counties where insurers pulled out have mostly rural populations.
Co-Op Collapse

• 23 co-ops failed. Only 7 remain.

• “These failures hurt rural America particularly hard because co-ops exist to serve harder to reach populations that aren’t as likely to have employer-based insurance.”
3. Ending Medicare Cuts...

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Critical Rural Medicare 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**
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.
Impact of Graves-Loebsack Save Rural Hospital Act

*Community Outpatient Hospital* status preserves emergency and outpatient care for rural communities. Conversion would financially benefit 97% of eligible hospitals currently operating at a loss.

- **$5.5B** in revenue preserved over 10 years
- **244,000** jobs preserved over 10 years
- **$28.7B** in GDP preserved over 10 years

This model is based upon the following elements of the Community Outpatient Hospital reimbursement structure. Note that this model is not inclusive grant funding.

- 105% of reasonable costs reimbursed
- 100% of bad debt reimbursed
- Exemption from 2% sequestration

Importance of Minnesota

• Senator Franken - lead of Senate Rural Health Caucus

• Opportunity to advance key rural legislation, including rural oral health legislation.
Celebrate the greatness of rural health care

- Minnesota rural health leads the way
- Higher quality
- Higher patient satisfaction
- Cost-effective
- Doing more with less

An October 2016 study from the Office of the Assistant Secretary for Planning and Evaluation at HHS:

- Rural hospitals outperform their urban counterparts on Medicare’s VBP program and in reducing hospital-acquired infection.
- Rural hospitals provide superior care coordination work on the part of rural providers and “can encourage collaboration across care types and settings.”
- “High levels of trust in providers may facilitate better patient experiences or outcomes both in the inpatient and outpatient setting.”
Let’s Fight for Rural Together!
Thank you!