Your voice. Louder.

May 3, 2012

The Rural Health Landscape

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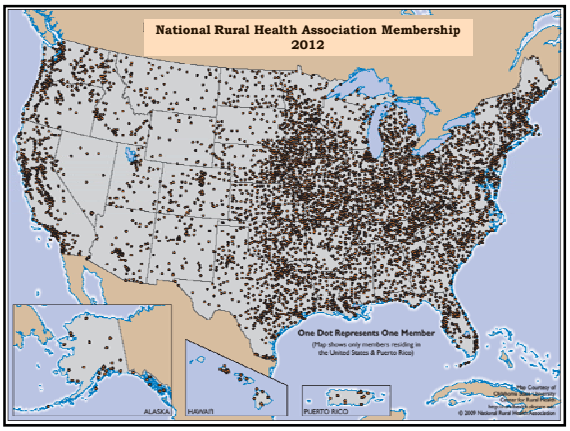


NRHA Mission

Your voice. Louder.

The National Rural Health Association is a national membership organization with more than 21,000 members whose mission is to ***provide leadership on rural issues*** through advocacy, communications, education and research.

- **Rural is often defined by what it is not…urban**
- Rural is defined by:
  - ✓ Geography
  - ✓ Population density (urban areas or urban clusters 1,000 per square mile is urban; 6 per square mile is frontier
  - ✓ Distance from an urban center (Rural Urban Commuting Area (RUCA codes)
  - ✓ Culture
  - ✓ Policy definitions (disparities, shortage areas, etc.)

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%

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.
  - IOM 2005

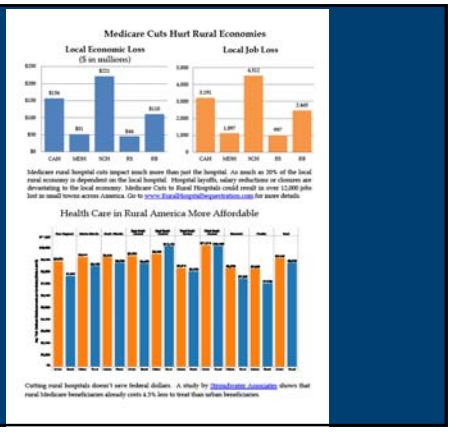
Medicare's payments to 50 bed or fewer hospitals represent less than two percent of overall Medicare budget.

Medicare patients accounted for almost half of all stays (45 percent) at rural hospitals.

-AHRQ 2007

On average, costs per stay in rural hospitals were less than those in urban hospitals (respective costs of $6,500 and $9,000).

- AHRQ 2007



Rural is Different

- Rural hospitals have lower risk-adjusted rates of potential safety-related events.
  - Jolliffe 2003

Rural is Different

- Rural hospitals have significantly lower adverse event rates than urban counterparts.
  - Whitener and McGranahan, 2003

Rural is Different

- Rural hospitals have significantly lower rates of postop hip fracture, hemorrhage, and hematoma.
  - Cromartie, 2002

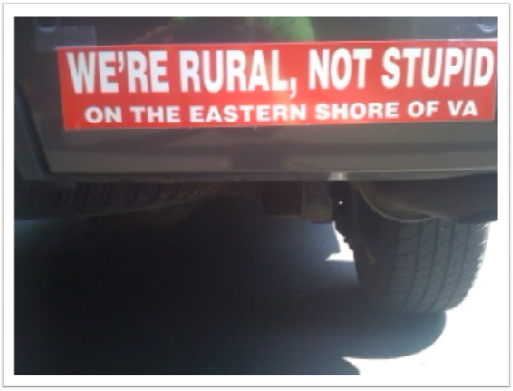
Rural is Different

- Rural areas score higher than urban on appropriate provision of preventative services related to breast exams/ family history of cancer, influenza immunization...
  - Pol et al., 2001


Keeping patients happy

National satisfaction survey shows room for improvement in Virginia

Rural is Different



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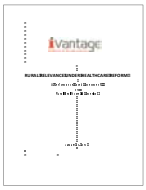


A comprehensive study of Rural Healthcare in America demonstrating rural vs. urban cost effectiveness, efficiency, patient perception and quality.

Rural Relevance Under Healthcare Reform Study

Study Area A: ACO Shared Savings (Medicare Beneficiaries)

- Approximately **$7.2 billion** in annual savings to Medicare alone if the average cost per urban beneficiary were equal to the average cost per rural beneficiary,
- Approximately **$2.2 billion** in annual cost differential (savings) occurred in 2010 because the average cost per rural beneficiary was **3.7% lower** than the average cost per urban beneficiary,
- Approximately **$9.4 billion** per year is the existing and potential differential between Medicare beneficiary payments for rural vs. urban.

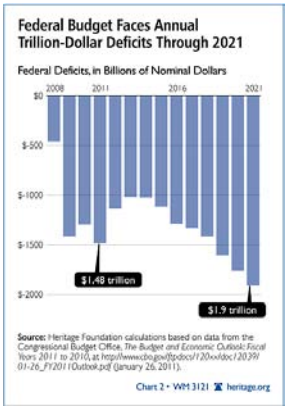
Rural Relevance Under Healthcare Reform Study

Study Area B: Hospital Strength Index™

- Rural hospital performance on CMS Process of Care measures is **on par** with urban hospitals,
- Rural hospital performance on CMS Outcomes measures is **better** than urban hospitals,
- Rural hospital performance on HCAHPS inpatient patient experience survey measures is **better** than urban hospitals,
- Rural hospital performance on price and cost efficiency measures is **better** than urban hospitals.

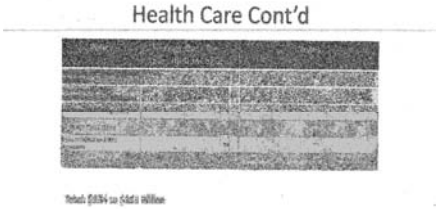
From 1980 to 1991 at least 360 rural hospitals were closed. -An average of 30 per year.

The Inpatient Prospective Payment System (PPS) led to the decline in the numbers of rural hospitals.



CBO Report on Deficit Reduction

House GOP Leadership



Hot off the Press

'The Path to Prosperity'

Different from last year's resolution, the House Republican budget attempts to eliminate the pending defense reductions planned for 2013 per the Budget Control Act thresholds. To accomplish this, this budget produces $18 billion of deficit reduction in the first year, $116 billion over the first five years, and $261 billion over ten years.

MedPAC joins in the assault on CAHs

- In preparation for 2012 report to Congress on health care in rural areas, MedPAC has held two troubling open meetings.
  1. Access in Rural America
  2. Medicare Reimbursement for Rural Hospitals

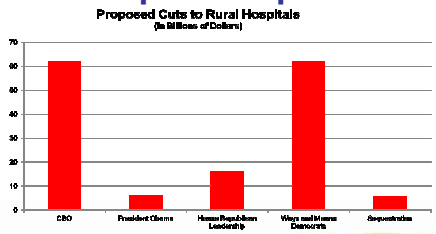
"I share your concern that critical-access hospitals are vitally important," - HHS Secretary Kathleen Sebelius.

March 30th 2011

- "Better align Medicare payments to rural providers with the cost of care:
  - Medicare makes a number of special payments to account for the unique challenges of delivering medical care to beneficiaries in rural areas.
  - But these programs have expanded so that they now include one-third of all hospitals and have exceeded the scope and purpose for which they were created.
  - The Administration proposes to improve the consistency of payments across hospital types, provide incentives for efficient delivery of care, and ***eliminate higher than necessary reimbursement***. Together, these rural proposals will save approximately $6 billion over 10 years." (emphasis added)

- Reduce cost-based reimbursement from 101% to 100%
- Eliminate CAH status if it is located within 10 miles of another hospital.

Rural Hospital Proposed Cuts



Sequestration

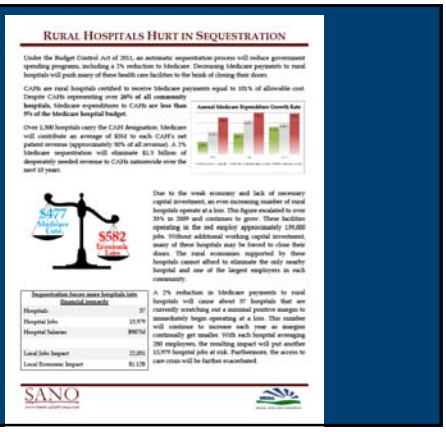
- Automatic, across-the-board cuts to specific programs and discretionary accounts.
- Medicare reimbursements will be cut 2%.
- Medicaid and Social Security will not be part of the automatic cuts.
- Total cuts will equal the $1.2 trillion dollar Super Committee goal.

NRHA Action

- Educate members and their staff in person about the nature of these programs, their costs, benefits, needs, etc.
- Held grassroots conference calls and webinars about the affects of these proposals and likely outcomes
- Sent daily alerts to congressional staff about the vital nature of these facilities and programs
- Posted up-to-date information on NRHA's blog and website.

Healthcare Critical to Rural Economy

- Healthcare is the fastest growing segment of rural economy.
- Each rural physician generates 23 jobs in the local rural economy.
- Health care often represent up to 20 percent of a rural community's employment and income.



Appropriations Conference Report

- Funding levels for "Rural Health" chapter remained the same
- The National Health Service Corps was funded at $295 million-$24 million below FY 2011 but $130 million above FY 2010
- Title VII, Title VIII and NHSC funding was lower than FY 2011 but *significantly* higher than the House had originally allocated
- AHECs were funded at $30 million—Title VII as a whole funded near FY 2011 levels
- Title VIII funded at $466 million

2013 Workforce Funding

Senators Kent Conrad and Chuck Grassley are sending a letter to appropriators in support of rural health care program funding in the Labor HHS Appropriations bill and the National Rural Health Association strongly urges individuals to call their Senators and urge them to sign on to this critical letter.

Medicare Extenders

- Reauthorization the Medicare Dependent Hospital designation (Oct. 1)
- Extension of the current Low-Volume Hospital Adjustment (Sept. 30)
- Hospital wage index flexibility for MMA Section 508 Classified Facilities (Feb 29)
- Extension of the Outpatient Hold-Harmless provision under the Prospective Payment System (PPS) (Feb 29)
- Extension of payment for the technical component of certain physician pathology services (Feb 29)
- Extension of the work geographic index floor under the Medicare physician fee schedule (Feb 29)
- Extension of all current ambulance including air ambulance services (Feb 29)
- Extension of the current physician fee schedule for mental health providers (Feb 29)
- Extension of exceptions process for Medicare therapy caps (Feb 29)
- Rural Hospital Flex grants (Sept. 30)

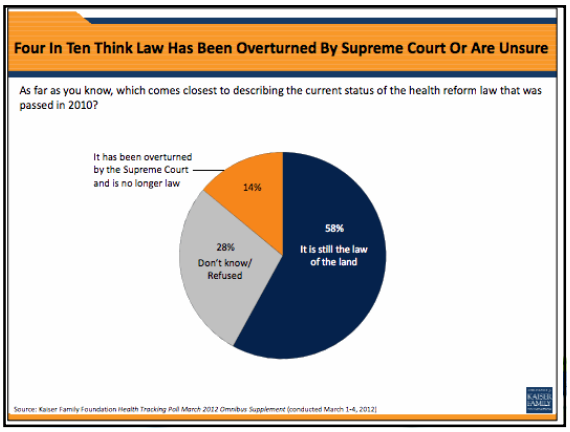
Extenders and the Conference Committee

- Outpatient hold harmless - - extended for 10 months
- SGR – extended 10 months
- GPCI – 10 months
- Ambulance – 10 months
- Therapy caps – 10 months
- Phased out: Section 508, pathology lab component – 4 months
- Mental health add-on – Eliminated
- All of the provisions that were extended include MANDATED studies of their effectiveness

Provisions not included:

- Medicare Dependent Hospital
- FLEX
- Low-volume hospital adjustment
- Reasonable cost reimbursement for clinical diagnostic lab services

HEALTH LEGISLATION FOR RURAL AMERICA



NRHA Fight: Insurance Access Does Not Equal *Access to Care*

Three reforms are crucial for health reform to work in rural America:

- The workforce shortage crisis must be abated;
- Equity in reimbursements must occur;
- Disparities must be eliminated.

August 2011

Thirty-nine percent of Americans say they have a favorable view of the law, 44 percent have an unfavorable one and another 17 percent don't know enough to register an opinion.

- Kaiser Health Tracking

According to the nationwide survey conducted in August 1-29, only 13 percent of physicians agree with the American Medical Association's stance on health reform.

-Jackson and Coker, 2011

Workforce Improvements

- Significant Expansion of NHSC
- Significant funding of Title VII and Title VIII
- Rural Physician Training Grants
- Graduate Medical Education Improvements
- Increased Residency Slots in Rural Areas
- Grants to Improve Primary Care Training
- New Residency Slots for RHCs
- Workforce Commission

Try, try again…

Created by the ACA to review criteria for the designation of Medically Underserved Areas and Health Professional Shortage Areas. The Committee comprises 28 members who are key stakeholders representing the programs most affected the designations, including health centers, rural health clinics and other rural providers, special populations with unique health care needs, and technical experts in health care access and statistical methods.

What was left out?

Short answer…a lot
Long Answer…

- CAH HIT Fix (ARRA)
- 340B for RHCs
- 340B expansion to inpatient drugs
- Continued support for State Offices of Rural Health
- Reinstate "Necessary Provider" for CAH status
- CAH Bed Flexibility
- RHC Payment Cap Increase
- Improve Rural Workforce Development
- Ensure Rural Access to Anesthesia Services
- Eliminate CAH "Isolation Test" for Ambulance Reimbursement
- Ensure Rural Representation on MedPAC and newly created similar Commissions (IPAB, HIT Policy Committee, etc.)
- Implement an Occupational Safety Program for Agricultural Workers
- Protect Access to Care for the Most Geographically Remote Americans
- And many more…

Our Message to the Hill:

- Educate: Rural America needs health care reform, but rural America needs health reform done correctly.

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THANK YOU

Alan Morgan
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