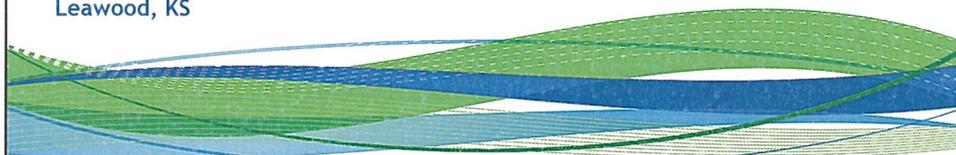




NM Legislative Health and Human Services Committee

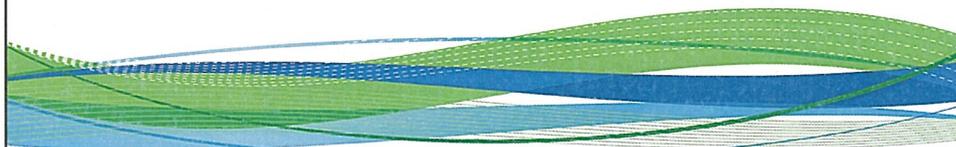
Roswell, NM

Brock Slabach, MPH, FACHE
Sr. Vice-President
National Rural Health Association
Leawood, KS



Improving the health of the 62 million who call rural America home.

NRHA is non-profit and non-partisan



Agenda



- Rural overview and history
- Financial status of rural hospitals
- Economic impact of rural hospitals, including their value proposition
- Summary Observations and Recommendations

Rural Overview



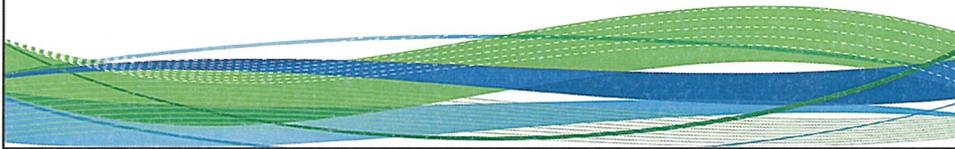
- 62 million patients rely on rural providers.
 - Population challenges
 - Geographic challenges
 - Cultural challenges
- Rural providers face health care delivery challenges like no other provider.
 - Workforce shortages
 - Fiscal constraints
- Rural providers and patients are disproportionately dependent on Federal Government.
 - Medicare, Medicaid
 - Appropriations
 - Regulatory Process
- Now, rural providers face unprecedented challenges from Washington, D.C.

Rural disparities/challenges



Your voice. Louder.

- War on Poverty in the 60's
- Community Health Centers, created in the War on Poverty
- Rural Health Clinics – now >4,500 RHC's nationwide
- Advent of PPS 1983: 400 hospital closures
- Policy Response: SORH, Flex, MDH, CAH and LVH
- Rural serves more challenging populations:
- "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.

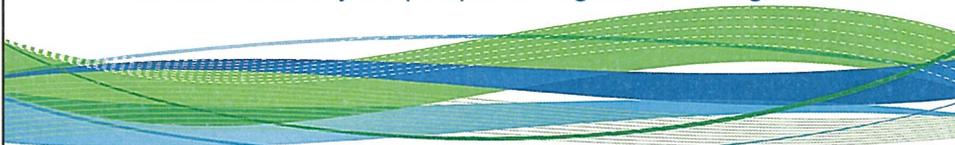


Problems still exist...



Your voice. Louder.

- *Health equates to wealth* according to Dr. Christopher Murray of the University of Washington, July 2013
- Largest report on status of America's health in 15 yrs.
- **Key Finding:**
- The study found that 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.



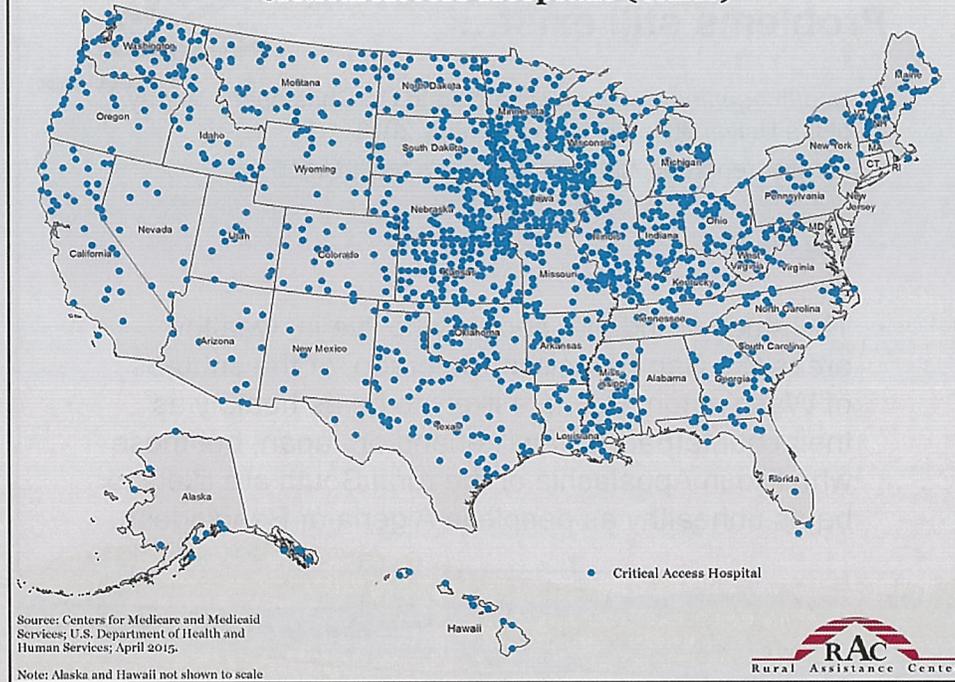
Critical Access Hospital (CAH) Program



- Licensed hospital in rural area
- Comply with CAH conditions of participation at the time of certification
- Furnish 24/7 Emergency Services
- Maintain no more than 25 beds: both acute and swing bed (skilled nursing)
- Annual average length of stay not greater than 96 hours (four days)
- Location:
 - Located 35 miles or greater from another hospital or CAH
 - Located 15 miles or greater from another hospital or CAH where mountainous terrain or where only secondary roads exist
 - Certified prior to January 1, 2006 under Necessary Provider designation provided through a state rural health plan
- CAHs are paid for most inpatient and outpatient services to Medicare patients at 101 percent of reasonable costs (minus sequestration)



Critical Access Hospitals (CAHs)



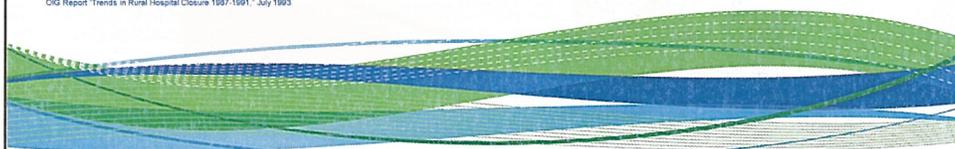
The History of Rural Hospitals



Your voice. Louder.

- 1986--46% of ALL short stay, acute hospitals were located in rural (non-MSA) counties
- During the 80's nearly 10% of all U.S. rural hospitals closed [Hart et. al, 1991]
- 1983-1998—217 Rural Hospitals Closed
- 1992-1999--122 Rural Hospitals Closed
- Total during this period: 439!
- 2000-2010 almost no hospitals closed due to CAH
- 60-80% of rural hospitals gross revenue come from Medicare and Medicaid

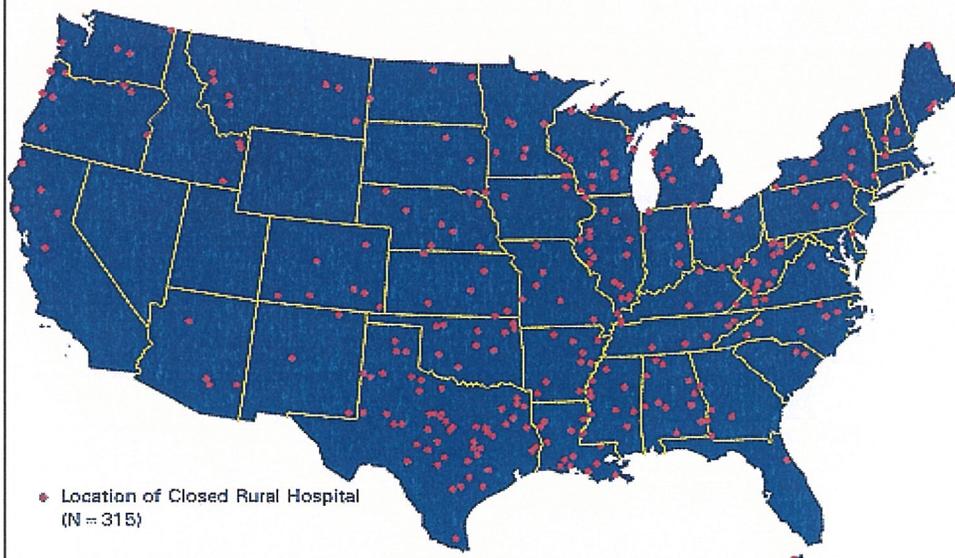
Moskovicz, J. Rural hospitals: a literature synthesis and health services research agenda
Dec. 13-15, 1987 (6) p. 4
OIG Report Trends in Rural Hospital Closure 1987-1991, July 1993



Rural Hospital Closures: 1980-90

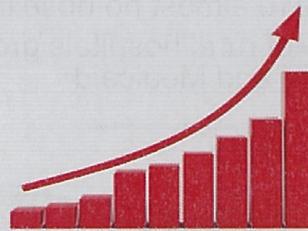


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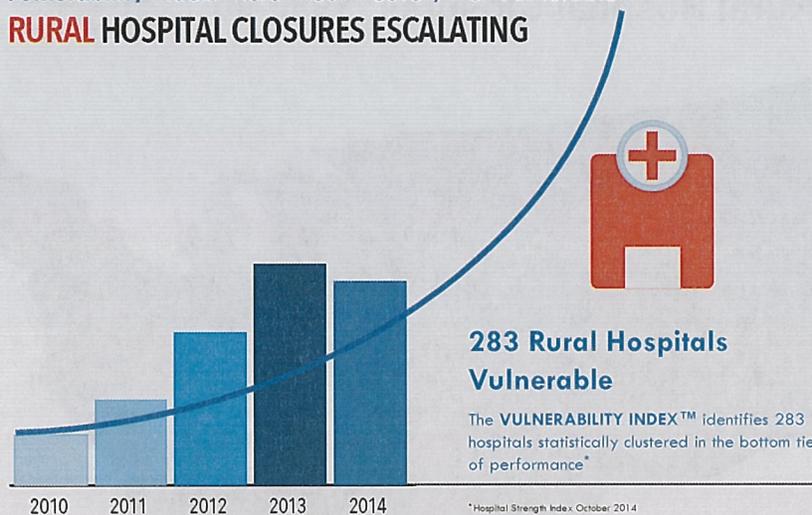


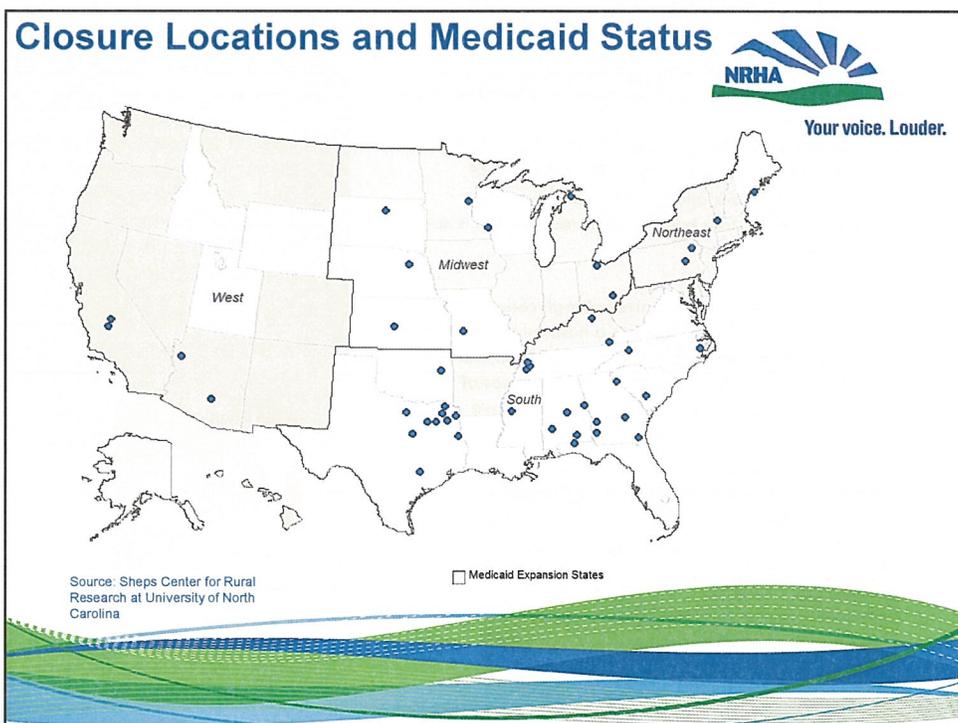
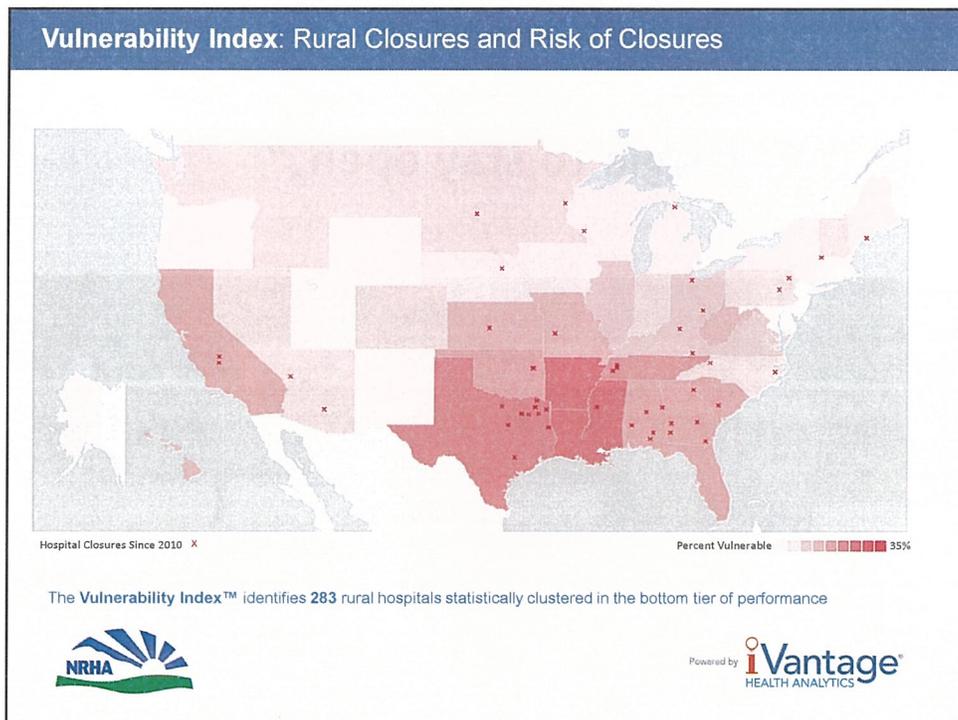
Closures are Coming Back

- 41 rural hospital closures since Jan. 1, 2013
- 59 since 2010
- Rate will likely double in 2015-16
- Nye Regional Medical Center, Tonopah, NV, the only hospital in a 100-mile radius, closed at noon on Friday, August 21, 2015. This was a Sole Community Hospital (SCH).



Vulnerability Index: Rural Health Safety Net **Vulnerable** **RURAL HOSPITAL CLOSURES ESCALATING**







“When rural hospitals close, towns struggle to stay open.”



It’s about the patients...

“Only four days after the Pungo District Hospital in Belhaven closed its doors for good on July 1, Portia Gibbs, 48, suffered a heart attack and died just as the chopper arrived to airlift her to a hospital. (Nearest hospital is now 75 miles away.)

“Before, she would have been given nitroglycerin, put in the back of an ambulance and been to a hospital in about 25 minutes,” said Belhaven Mayor Adam O’Neal. “In that hour that she lived, she would have received 35 minutes of emergency room care, and she very well could have survived.”
- Belhaven Mayor Adam O’Neal.



“[It] ends up with rural communities, such as Hancock County (Georgia), where 39 percent of the folks who have a stroke or have a heart attack die. That’s a lot higher than in counties with hospitals close by.”

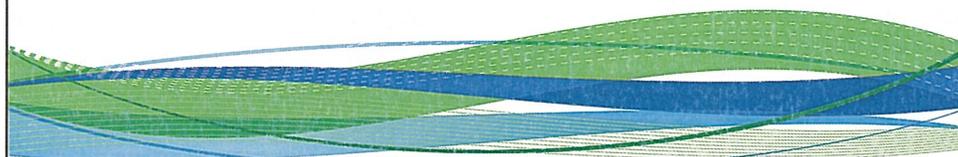
David Lucas, Georgia State Senator.



It's about access to care...



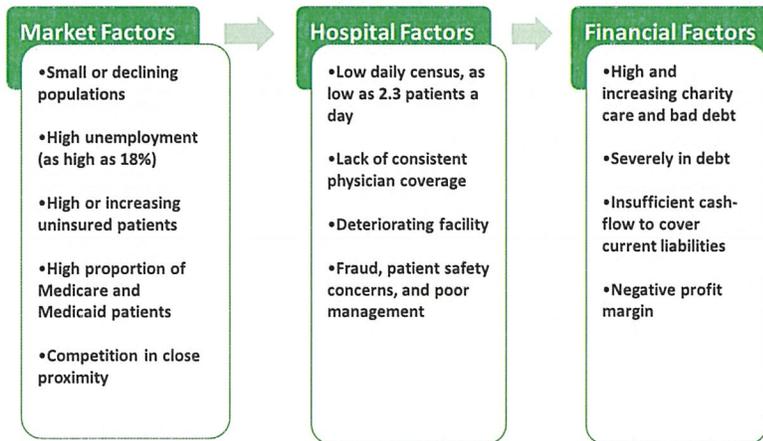
- 640 counties across the country **without** quick access to an acute-care hospital. *UNC Sheps Center*
- "Access to care remains the number one concern in rural health care." Rural Healthy People
- [The closings] "are a growing problem of **'medical deserts'**...it is much like the movement of a glacier: nearly invisible day-to-day, but over time, you can see big changes."
Alan Sager, Boston Univ. professor of health policy



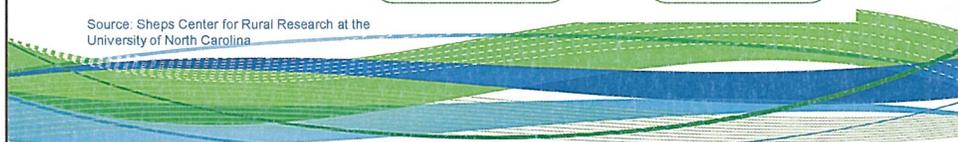
Why did they close?



Your voice. Louder.



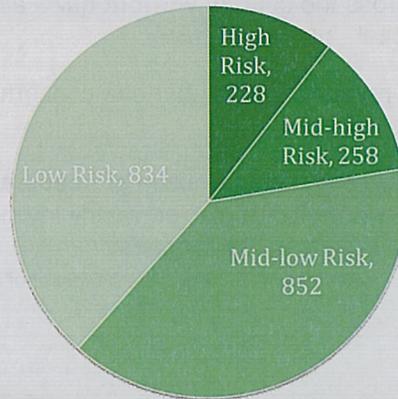
Source: Sheps Center for Rural Research at the University of North Carolina



Model Predictability



Hospitals by Risk Level (2013)

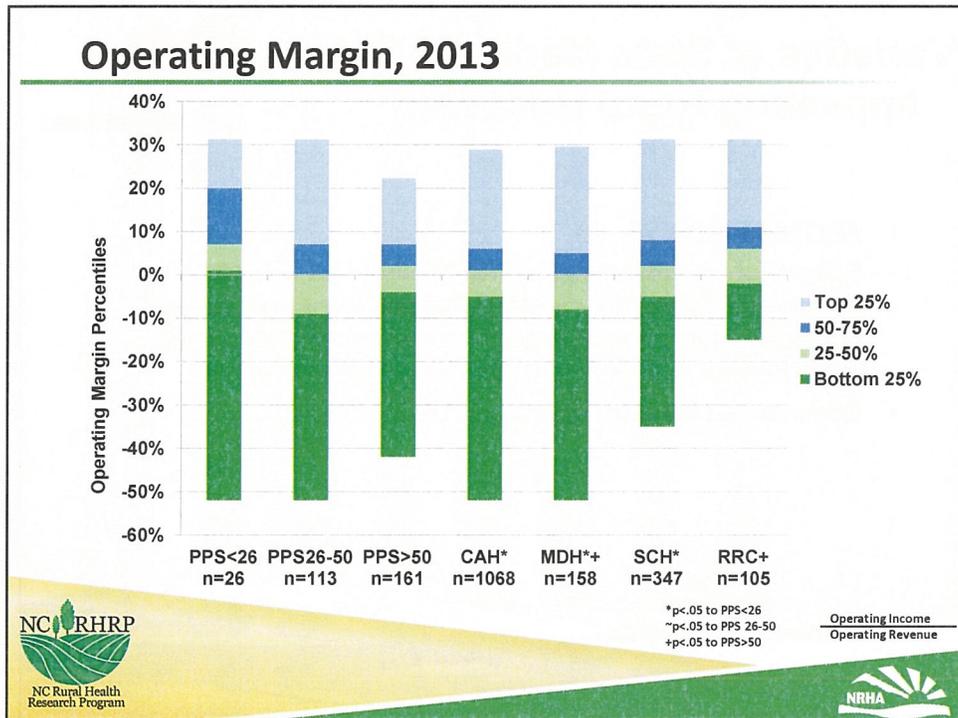


Source: Sheps Center for Rural Research at the University of North Carolina

2013 Rural hospitals in US with financial distress signals

Financial distress signal	Number	Percent
Unprofitability:		
2 years negative operating margin	659	30%
Negative cash flow margin	537	24%
Net assets decline:		
>20% decline in net assets	355	16%
Insolvency:		
Negative net assets	237	11%
Closed:		
No longer provides inpatient care	14	1%





Medicare Cuts Enacted



Your voice. Louder.

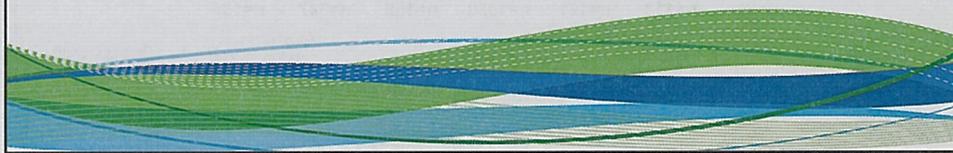
- ACA Hospital Reductions: \$159B
- Sequestration cuts – 2% for nine years
- Bad debt reimbursement cuts
- Documentation & coding cuts
- Readmission cuts
- Multiple therapy procedure cuts
- ESRD reimbursement cuts
- Outpatient hold harmless payments (TOPS) – expired
- 508 reclassifications – expired



Varieties of State Medicaid Cuts Impacting Rural Hospitals



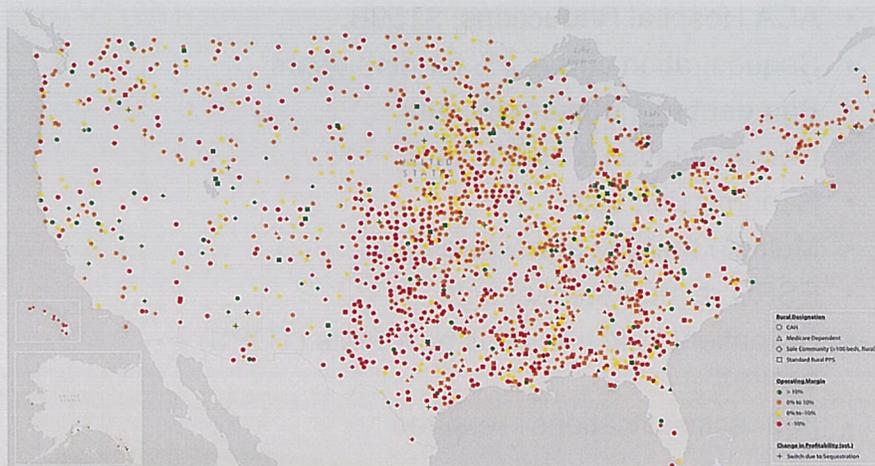
- ACO Model (OR, AL, IL)
- Episode of Care/Bundled Payment Models (AR, TN, OH)
- Delivery System Reform Incentive Payment (DSRIP) Model (TX, CA and NY): Program pays for system transformation, clinical improvement and population health improvement
- Commercial Medicaid Expansion (AK, IA, PA, KS)



Sequestration Impact to Rural Hospital Profitability

SEQUESTRATION
2% CUT

Sequestration effects on Rural, Urban Hospitals in the United States
Estimated effects of a two percent Medicare sequestration on Rural Hospitals (Sole Community, Standard Rural PPS, CAH, Medicare Dependent)



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HEALTH ANALYTICS

“Rural hospitals and the rural economy rise and fall together”



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

Mark Holmes, professor,
University of North Carolina

- 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)
- A rural physician generates 23 jobs in the local economy

Delivering Value

Study Area A - Medicare Costs and Charges



Critical Access Hospitals vs. Non-CAH

Total Medicare Charges



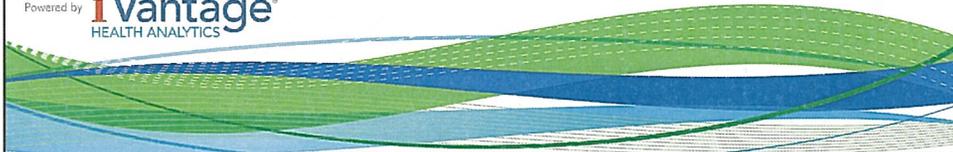
What if non-CAHs charged a CAH per case rate?

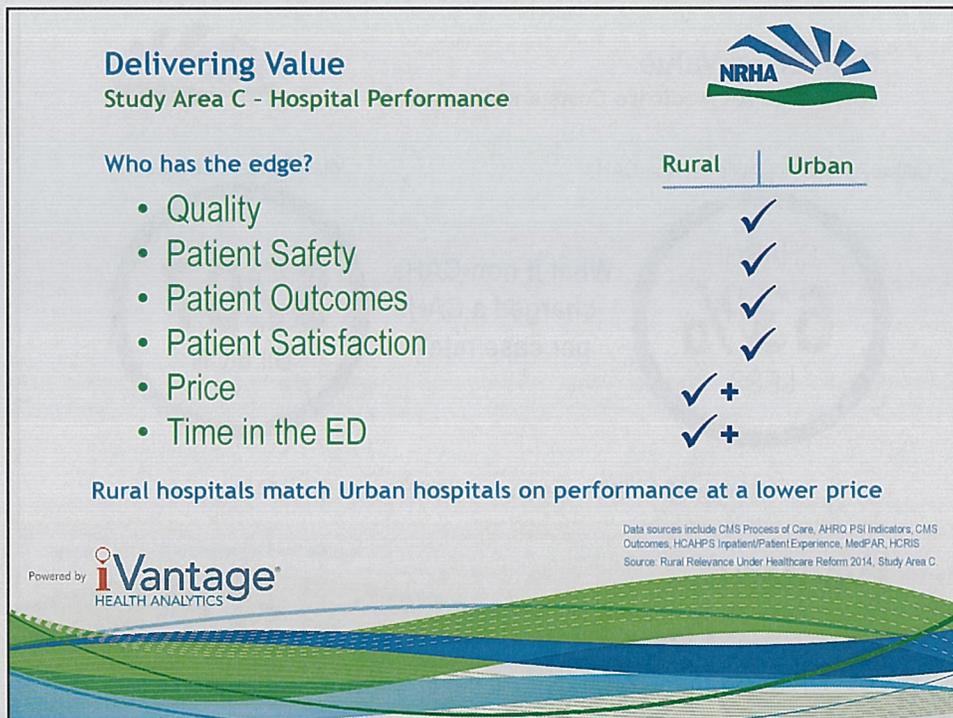
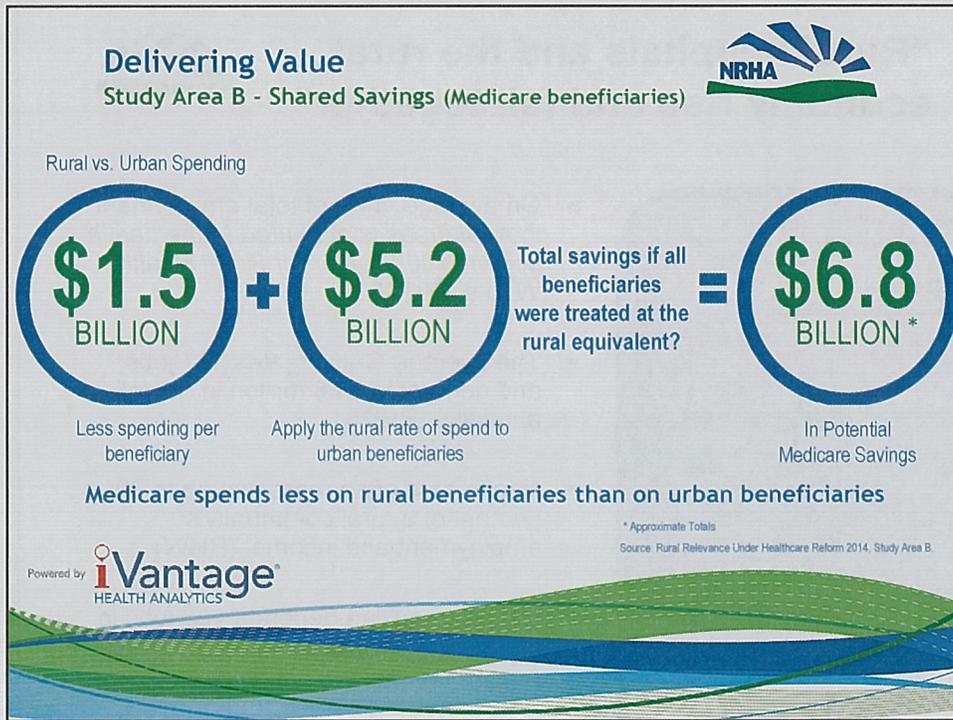


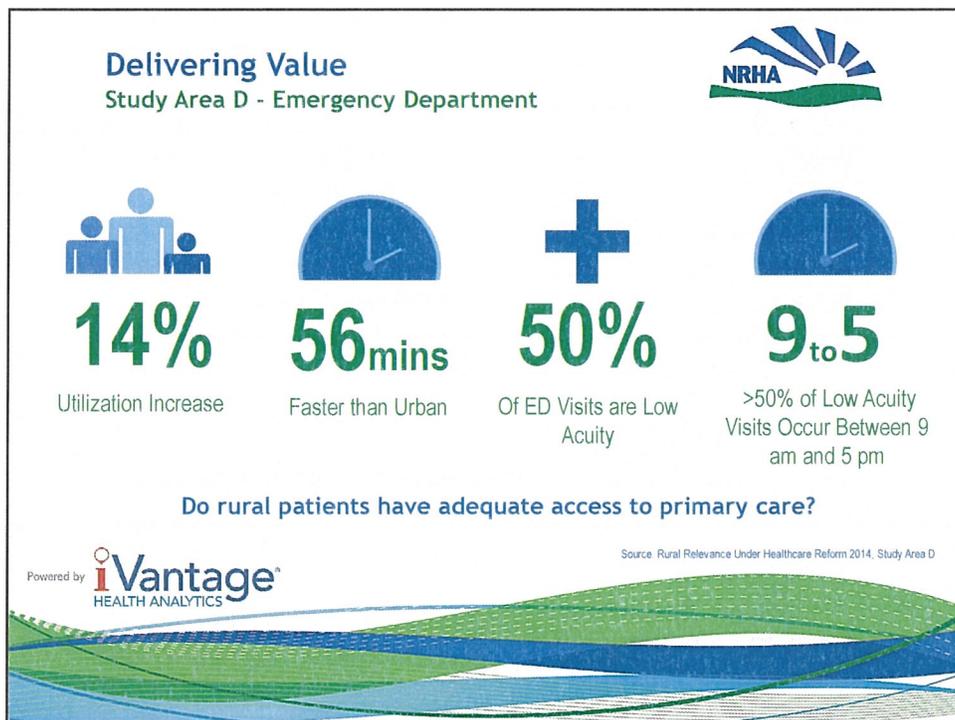
Of the 351 DRGs common to CAHs and non-CAHs

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HEALTH ANALYTICS

Source: Rural Relevance Under Healthcare Reform 2014, Study Area A





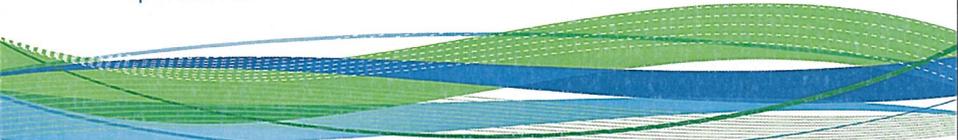


Key Observations and Recommendations



Your voice. Louder.

- Law of unintended consequences... small, rural hospitals are not miniature versions of large, urban facilities.
- Rural Proofing. Consider a guiding principal that before any legislation or regulation is considered or implemented that will affect Hospitals, that a specific impact analysis is performed detailing its impact on rural hospitals.
- Federal policy is key to the operations of rural hospitals, urge your Representatives and Senators to Congress to protect rural hospitals.
- Medicaid expansion has been crucial in states that have expanded to reducing bad deb/charity and improving their operations.



Key Observations and Recommendations



- Rural Hospitals are economic engines of their communities, providing good, high-paying jobs.
- Access to care is essential to economic development, without this access businesses will not locate to a rural area.
- Rural Hospitals provide access to care, reducing critical time to treatment, especially in an emergency.
- Rural Hospitals provide services that are high value to payers and their patients alike.
- Finally, rural healthcare is like Arctic Tundra, once you step on it, it is gone. And won't ever come back.



Questions?

THANK YOU

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