

Missouri Rural Hospital Meeting

Missouri Office of Rural Health

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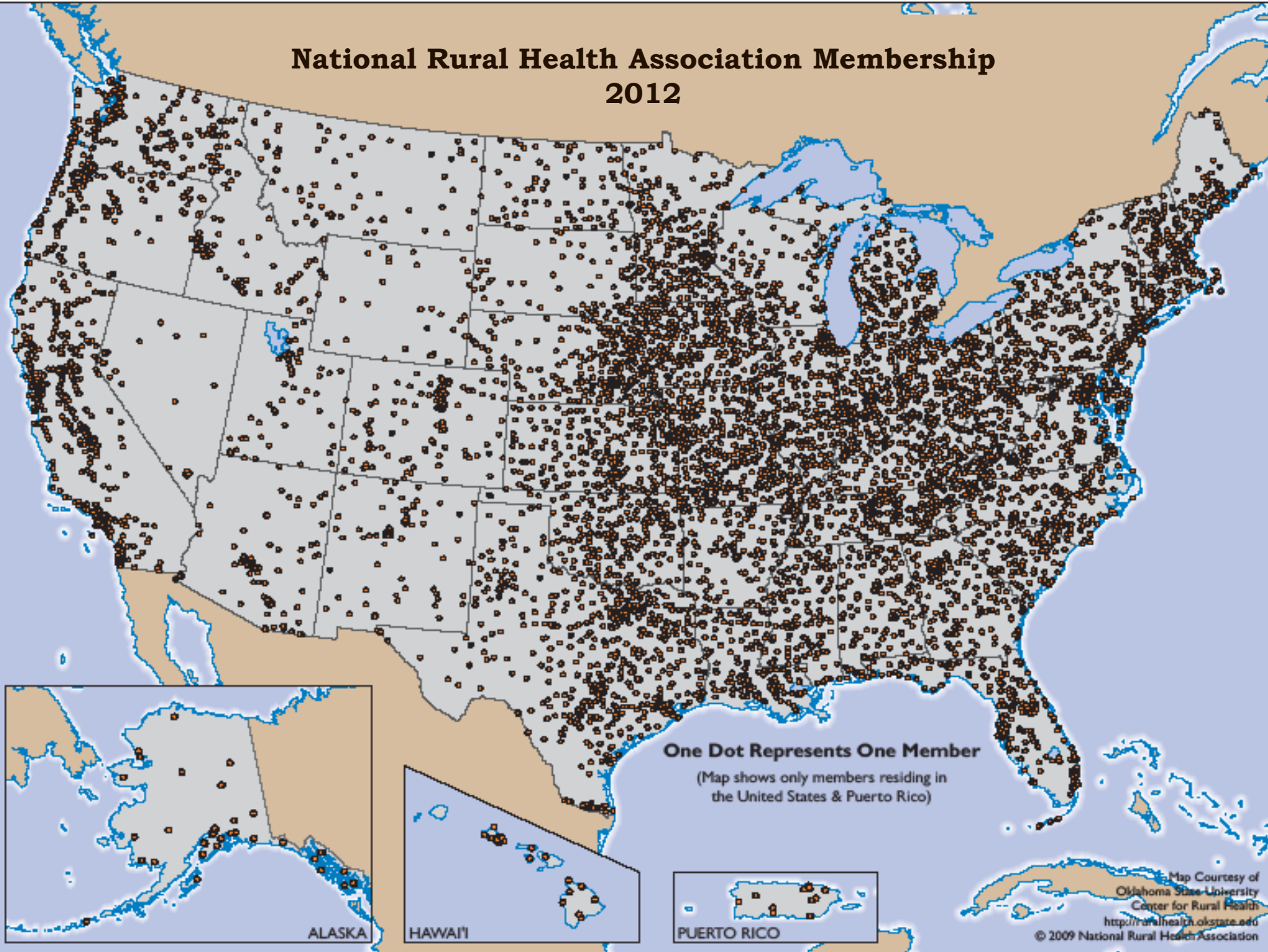


Improving the health of the 62 million who call rural America home.

NRHA is non-profit and non-partisan.



National Rural Health Association Membership 2012



2012-13 Meetings

- Quality & Clinical Conference
Seattle, WA, July 18-20, 2012
- RHC/CAH Conference
Kansas City, MO, September 25-28, 2012
- M&M Conference
Asheville, NC, December 5-7, 2012
- Rural Health Policy Institute
Washington, DC, February 3-5, 2013
- Annual Conference
Louisville, KY, May 7-10, 2013



NRHA's Principles

To resolve the health care crisis in rural America, the rural health care safety net must be prevented from crumbling. Four reforms are crucial:

- The workforce shortage crisis must be abated;
- Equity in reimbursement must occur;
- Decaying rural health care infrastructure must be repaired and non-existent infrastructure must be created; and
- Health disparities among vulnerable populations must be corrected.



- 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%

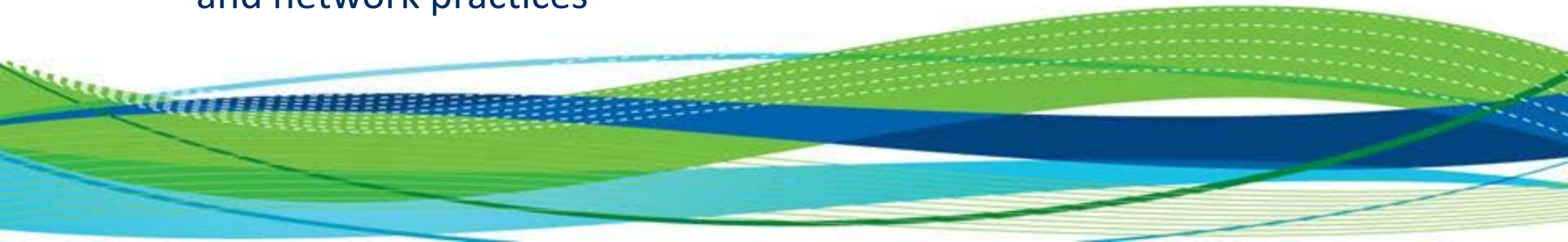


Your voice. Louder.

Primary Care Challenges

Only 65 primary care physicians/100,000 rural Americans compared with 105 PCPs/100,000 urban and suburban Americans

- Physicians living in rural areas are more likely to encounter patients with diabetes, hypertension, heart problems and cancer
- Also more likely to perceive drug abuse and teenage pregnancy as major concerns affecting their patient populations
- Primary care landscape shifting from solo/small practices to group and network practices





Rural is Different

Quality Measures: 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.



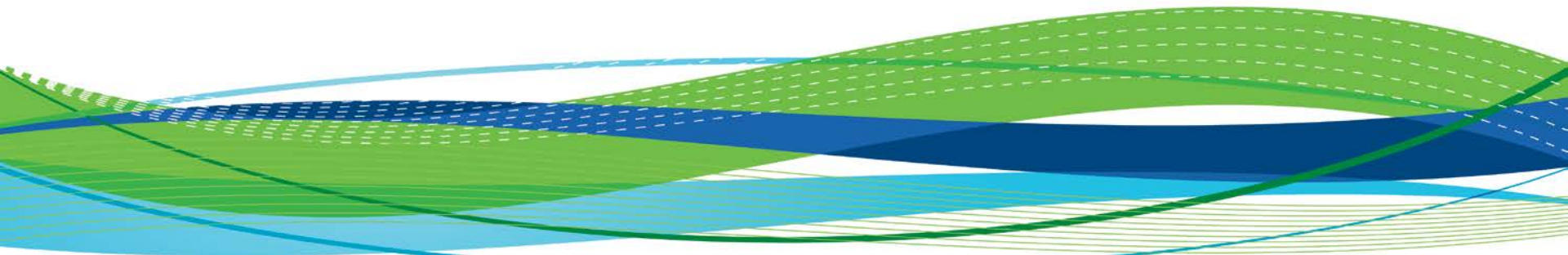
Rural is Different Emergency Department

- The mean **Total Wait Time** in a rural Emergency Department is approximately **half as long** as the wait in an urban Emergency Department (29 vs. 56 minutes),
- The mean **Wait Time to see a Physician** in a rural Emergency Department is **nearly 2.5 times less** than the wait in an urban Emergency Department (98 vs. 247 minutes),
- **More than 50%** of all Emergency Department visits to Critical Access Hospitals were categorized as low acuity cases.



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

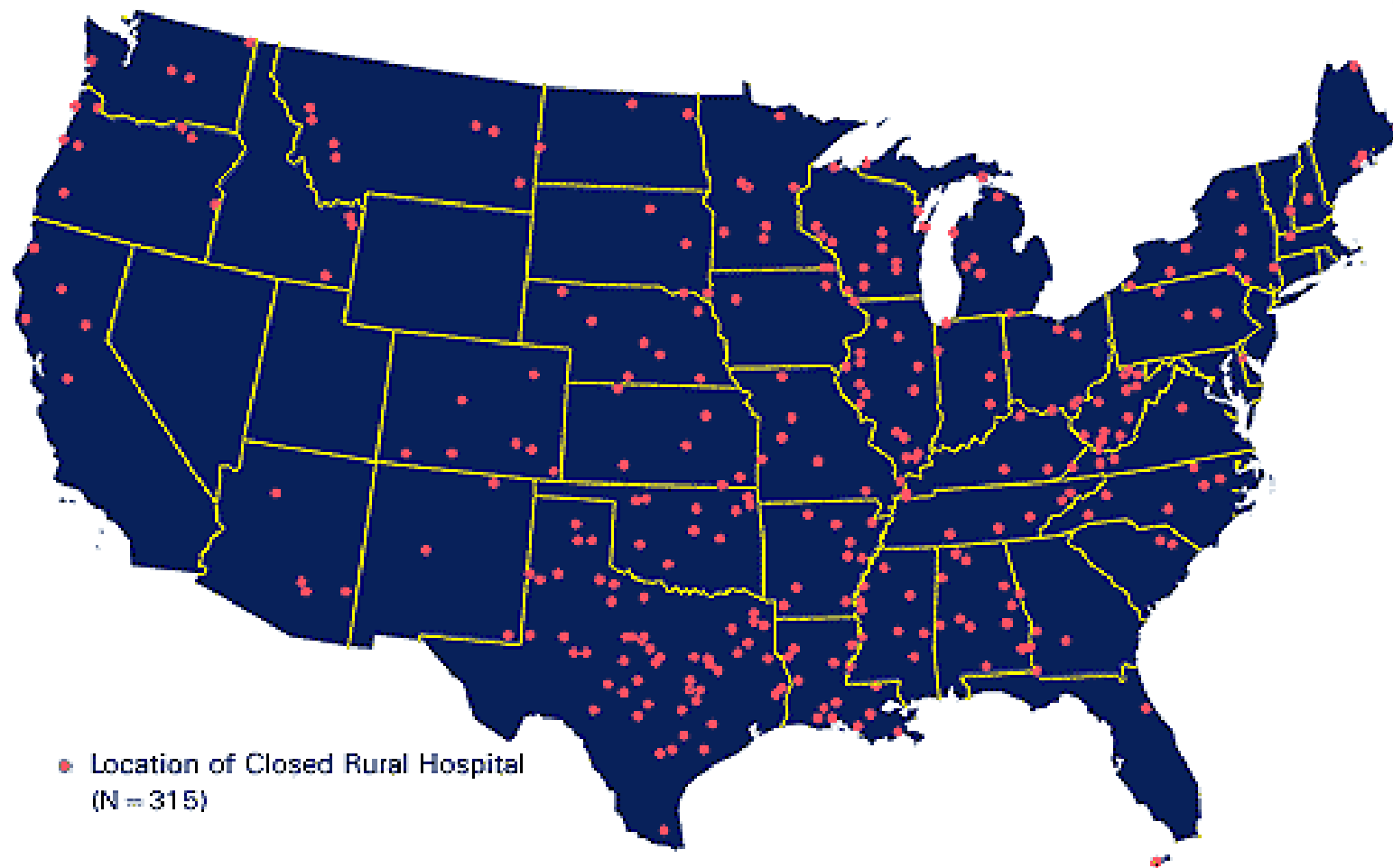
The Inpatient Prospective Payment System (PPS) led to the decline in the numbers of rural hospitals.



Rural Hospital Closures: 1980-90



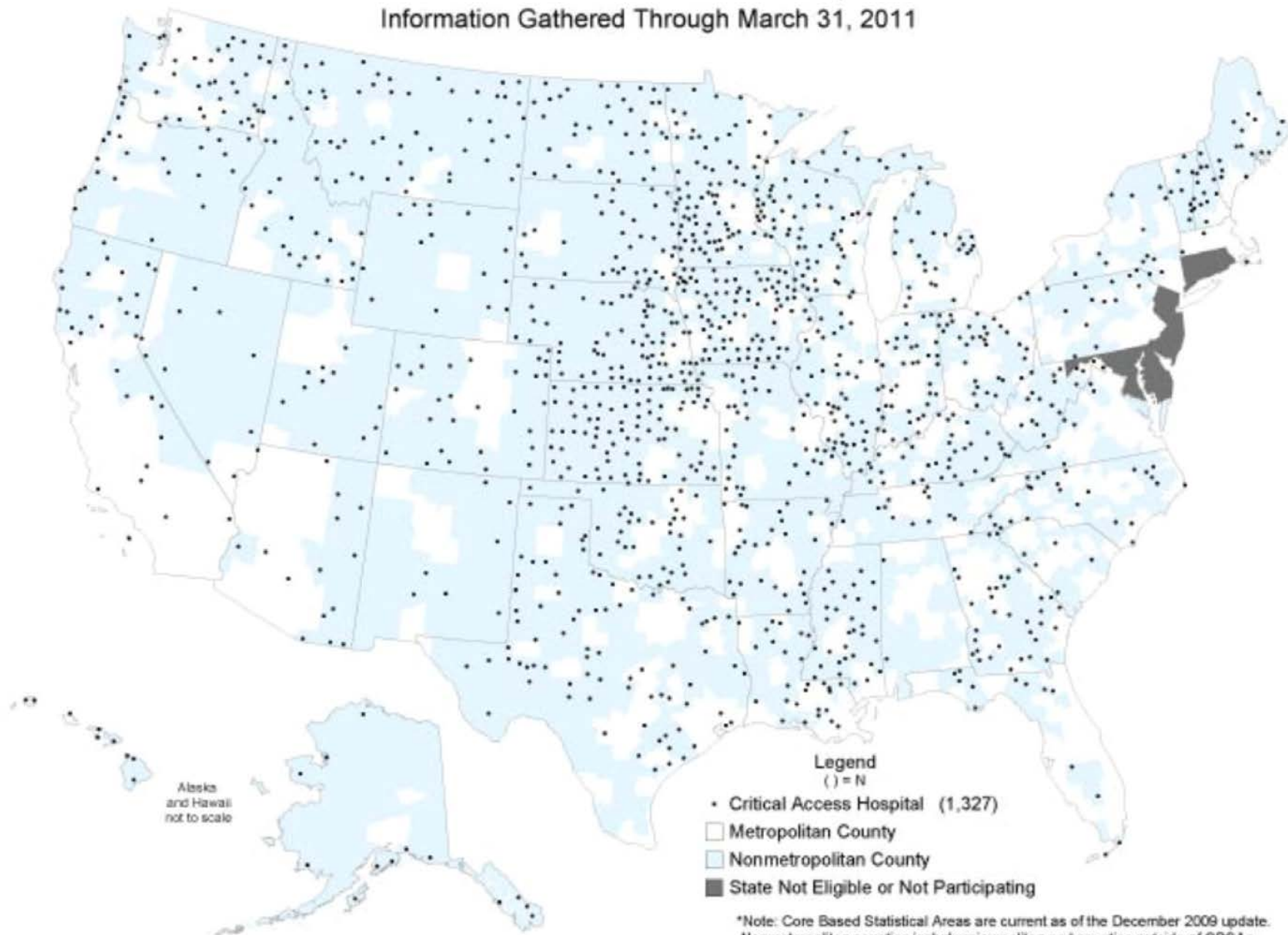
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● Location of Closed Rural Hospital
(N = 315)

Location of Critical Access Hospitals

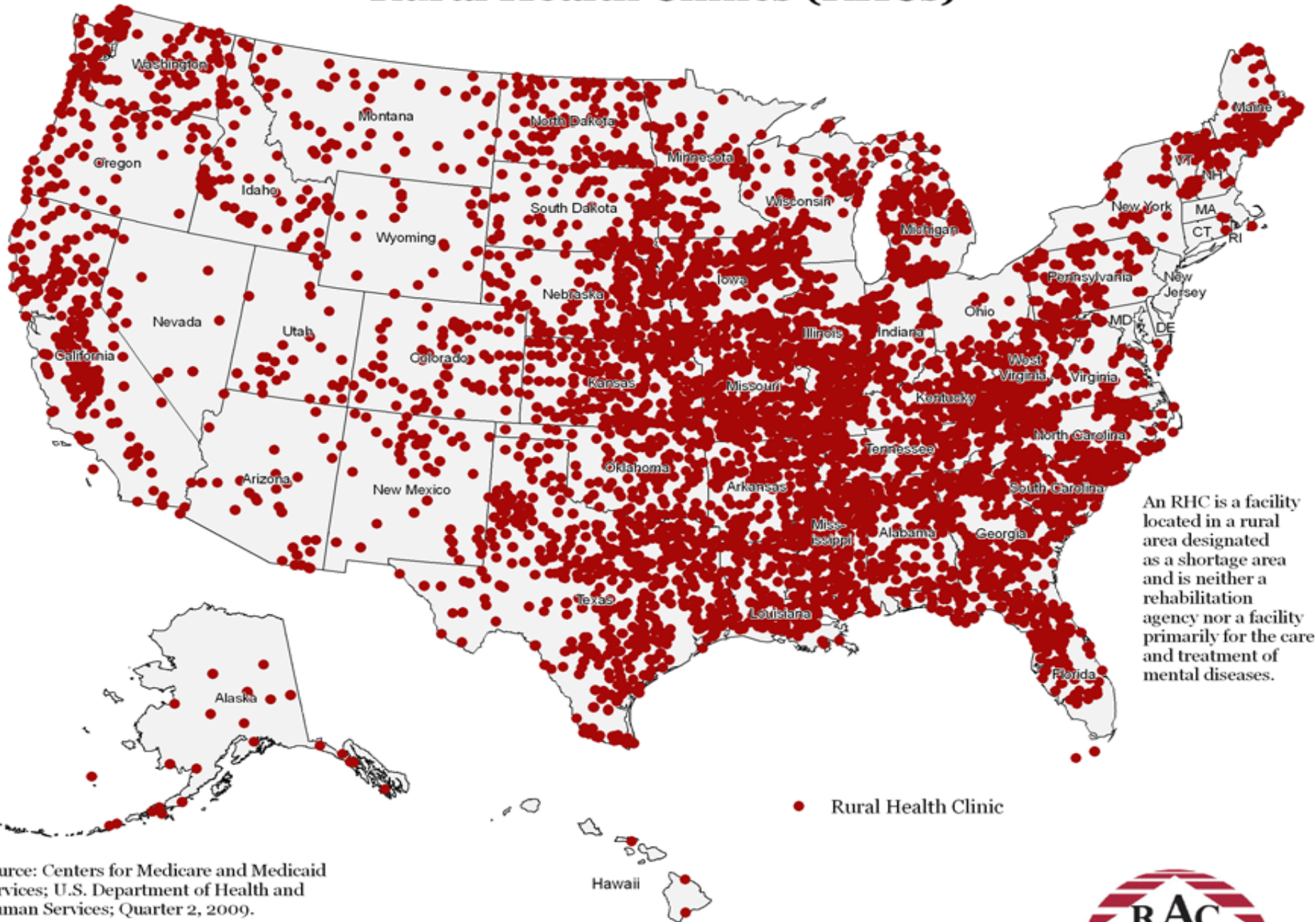
Information Gathered Through March 31, 2011



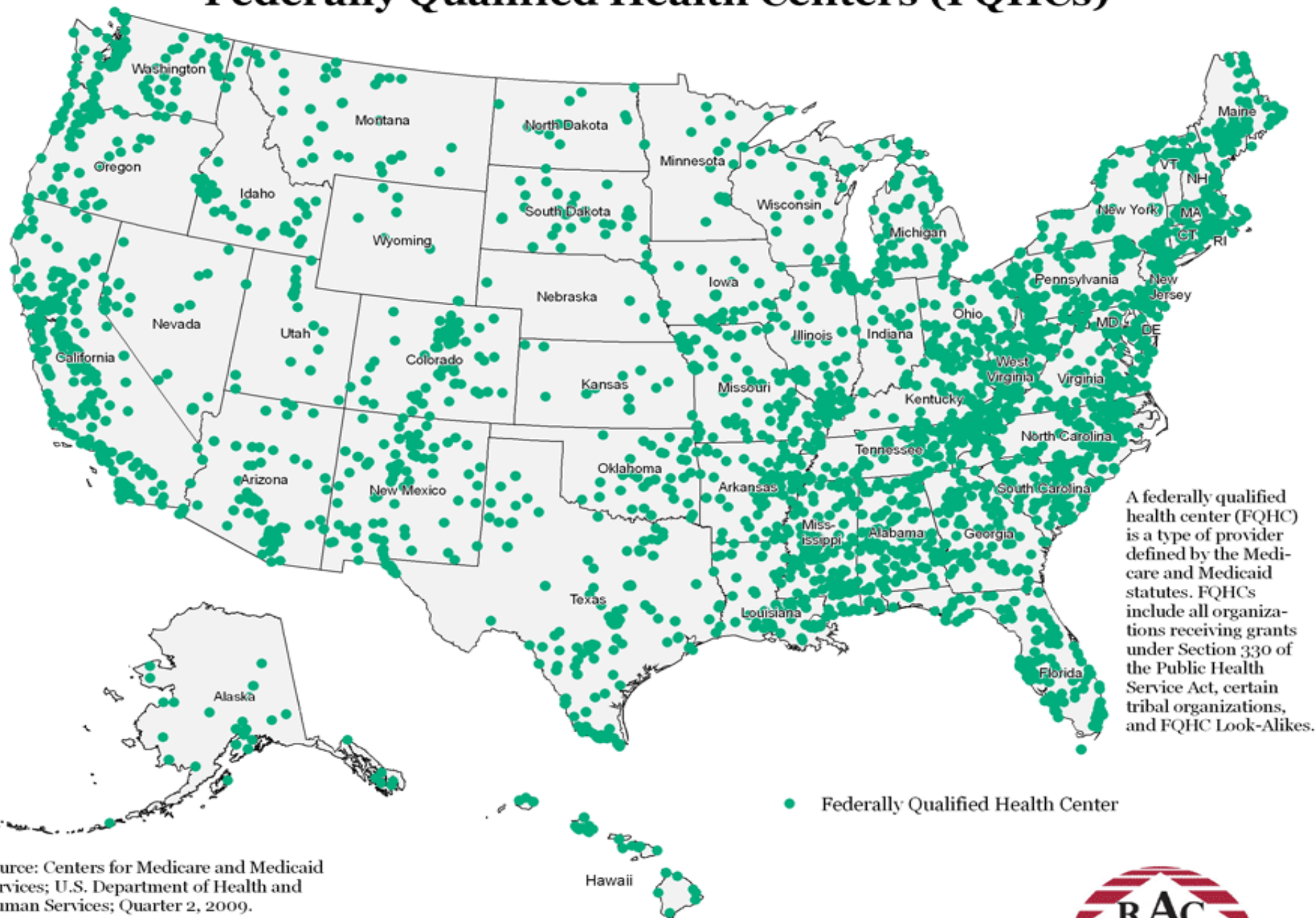
Sources: US Census Bureau, 2009; CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2011.

*Note: Core Based Statistical Areas are current as of the December 2009 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs. Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Rural Health Clinics (RHCs)



Federally Qualified Health Centers (FQHCs)



A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 2, 2009.

Note: Alaska and Hawaii not shown to scale

IN BILLIONS

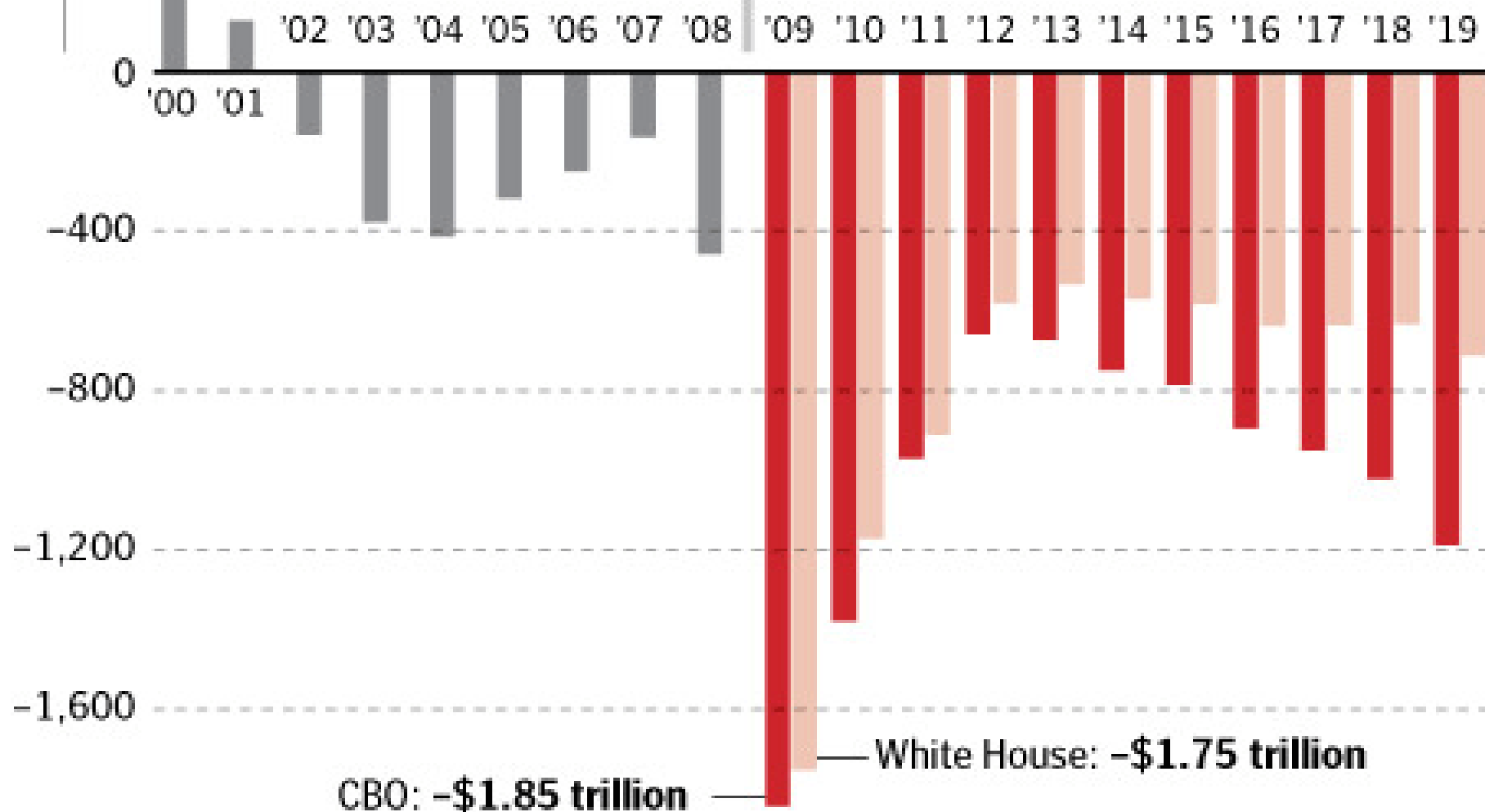
ACTUAL

PROJECTED

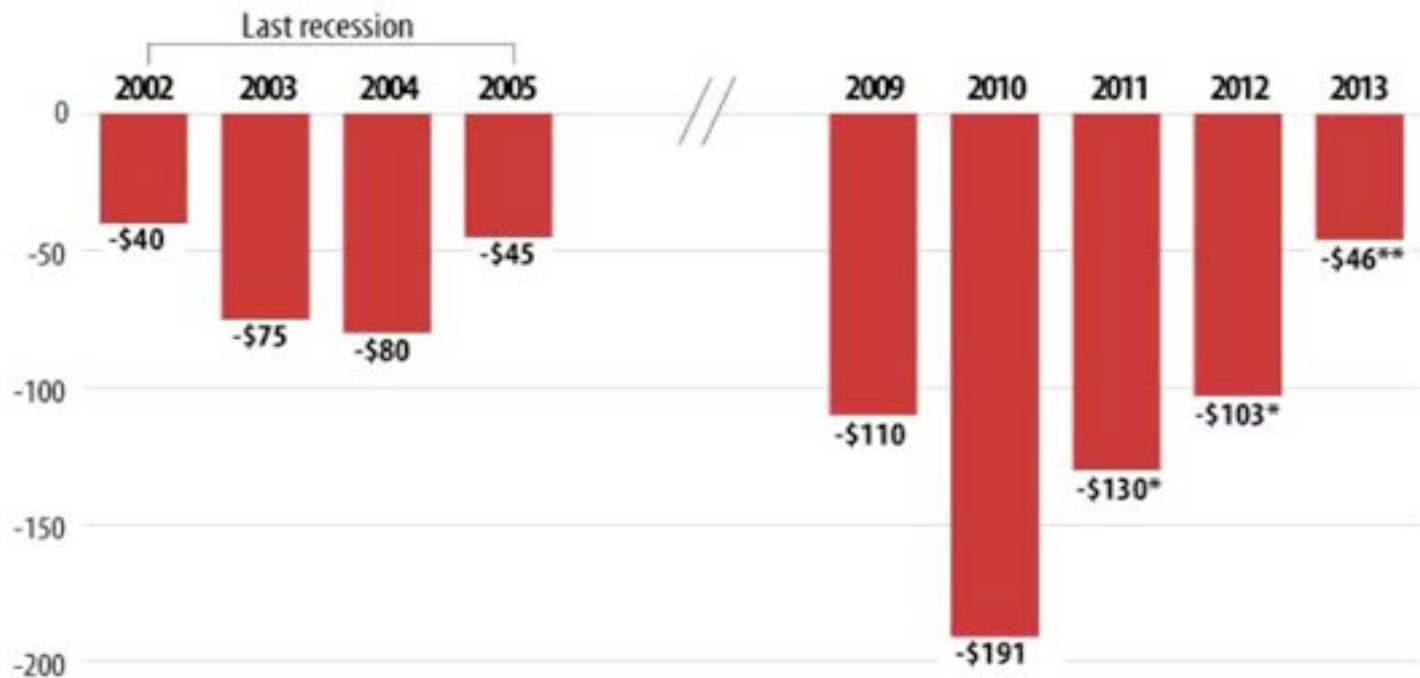
**\$236.2
billion**

CBO estimate

**White House
estimate**



Total state budget shortfall in each fiscal year, in billions



* Reported to date

** Preliminary

Source: CBPP survey

Special report: A better way to handle device and drug recalls / Page 28

Modern Healthcare

THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY

AUGUST 8, 2011

\$5.50

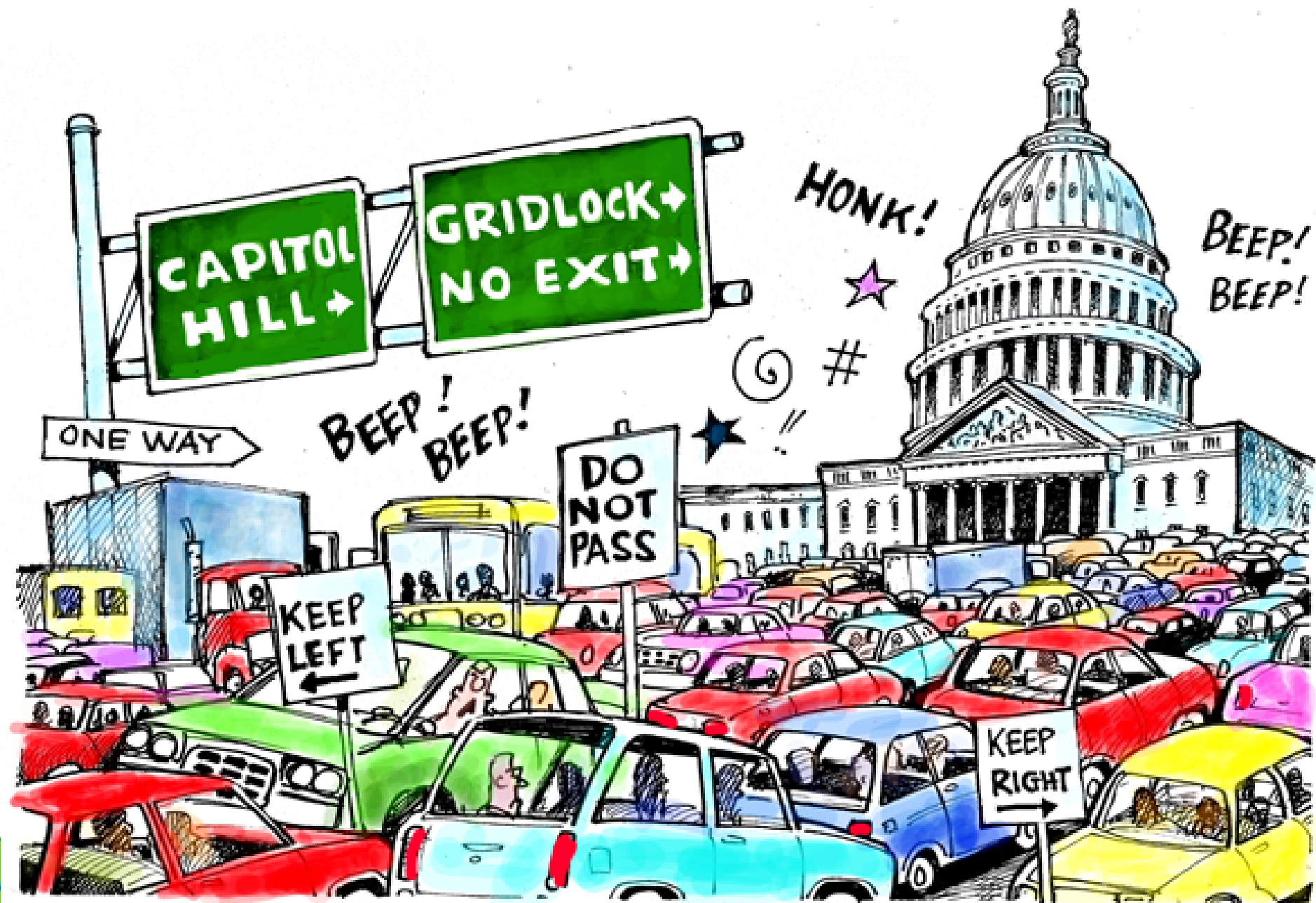
DEBT-CEILING LAW CREATES COMMITTEE CHARGED WITH FINDING \$1.5 TRILLION IN FEDERAL SAVINGS

THIS MIGHT HURT A BIT

*Fearing Medicare pay
is in the cross hairs,
providers gear up for
a tough fight / Page 6*

Under the law championed
by Senate Minority Leader
Mitch McConnell (R Ky.),
Medicare payment rates
could be reduced by 2%.

NEWSPAPER



CBO Option #24 for Deficit Reduction

- Eliminate the following:
 - ✓ Critical Access Hospitals (CAH)
 - ✓ Medicare-Dependent Hospital (MDH)
 - ✓ Sole Community Hospital (SCH)
- Projected Savings over 10 Years,
\$62.2B

What about President's Budget?

- Still being haunted by old ghosts
 - ✓ CAH mileage
 - ✓ CAH reductions
 - ✓ Pay-fors
 - ✓ FLEX grants
 - ✓ AHECs
- Political posturing but must be mindful of message being sent to the Hill.



Your voice. Louder.



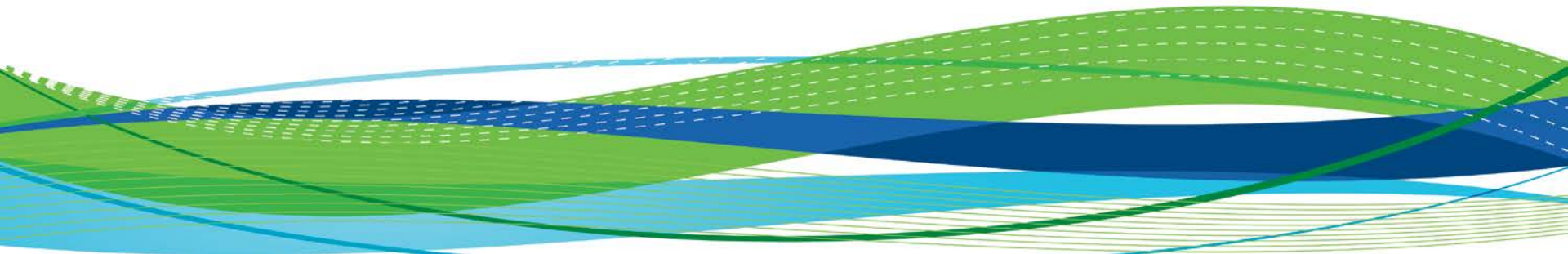
President's Proposal

- “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)



President's FY 2013 Budget

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





MedPAC joins in the assault on Rural Hospitals

- 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

The Joint Select Committee on Deficit Reduction



- Budget Control Act (BCA) of 2011 mandated the creation of the Joint Select Committee on Deficit Reduction (Super Committee)
- A majority of Committee members had to approve the proposal before submission.
- Proposal needed to produce \$1.2 trillion in deficit reduction over 10 years.



Sequestration

- Medicare provider reimbursements will be cut 2%. Medicare will not alter procedures (DRGs) and will not limit beneficiary services.
- Medicaid and Social Security will not be part of the automatic cuts.
- Total cuts will equal the \$1.2 trillion dollar Super Committee goal.
- The total increase allowed for new borrowing authority will be \$1.5 trillion

Sequestration Continued

- Some groups are asking that Congress modify the programs that are protected in sequestration.
- Asking for modifications to defense share, discretionary account cuts, types of Medicare cuts, etc.
- Some groups are claiming that modifications would require congressional action while others point to executive discretion in the administration of the cuts.

Sequestration Continued

- President has promised not to lift the sequester or modify the implementation of cuts.
- Congress may attempt to override a veto before the cuts take effect in 2013. Unlike the up or down vote for a Super Committee proposal, the override must occur in “normal order”.
- The caps, cuts, modified payments are set to continue until 2021.



“Medicare Extenders”

- Various provisions have expired or are set to expire at the end of FY or CY 2012
- **SGR Fix.** Part of budget deal through end of year.
- **Hospital wage index improvement**
 - ✓ Extended reclassifications under section 508 of the Medicare Modernization Act (modifies payment to “super rural” facilities). Congress extended this provision through June, 2012. Phased out over time.
- **Extension of outpatient hold harmless provision**
 - ✓ Extended outpatient hold harmless provision and allows Sole Community Hospitals with more than 100 beds to also be eligible for this adjustment. Budget deal extended through Dec. 31, 2012, limited to less than 100 beds. Requires GAO/MedPAC Report.

Importance of Hold Harmless Provision

- Of the 138 hospitals with SCH status that received OPPS Hold Harmless or TOPS payments in CY 2009, 137 had a negative outpatient service margin on Medicare payments.
- If these hospitals were to lose hold harmless payments, their losses would be far more profound: 34 hospitals would have negative margins exceeding 50%; 103 hospitals would have negative margins exceeding 25%.
- Congress provides protections for SCHs because if these hospitals were to fail, residents of the communities they serve would be without hospital services.





Medicare Extenders

- Extension of exceptions process for Medicare therapy caps
 - ✓ Extended the process allowing exceptions to limitations on medically necessary therapy. Extended until Dec. 31, 2012.
- Extension of payment for the technical component of certain physician pathology services.
 - ✓ Extended provision that allows independent laboratories to bill Medicare directly for certain clinical laboratory services. In budget deal and expires June 30, 2012 then phased out.
- Extension of the work geographic index floor under the Medicare physician fee schedule.
 - ✓ Extended a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. In budget deal and expires Dec. 31, 2012.

Medicare Extenders

- Extension of ambulance add-ons
 - ✓ Extended bonus payments made by Medicare for ground and air ambulance services in rural and other areas. Included in budget deal, expires Dec. 31, 2012 and requires GAO/MedPAC analysis.
- Extension of physician fee schedule mental health add-on
 - ✓ Increased payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent. NOT EXTENDED.

Other Extenders

A second group of “extenders” are set to expire at various points in 2012:

- **Medicare Dependant Hospital**
 - ✓ ACA reauthorized the Medicare Dependant Hospital Program. To be classified as an MDH, a rural hospital under 100 beds must have at least 60 percent of its days or discharges covered by Medicare Part A. MDH classification payments were extended in the Affordable Care Act. MDH is scheduled to expire for discharges occurring on or after October 1, 2012.
- **Extension of improved payments for low-volume hospitals**
 - ✓ Applied a percentage add-on for each Medicare discharge from a hospital 15 road miles from another hospital that has less than 1,600 discharges during the fiscal year. The Affordable Care Act § 3125 made this policy effective through fiscal year (FY) 2012.

- Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas
 - ✓ Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals. Medicare and Medicaid Extenders Act of 2010 extended this policy through July 1, 2012.
- Extension of Community Health Integration Models
 - ✓ The Affordable Care Act temporarily removed the cap on the number of eligible counties in a State that can apply for the program. Valid through FY 2012.
- Extension of Payment for Qualifying Hospitals in Low Spending Counties
 - ✓ 1109 of the Health Care and Education Reconciliation Act of 2010 provides for additional funding of \$400 million in FY2011 and FY2012 for hospitals located in counties that rank in the lowest quartile for Medicare Parts A and B per capita spending. This funding will expire at the end of FY 2012.



Offsets

- Bad Debt Reduction: Reduce bad debt reimbursement for ALL facilities to 65%. CAH and RHC (and all other facilities currently receiving 100%) will draw down over 3 years
- “Rebase” DSH payments: Rebase Medicaid DSH payments to States starting in 2021
- “Rebase” Clinical Laboratory Payments starting in 2013
- Reduce funding for Public Health and Prevention Fund
- Technical correction for FMAP Disaster funding



IPPS FY 2013 NPRM

- Overall, average payment increase of 0.9%
- Rural hospitals disproportionately harmed by payment formulas:
 - 0.5% cut for rural hospitals
 - 1.2% increase for urban > 1M people
 - 0.9% increase for other urban

R-HOPE and Extender Letter

- S. 1680, HR 3859 The Rural Hospital and Provider Equity Act of 2011, expands these vital provisions
- Cathy McMorris Rodgers and Mike Thompson sent [dear colleague letter](#) to Conference Committee urging them to extend these provisions.
- NRHA encourages cosponsorship of this legislation and cosigning this letter.



Senate Rural Health Caucus Letter



- Ask your Senator to support the [Dear Colleague Letter](#) authored by Senators Conrad and Chuck Grassley
- Call today!



How we fight it...

- Congress (especially conferees) need to know how important these programs are.
- Need to know that an investment in rural makes fiscal sense.





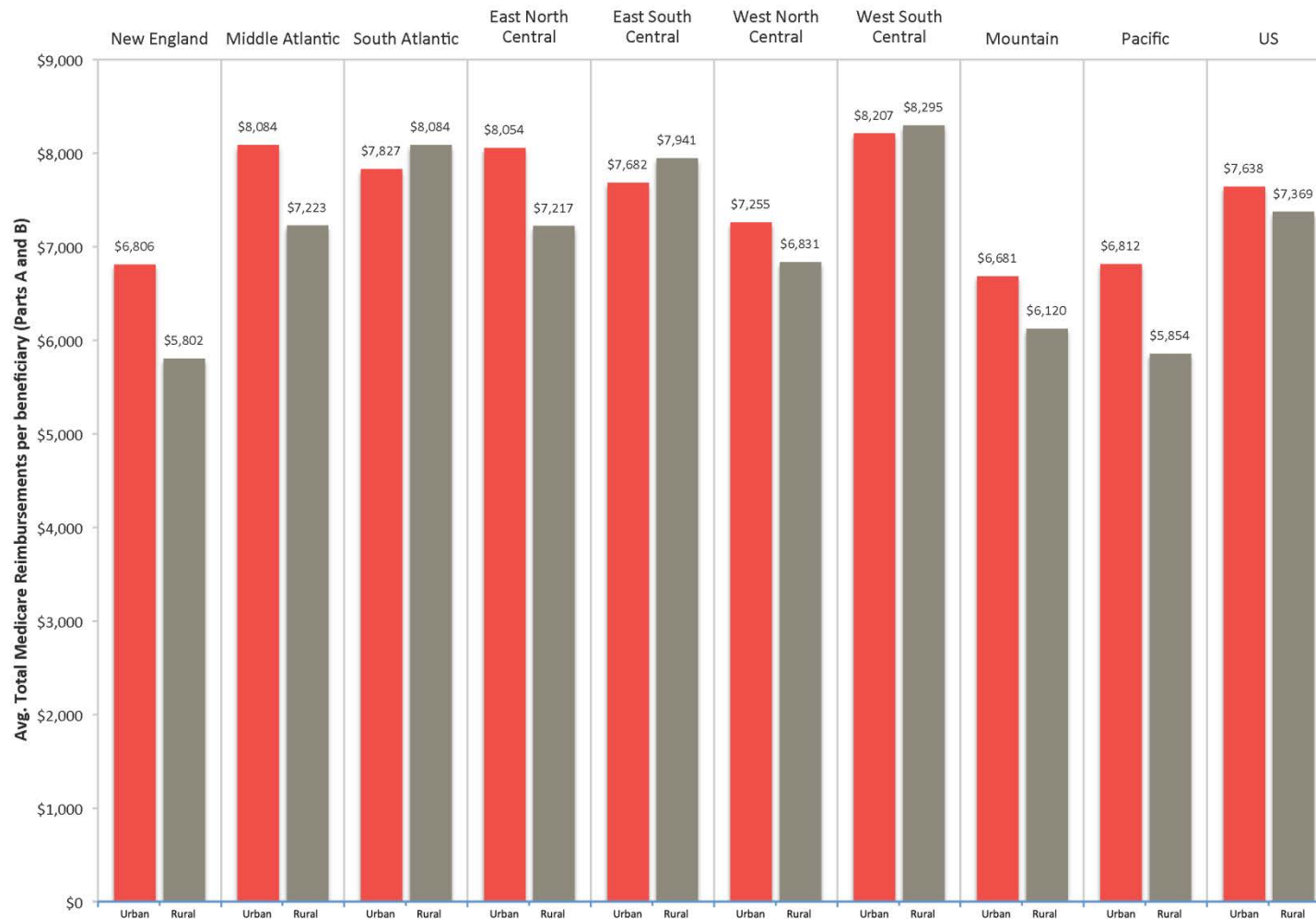
Rural Relevance Under Healthcare Reform Study

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 including the opportunity for savings if all urban populations could be treated at the rural equivalent

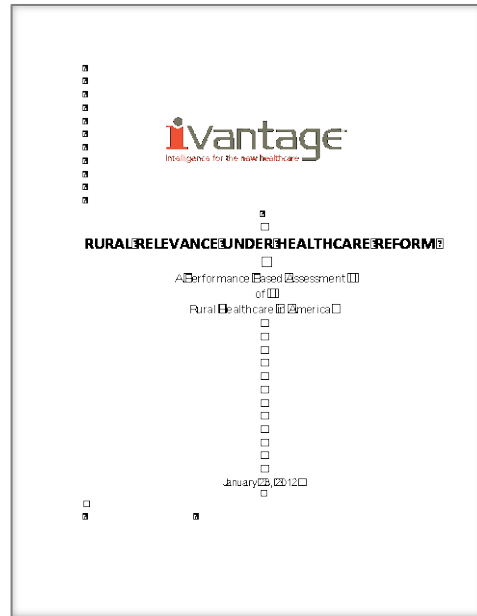
Rural vs. Urban Medicare Payments

Average Medicare Beneficiary Payments for IP, OP and Physician Services by CMS Region (2010)





Your voice. Louder.



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

<http://www.ivantagehealth.com/rural-relevance-under-healthcare-reform/>

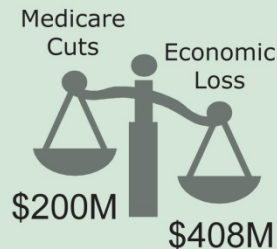
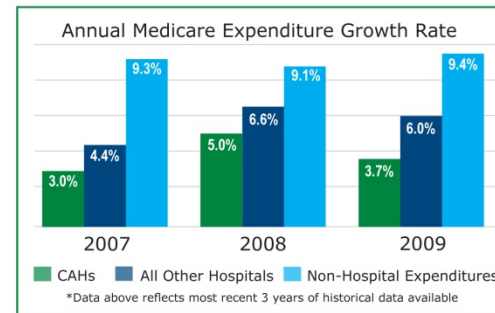
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Medicare 2% Sequestration - CAH Impact

Under the Budget Control Act of 2011, if congress fails to meet the \$1.2T budget reduction goal by November 23, 2011 an automatic sequestration process will reduce government spending programs, including up to a 2% reduction to Medicare. Decreasing Medicare payments to Critical Access Hospitals (CAHs) will push many CAHs to the brink of closing their doors.

CAHs are rural hospitals certified to receive Medicare payments equal to 101% of allowable cost. Despite CAHs representing **over 26% of all community hospitals, Medicare expenditures to CAHs are less than 2% of the entire Medicare budget.** Medicare payments to non-hospital services grow at over twice the rate of CAHs.

By the end of 2011, about 1,340 hospitals will carry the CAH designation. Medicare will contribute an average of \$7.5M to each CAH's net patient revenue (approximately 42% of all revenue). A 2% Medicare sequestration on the \$10B annual payments will eliminate \$200M of desperately needed revenue to CAHs nationwide.



Due to the weak economy and lack of necessary capital investment, an ever-increasing number of CAHs are operating at a loss. This figure escalated to 41% in 2009 and continues to grow. These facilities operating in the red employ approximately 138,000 jobs. Without additional working capital investment, many of these hospitals may be forced to close their doors. The rural economies supported by CAHs cannot afford to eliminate the only nearby hospital and one of the largest employers in each community.

A 2% reduction in Medicare payments to CAHs will force about 40 hospitals that are currently scratching out a minimal positive margin to operate at a loss. With each hospital averaging 143 employees, the resulting impact will put another 5,764 hospital jobs at risk. If all 40 CAHs closed their doors, the rippling effect in these communities alone could total near 8,000 jobs with an economic loss of over \$400 million.

Additional CAHs in Jeopardy from 2%

Hospitals	40
Hospital Jobs	5,764
Hospital Salaries	\$334M
Local Jobs Impact	7,955
Local Economic Impact	\$408M

Rural Federal Update

REGULATORY ISSUES



FY 2013 IPPS NPRM



- Quality Reporting:
 - Makes changes to four different quality reporting programs (IQR, LTCH, IPF, CA)
 - Add 5 measures to IQR program for 2015
 - Add 1 new measure for FY 2016 (safe surgery checklist)
 - Remove 17 measures for FY 2015
 - 59 measures for FY 2015s
 - 60 measure for FY 2016



Your voice. Louder.

FY 2013 IPPS NPRM

- Readmissions for FY 2013
- CMS still ignores Congressional intent that readmissions be modified to explicitly exclude unrelated and planned admissions
- CMS to release to PPS Hospitals confidential readmission scores by June 20, 2012.

National Priorities Partnership

6 Priority Areas



- Engage PT and families in managing health and decisions about care
- Improve health of the population
- Improve safety/reliability of HC system
- Ensure patients receive well-coordinated care within and across boundaries
- Guarantee appropriate end-of-life care
- Eliminate overuse while ensuring delivery of appropriate care



Your voice. Louder.

Small Hospital Quality Metrics

- Relevant quality measures for small, rural hospitals
- Published by University of Minnesota and FLEX Monitoring Team.
- [Released January, 2012](#)



Key Findings

- A comprehensive set of quality measures are relevant for Critical Access Hospitals (CAHs), including measures addressing appropriate care for inpatients with specific medical conditions, global measures addressing appropriate care across multiple medical conditions, and Emergency Department measures.
- Although CAHs have low volumes of patients for some measures, the measures are relevant because they address serious conditions, are based on strong evidence, and reflect the standard of care that all hospitals should aim to provide for every patient.

Key Findings



- Many relevant quality measures are now ready for reporting. Other measures need specifications to be finalized and/or a data reporting mechanism to be established; these could be reported starting in January 2013.
- It would significantly reduce the reporting burden for CAHs if all entities involved in regulation, accreditation, and payment would agree to accept a single set of quality measures with common specifications. Implementation of a common set of CAH quality measures and a unified data reporting structure will require coordinated actions by multiple organizations.
- To motivate improvement in the quality of care and help patients make informed decisions in selecting health care providers, all CAHs should publicly report on relevant quality measures.



Meaningful Use Stage 2 NPRM

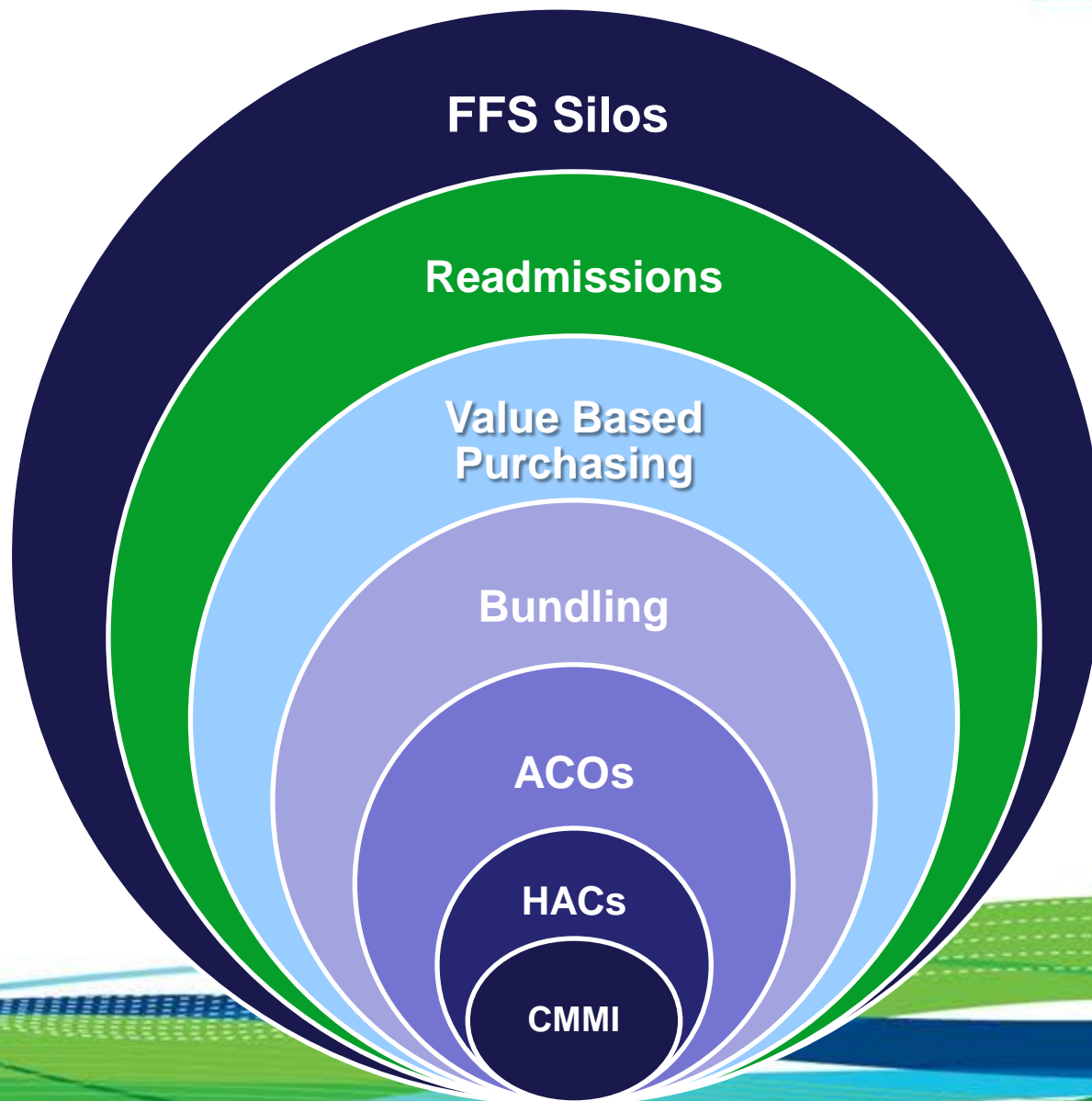


- Comments due May 7!
- [NRHA Comment Letter](#)
- Rural specific issues addressed
- Key features:
 - Quality metrics reporting
 - CPOE
 - Patient Portal, including access to broadband
 - Care transition standard

Layers of Regulatory Complexity



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Summary

Changes in Medicare and Medicaid payment and delivery systems will have the most direct impact on providers

- There will be increased pressure on **operating margins** due to payment reductions.
 - Generation of and access to capital more difficult
- **Physician alignment** will become increasingly important
 - Physician integration will be necessary to support accountable care organizations or medical home models
 - Capital will be required to implement a robust physician alignment strategy
- **Quality will drive reimbursement levels** and will become a differentiator in the market
 - Quality reporting will require the development of a more **sophisticated infrastructure**
 - **Health Information Technology**

THANK YOU

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