Improving Access to Quality Medical Care Webinar Series

Presented by

Southwest Telehealth Resource Center and Arizona Rural Health Association

Welcome

- AZ, UT, CO, NM & NV FLEX Programs
- Arizona Rural Health Association Members
- Fellow Rural Health Association Members
- All other participants

The **Arizona Rural Health Association** & the **Southwest Telehealth Resource Center** welcomes you to this free webinar on the implementation & practice of telemedicine.

The practice & deliver of healthcare is changing, with an emphasis on **improving quality, safety, efficiency, & access to care**.

Telemedicine can help you achieve these goals!

Webinar Tips & Notes

- Mute your phone &/or computer microphone
- Time is reserved at the end for Q&A
- Please fill out the post-webinar survey
- Webinar is being recorded
- Recordings will be posted on the SWTRC & CRH websites

http://www.southwesttrc.org

http://crh.arizona.edu/

"2015 Mid-Year Rural Health Policy Roundup"

Maggie Elehwany, JD
Government Affairs and Policy Vice President
National Rural Health Association (NRHA)
September 15, 2015

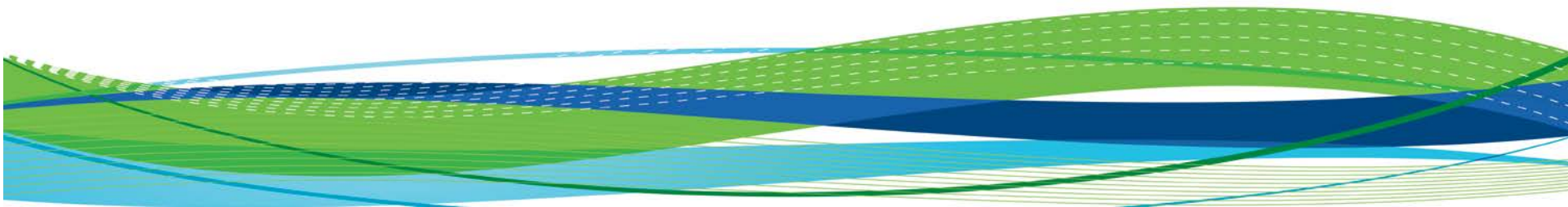
NRHA Mission

The National Rural Health Association is a national membership organization with more than 18,000 members whose mission is to ***provide leadership on rural issues*** through advocacy, communications, education and research.

NRHA

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

NRHA is non-profit and non-partisan.



Today

- 114th Congress and Telehealth Legislative Advancements.
- NRHA's campaign on the rural hospital closure crisis.

Appropriations

Your voice. Louder.

- *More progress has been made to have Regular Order: 12 spending bills on the floor of each chamber, conference committees, and measures signed into law*
  - *Labor –HHS traditionally last considered*
  - *President issued Veto blanket threat*
  - *First to the President – MilCon/VA*
- *Despite progress, so many fights ahead…: Planned Parenthood, grumbling over restrictive spending levels and a number of controversial policy riders could halt appropriators' momentum.*
- *Time consuming process – bills generally considered in open amendment process* (can take weeks per bill

Another Fiscal Cliff

Increasingly likely that Congress will pass a short-term spending bill in September that would expire during the holiday season.

That could mean the two upcoming fiscal battles — keeping the government funded and raising the debt ceiling — could merge into a single, staggering task.

SGR Passes (finally!) Surprisingly Congress still has an appetite for health care legislation

Your voice. Louder.

- Ways and Means - - Major hospital bill in October.
  - Rural health hearing in July 31st

- Senate Finance - -smaller, non-controversial health care packages.

SGR Repeal and…Rural Impacts

Your voice. Louder.

Two-Year Extension:

- **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**
- **Community Health Centers (CHC), National Health Service Corps Fund (NHSC), and Teaching Health Centers**

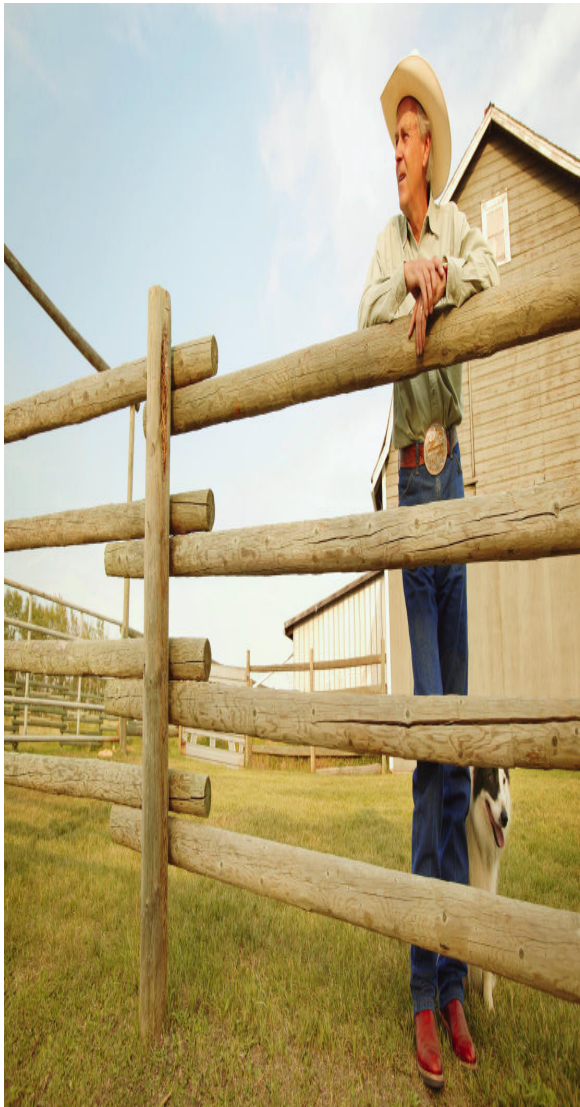
Why are our legislative challenges so tough?

NRHA
Your voice. Louder.

- Loss of champions;
- MANY new members who won't know why certain rural payments exist;
- Strong fiscal conservative movement noted;
- CMS negative attitude toward CAHs;
- Confusing rural payment system - - many see payments as "bonuses"

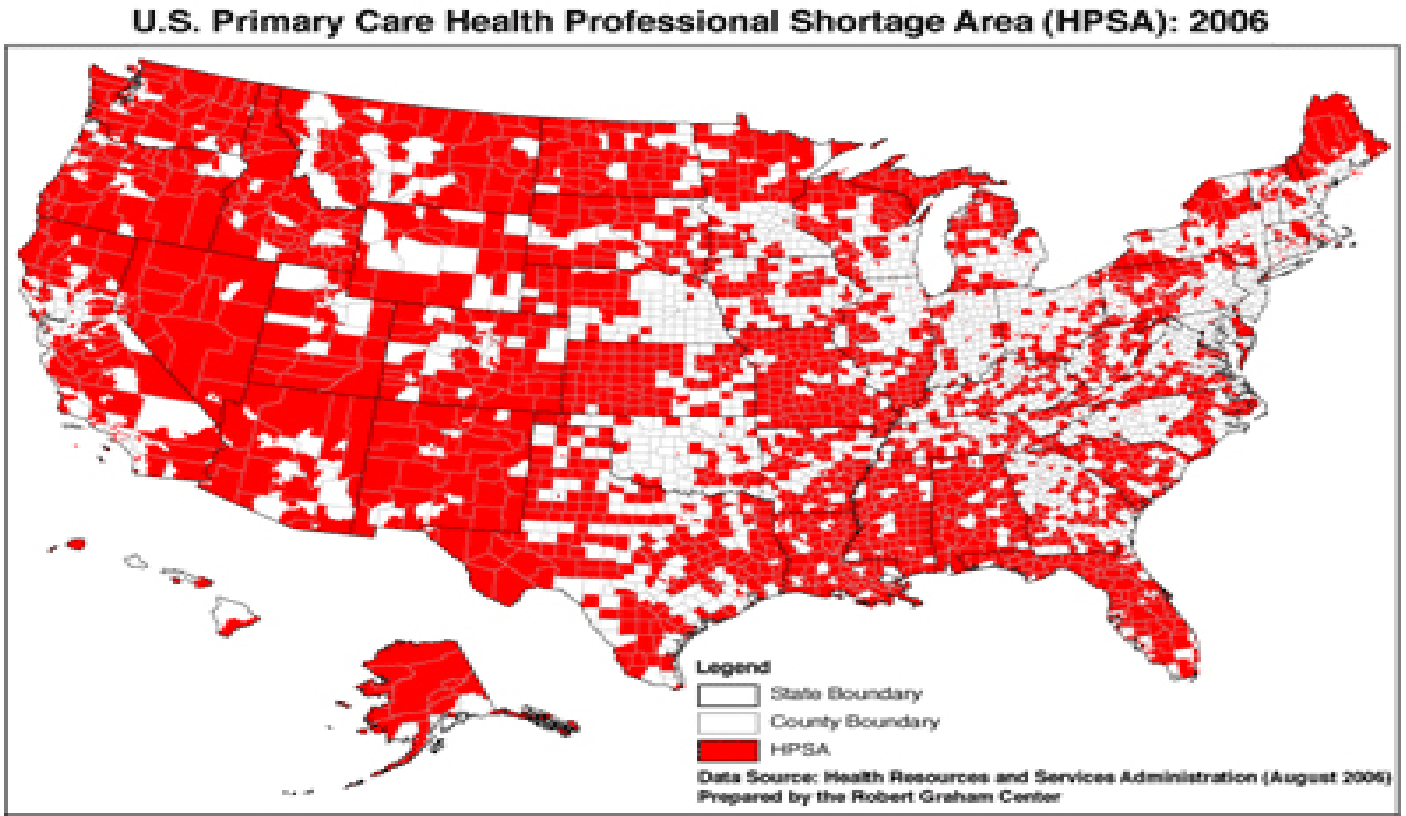
Rural Patients

- 62 million rural Americans rely on rural health providers.
- 20 percent of the population lives in rural America, yet they are scattered over 90% of the landmass.
- Extreme distances, challenging geography and weather complicate health care delivery.
- "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.



Workforce Shortages

- "Access to Quality Health Care" is the number one health challenge in rural America. Rural Healthy People 2020
- 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.



Alleviating shortage crisis/Saving Costs/ Improving Quality

- Telemedicine can deliver services efficiently, reduce costs and travel time for consumers, decrease medical errors, and enable health care providers to share critical information.

- Ten studies have been done on cost savings associated with the treatment of heart failure. Each study found significant savings, including, in one case, savings up to 68 percent.

- For every one percentage point increase in broadband penetration rate, employment is projected to increase by .2 to .3 percentage per year.

- *"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).* ***RUPRI Policy Brief, December, 2008.***

Telehealth Enhancement Act

- HR 2066
  - Incentives for Medicare's hospital readmission reduction program;
  - Ensuring the use of telehealth in health homes and medical homes;
  - Allow flexibility in ACO coverage of telehealth; and
  - Add additional sites to be considered originating sites for purposes of payments for telehealth services under Medicare such as a 'home telehealth site.'

Medicare Telehealth Parity Act

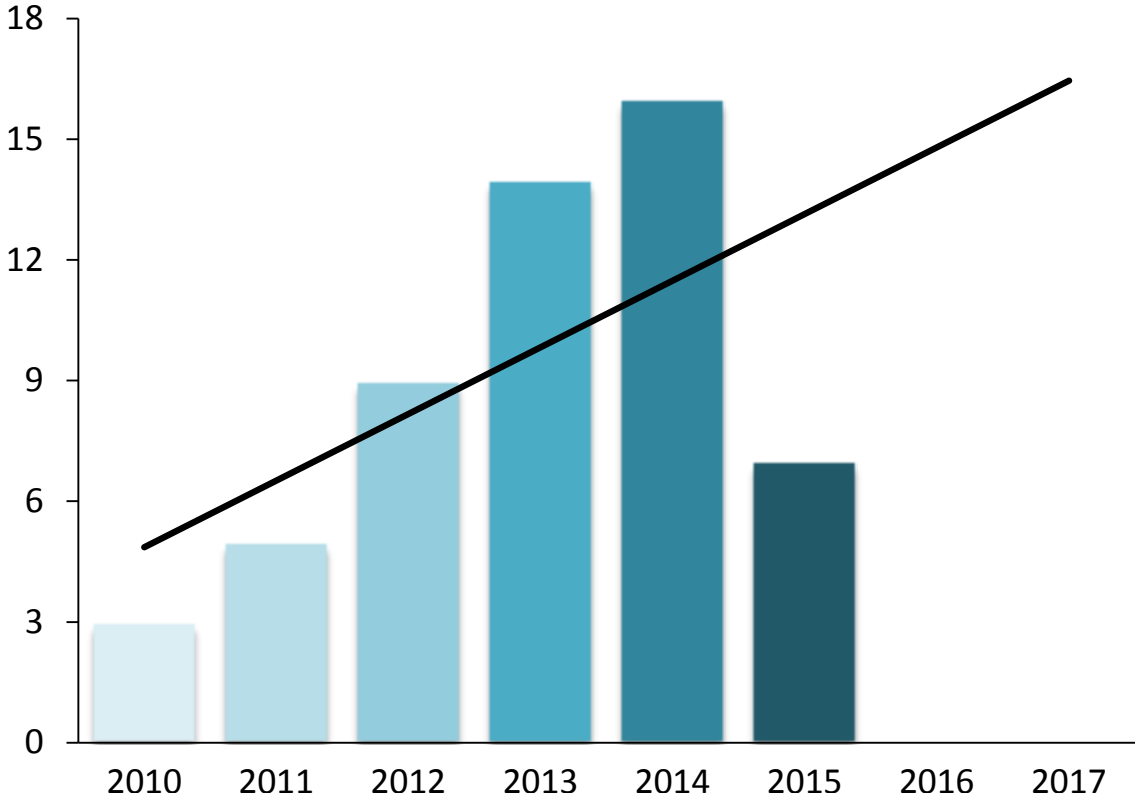
HR 2948

- **Phase 1** expands qualifying originating sites to include all federally qualified health centers and all rural health clinics, and the qualifying geographic location also includes counties in Metropolitan Statistical Areas with populations fewer than 50,000. Additionally, Phase 1 expands telehealth coverage to include services provided by certified diabetes educators, respiratory therapists, audiologists, occupational therapists, speech language therapists, and physical therapists. Phase 1 also provides Medicare coverage of asynchronous (store & forward) telehealth services across the country (not just Alaska and Hawaii).
- **Phase 2** expands qualifying originating sites to include a home telehealth site, and the qualifying originating geographic location include counties in Metropolitan Statistical Areas with populations of 50,000-100,000.
- **Phase 3** expands qualifying originating geographic locations include counties in Metropolitan Statistical Areas with populations above 100,000. Additionally, the Act authorizes CMS to develop and implement new payment methods for these telehealth services.
- The Act also includes provisions for Medicare coverage of remote patient monitoring services (RPM) for covered chronic care conditions, and home dialysis services for those with end stage renal disease.

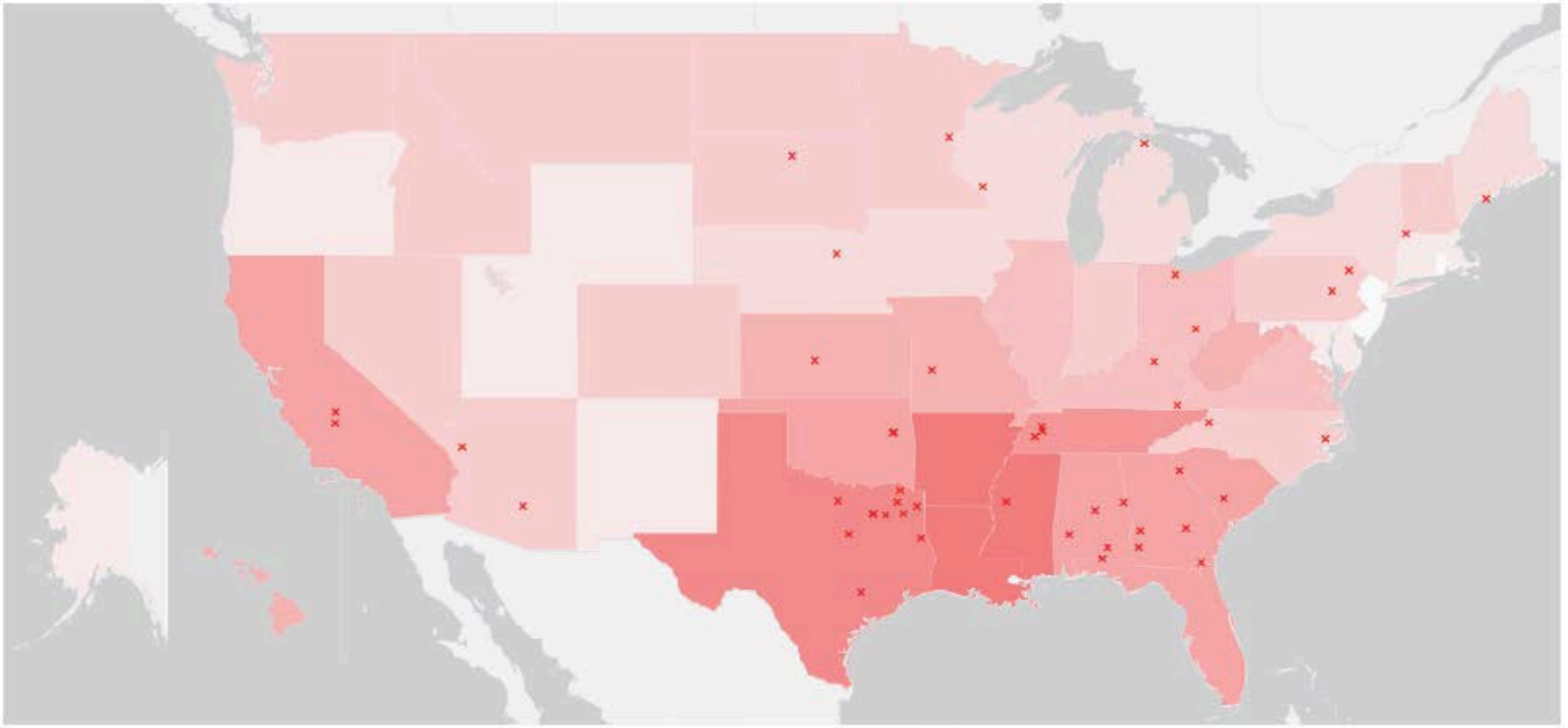

STEWART WEBSTER HOSPITAL
CALHOUN MEMORIAL HOSPITAL
SAC-OSAGE HOSPITAL
CHARLTON MEMORIAL HOSPITAL
MAIN ENTRANCE
CLOSED
GOOD SHEPHERD
LINDEN
LAKE WHITNEY
MEDICAL CENTER
LOWER CONEE
EMERGENCY
Mid-Valley Hospital
EMERGENCY ENTRANCE
Shelby Regional Medical Center closed on July 11, 2013 at noon
If you need medical attention, go to the nearest hospital or call 911.
If your doctor needs a copy of your medical records,
Humboldt General Hospital
RENAISSANCE HOSPITAL
North Adams

A Rural Hospital Closure Crisis

- 57 Rural Hospitals have closed since January 2010;
- Rate of closures are escalating;
- 283 rural hospitals are vulnerable.



Vulnerability Index: Rural Closures and Risk of Closures



The **Vulnerability Index™** identifies **283** rural hospitals statistically clustered in the bottom tier of performance

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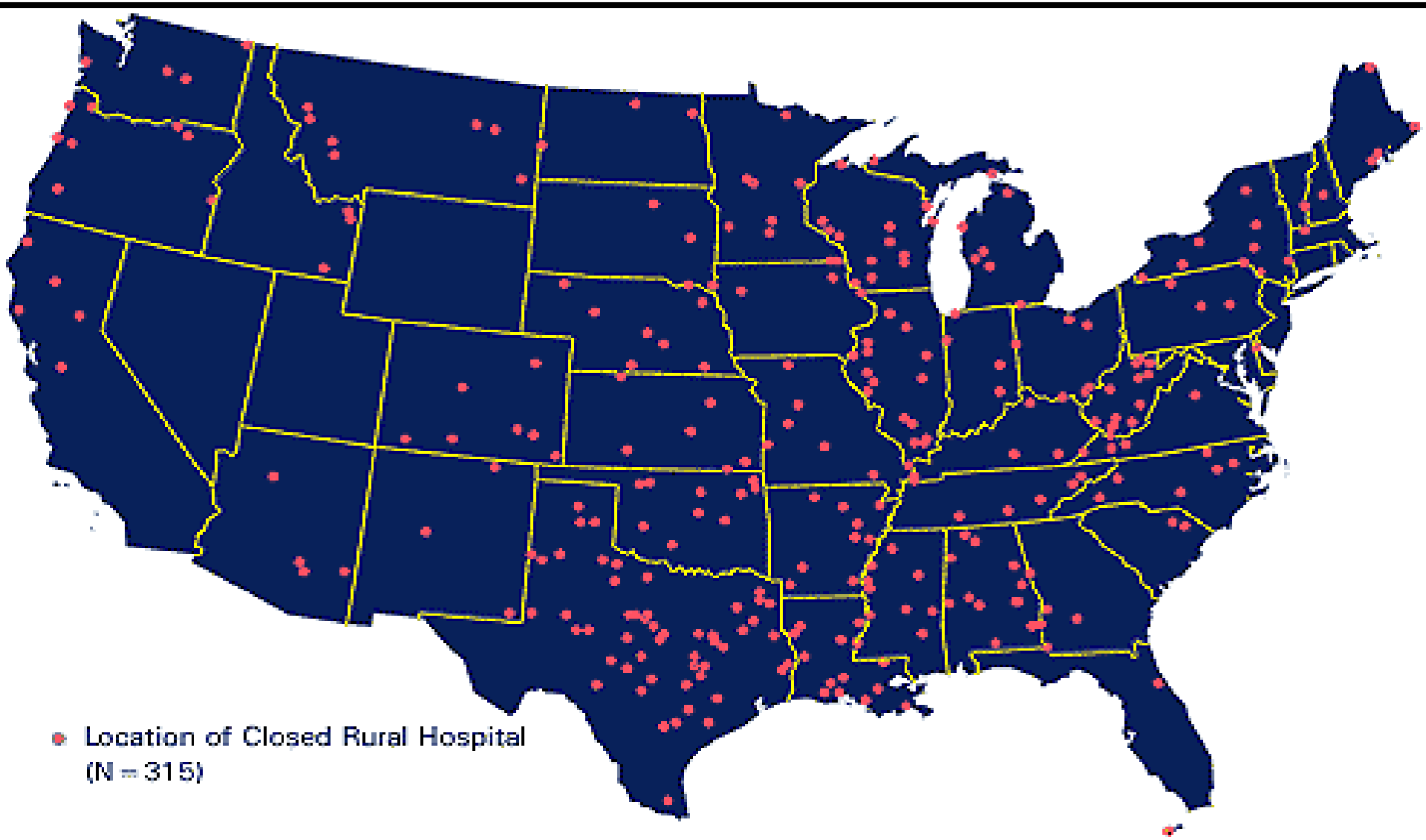
The researchers tell us…

- Most closures in South
- Annual number of closures increasing
- Most are CAHs and PPS hospitals (vs MDH and SCH) but more are rural PPS than CAHs.
- 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

Rural Hospital Closures: 1983-97



Impact of 283 Hospital Closures

700,000
Patient Encounters

36,000
Healthcare Jobs Lost

50,000
Community Jobs Lost

$10.6 Billion
Loss to GDP

Source: Hospital Strength Index- Vulnerability Index

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

Marketplace, April 2014

“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.”

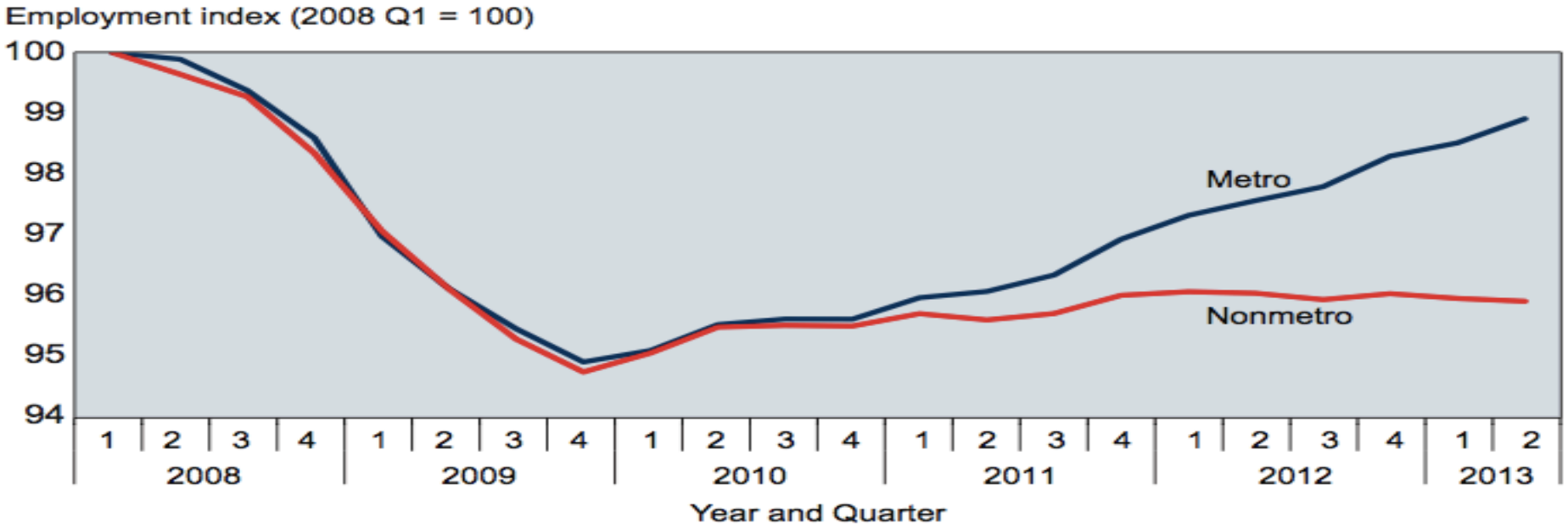
Mark Holmes, professor,
University of North Carolina

- 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

"The Real Loser of the Recession is Rural America" *The Washington Post, Nov. 2013*

- 90% of permanent job loss since recession focused in counties outside metropolitan areas (Daily Yonder)

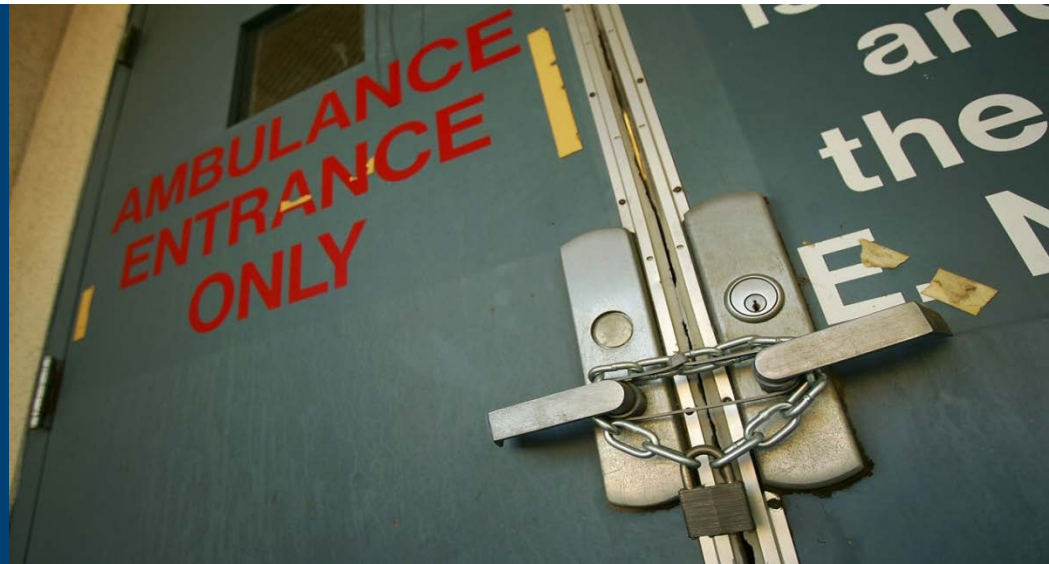
No net employment growth in nonmetro counties in 2012 and first half of 2013



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.

What Happens When a Town's Only Hospital Shuts Down?

- "It was a tragedy that stunned a small Texas town: 18-month-old Edith Gonzales, a grape lodged in her tiny throat, died in her desperate parents' arms because the county's only hospital and emergency room had closed for good a few months earlier." *US News and World Report, Nov. 2013*
- "The toddler's Aug. 12 death has starkly exposed the vulnerabilities of a rural community suddenly left without its longtime safety net." *Dallas News, Nov. 2013*



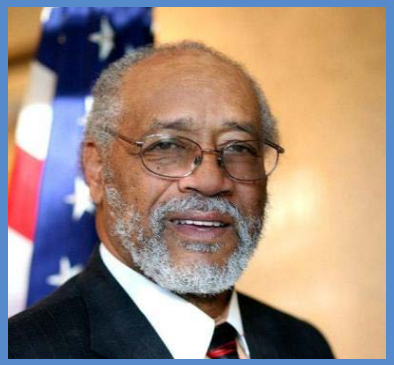
It's about the patients...

"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'Neil.

"[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.




MARCH FOR
RURAL HOSPITALS


SAVE
RURAL
HOSPITALS
Impact of 28
700,000
Patient Encounters
36,000
iVantage

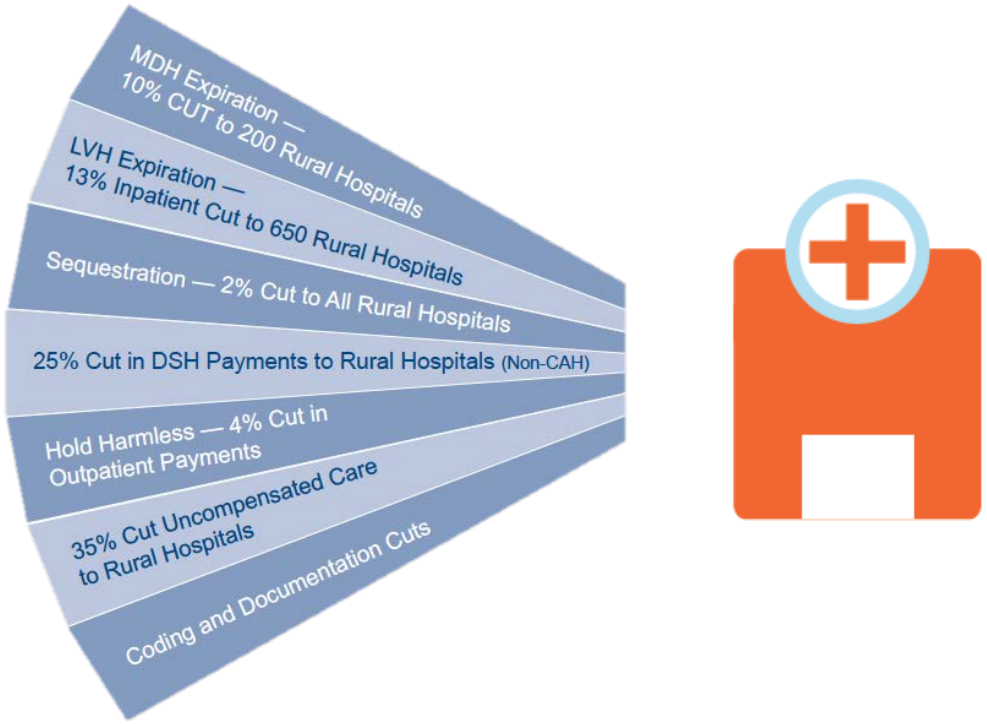
It's about access to care…

- 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

Why are Rural Hospitals Closing?

Policy Consequences **Impact** Rural Hospitals



THE BOTTOM LINE: 35%* of RURAL HOSPITALS OPERATING AT LOSS

- 69% of Rural Hospitals have negative *OPERATING profit.*

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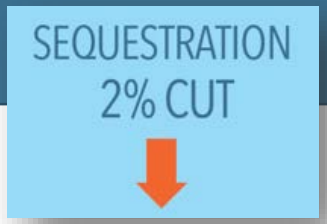
Sequestration **Impact** to Operating Margin



	Profitable	Switch	Unprofitable	Grand Total
CAH	358	27	917	1,302
Medicare Dependent	54	7	138	199
Sole Community	94	2	156	252
Standard Rural PPS	52	1	101	154
Urban	1,319	53	1,287	2,659
Total	**1,877**	**90**	**2,599**	**4,566**

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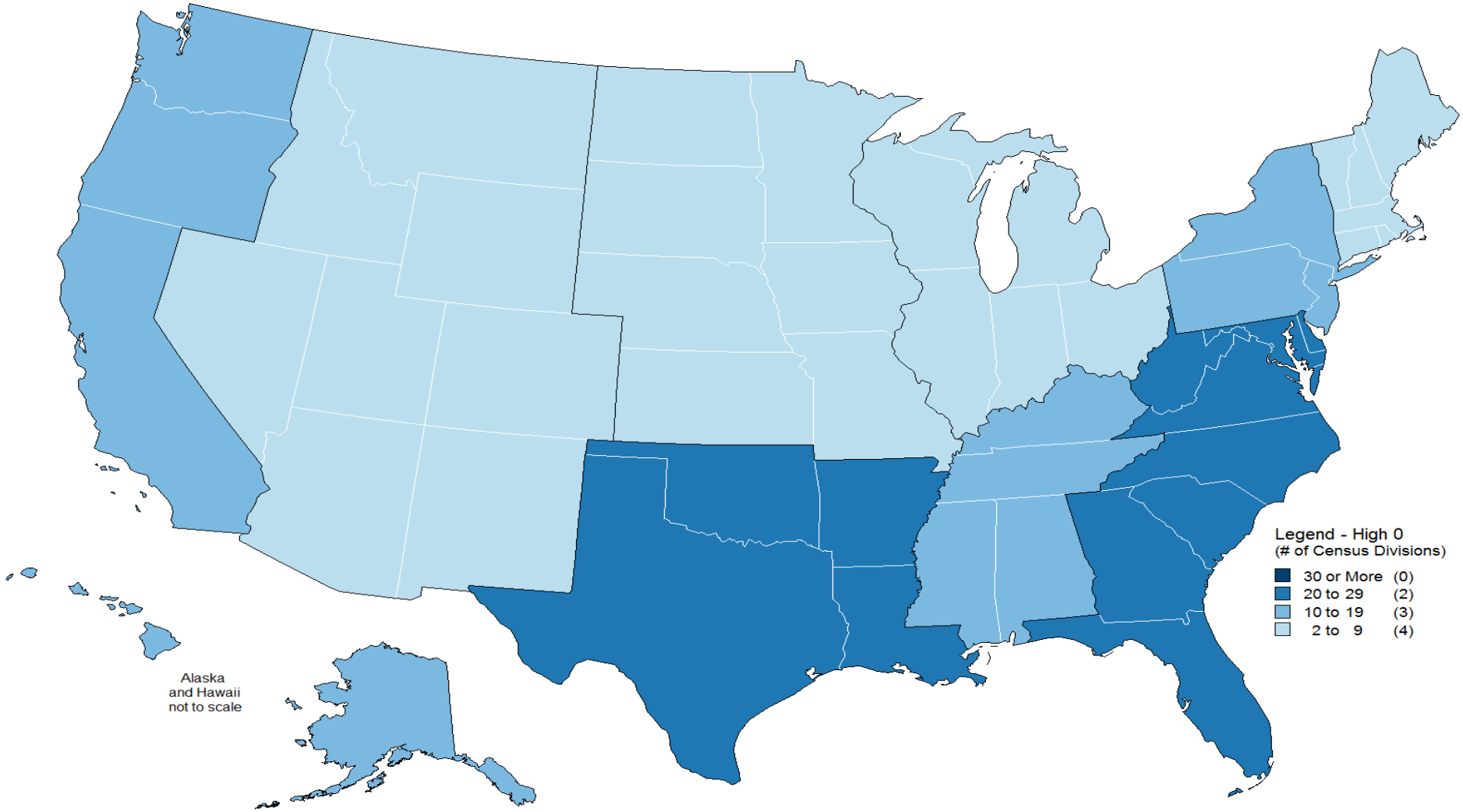
…And Congress and the Administration Continue to Propose More Cuts

- If Congress acts on any of the proposed cuts to CAHs, there will likely be a reduction of 20-30% in Medicare payments (depending upon proposal).
- If 20% reduction: 72% of CAHs would operate in negative financial margins; 39% would be at high or mid-high financial risk.
- If 30% reduction, 80% of CAHs would operate in negative financial margin; 45% would be a high or mid-high risk of financial distress.
- CAHs in the south see the sharpest increase in risk.

"Such a substantial reduction in financial viability could lead to an increase in the number of CAHs experiencing insolvency, bankruptcy or closure, with deleterious effects on the health and economic well-being of these communities."

CAHs at high risk of financial distress:

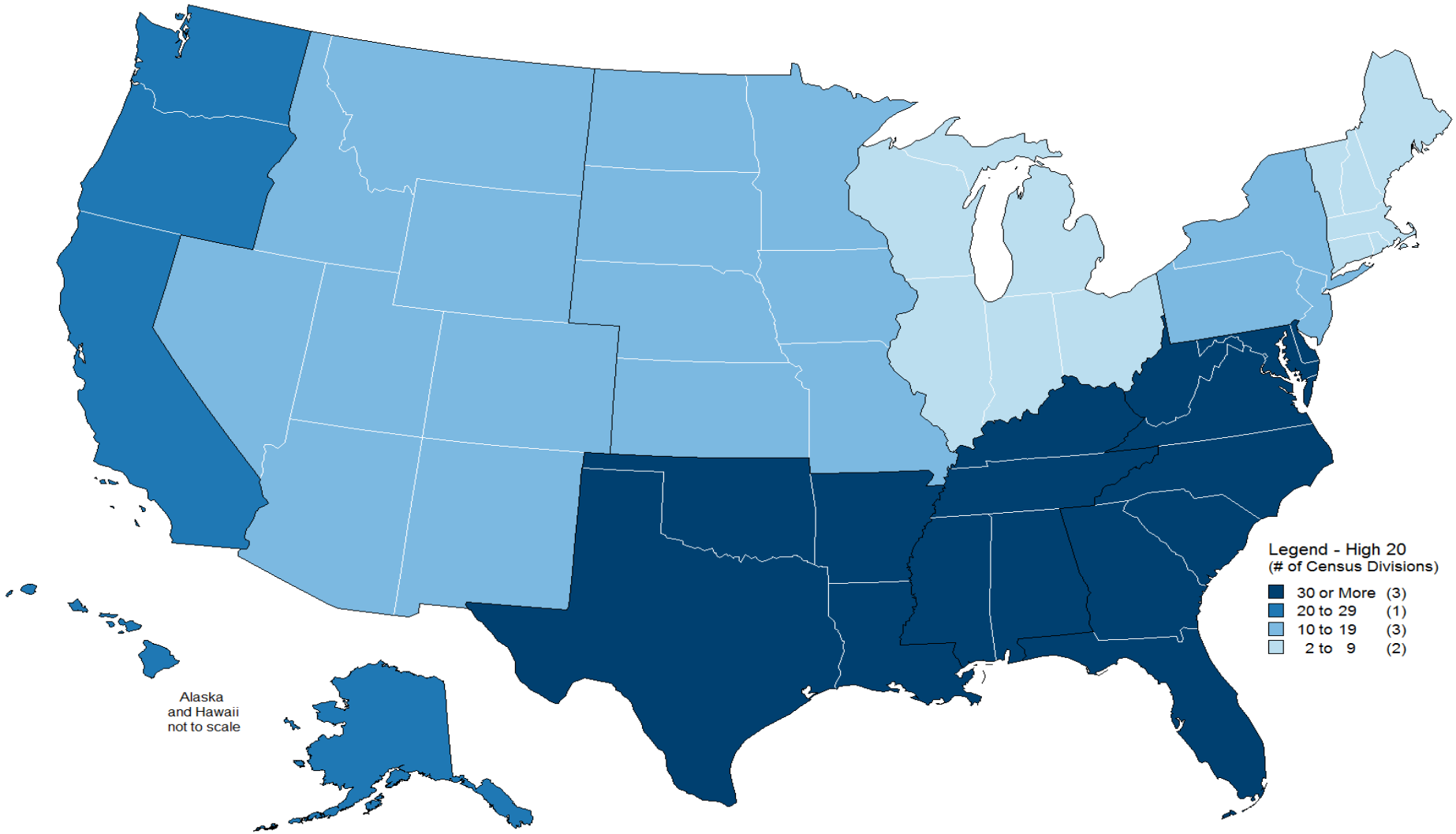
Status quo - No reduction in Medicare reimbursement



NC RHRP

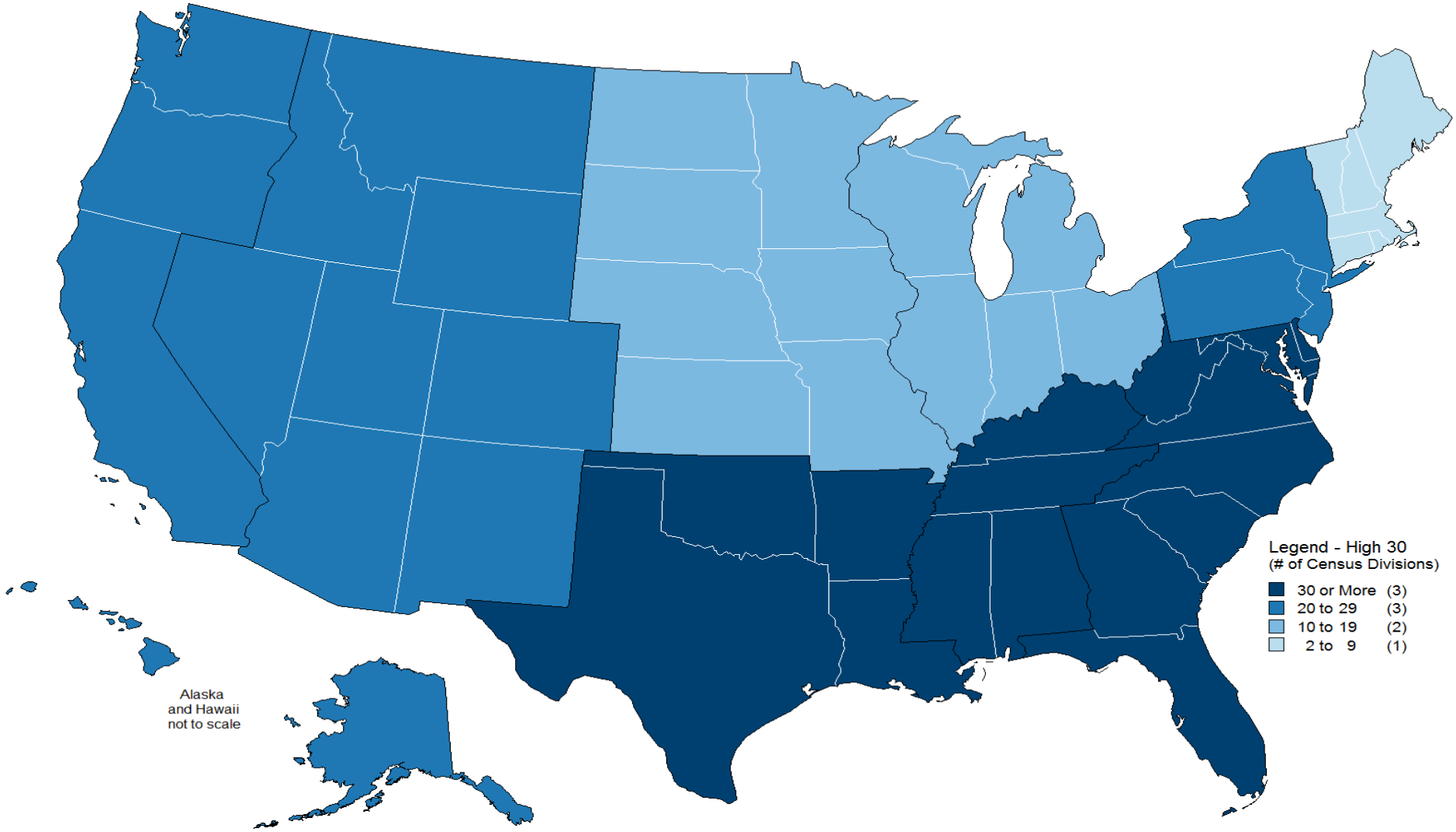
CAHs at high risk of financial distress:

20% cut in Medicare

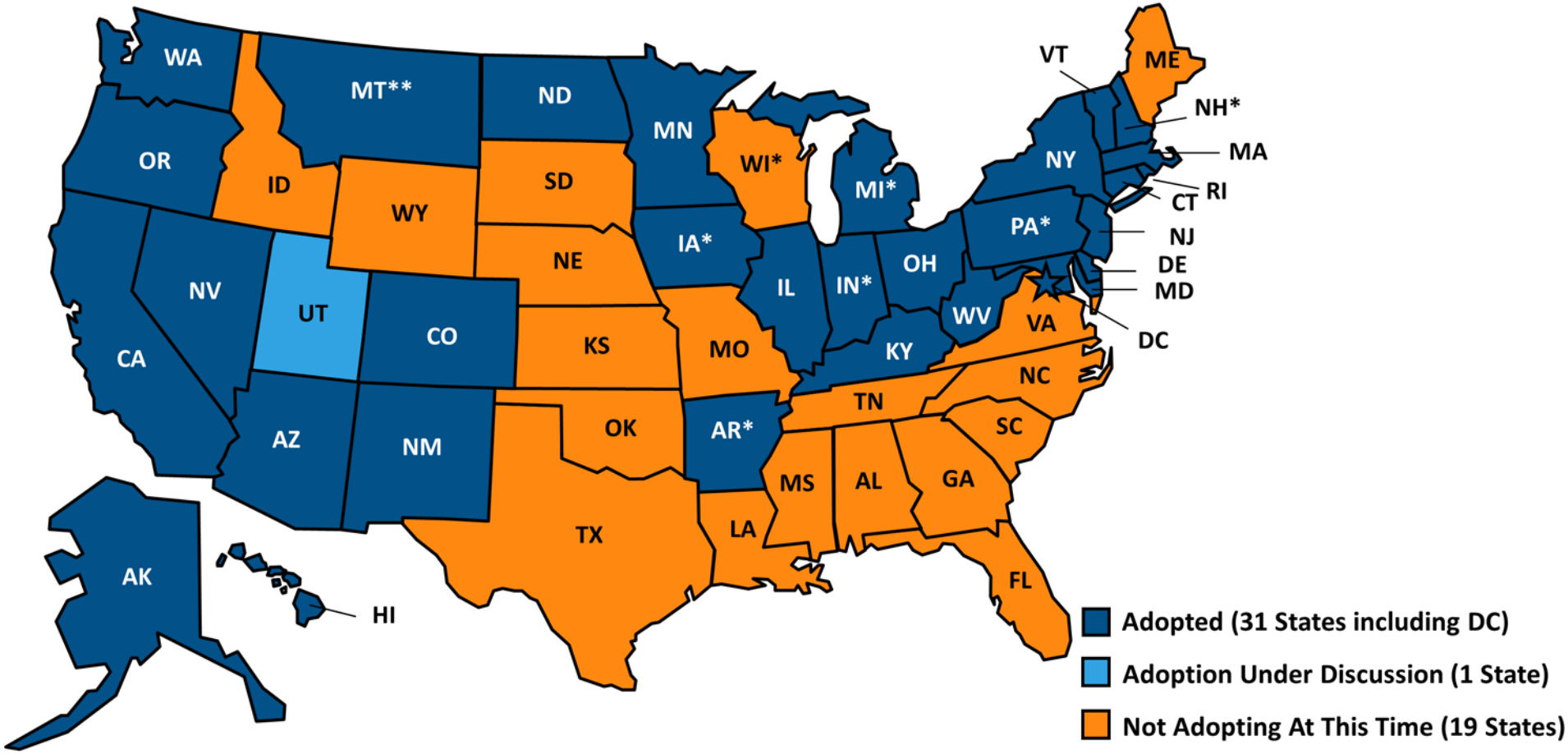


CAHs at high risk of financial distress:

30% cut in Medicare



Current Status of State Medicaid Expansion Decisions

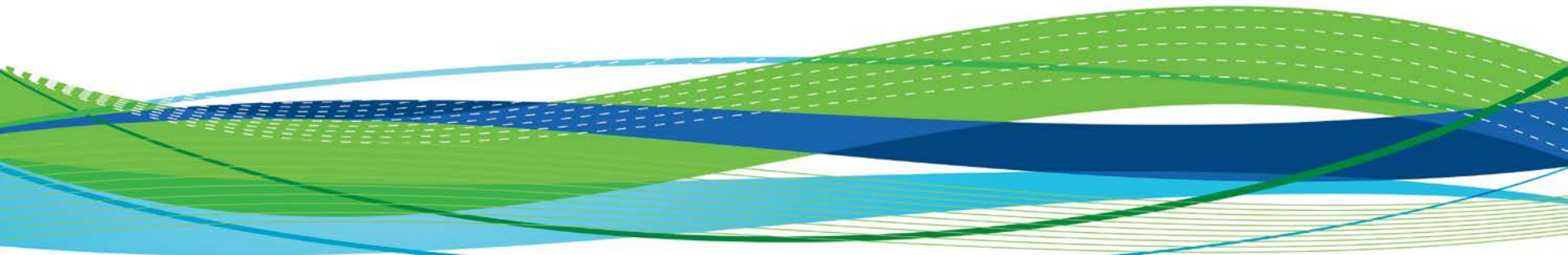


NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 1, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

How Does Medicaid Expansion Affect Insurance Coverage of Rural Populations

- A majority of the states with the largest percentage of population living in rural areas are not expanding, while nearly all of the least rural states are expanding.
- Rural, poor states are the least likely to expand Medicaid.
- The majority of rural residents in the U.S. live in states that are not expanding. Only 3 of the 11 states with the largest rural population have expanded (IA, KY, MI)
- There is a wider rural-urban insurance coverage that existed pre-ACA.

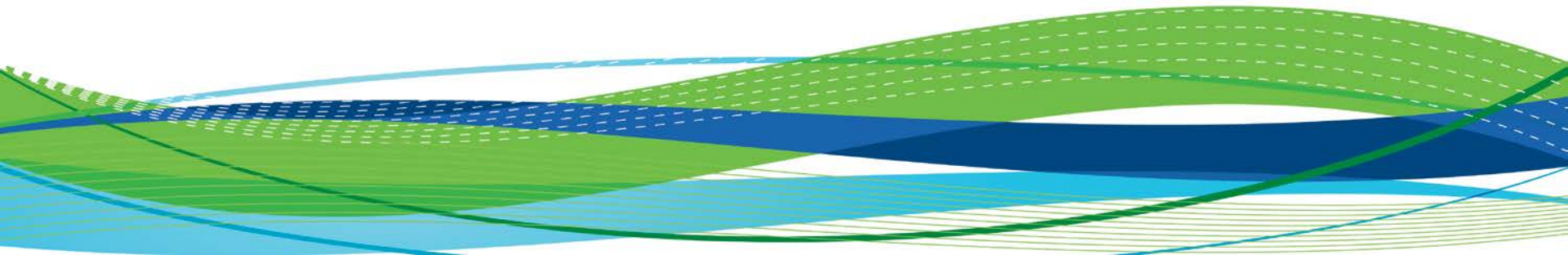


Our Campaign

NRHA

Your voice. Louder.

#SaveRural



We ask state offices to join us.

NRHA

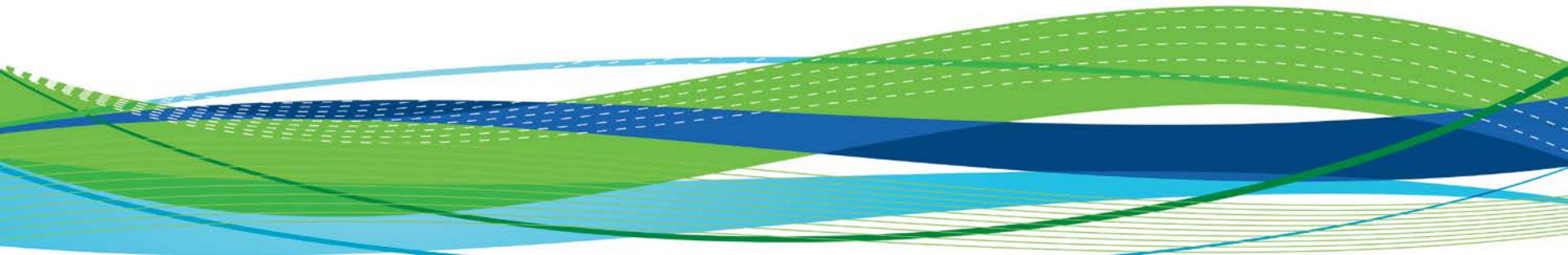
Your voice. Louder.

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.

@SaveRural…Fighting Back



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 Hospital

NRHA
Your voice. Louder.

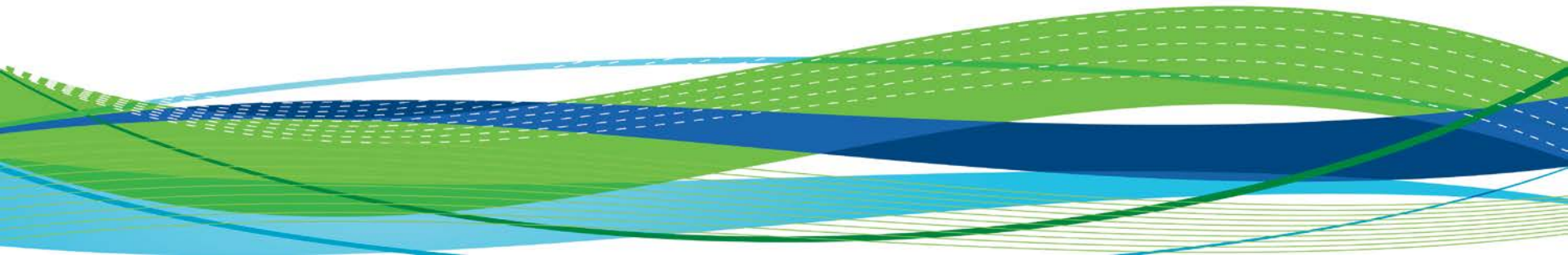
- 24/7 Emergency Services
- Meeting the needs of rural communities. Additional service based on community needs assessment: observation care, skilled nursing facility (SNF) care, infusion services, hemodialysis, home health, hospice, nursing home care, population health and telemedicine services.
- Primary Care – FQHC (or look alike) or Rural Health Clinic

- "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."

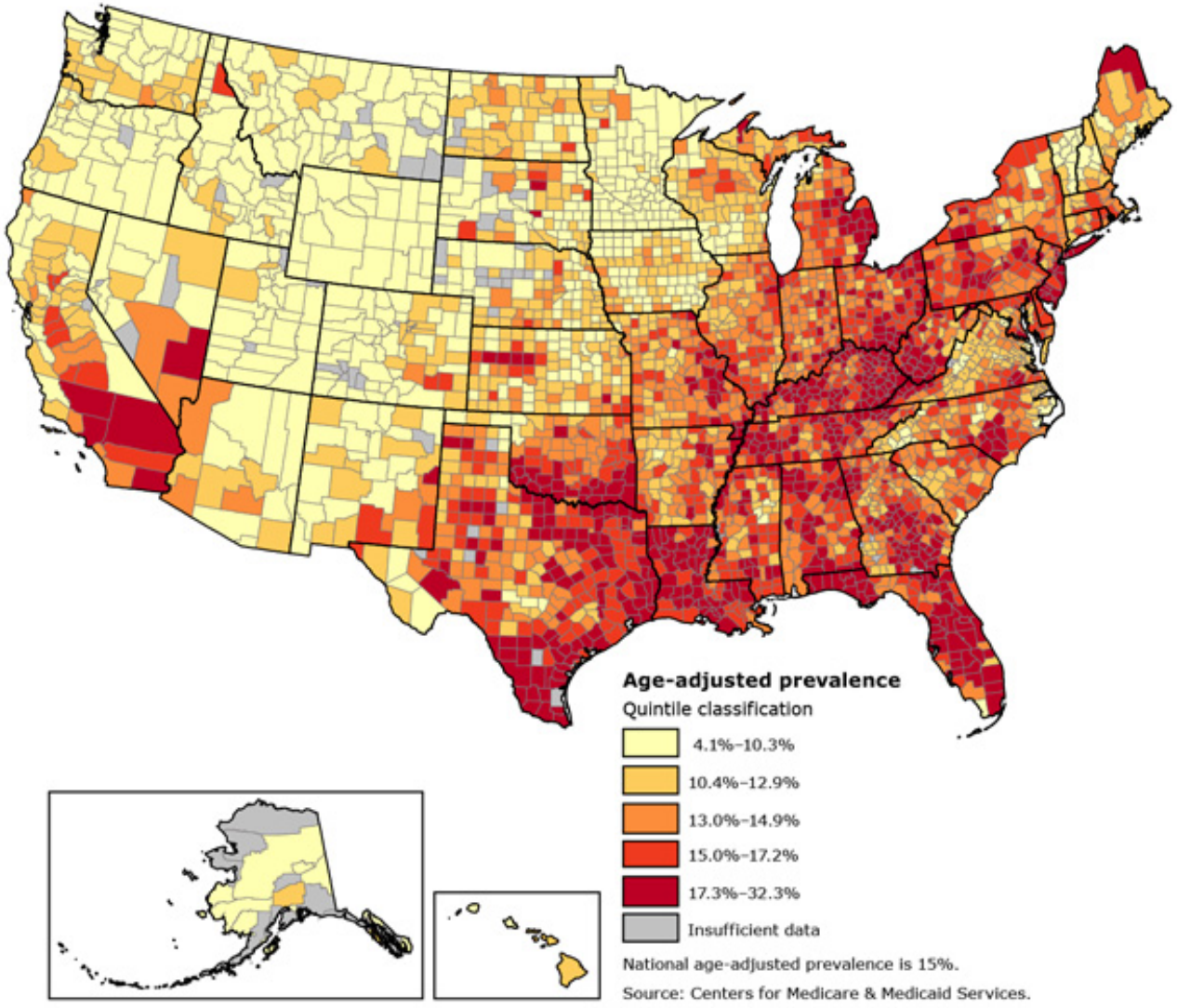
Senate Focus on Chronic Disease

- Major legislation forming.

- Stake holders submit information to Senate Finance Committee.
- Important to have rural at the table.



The Prevalence of Medicare Fee-for-Service Beneficiaries 65 Years or Older With 6 or More Chronic Conditions, by County, 2012



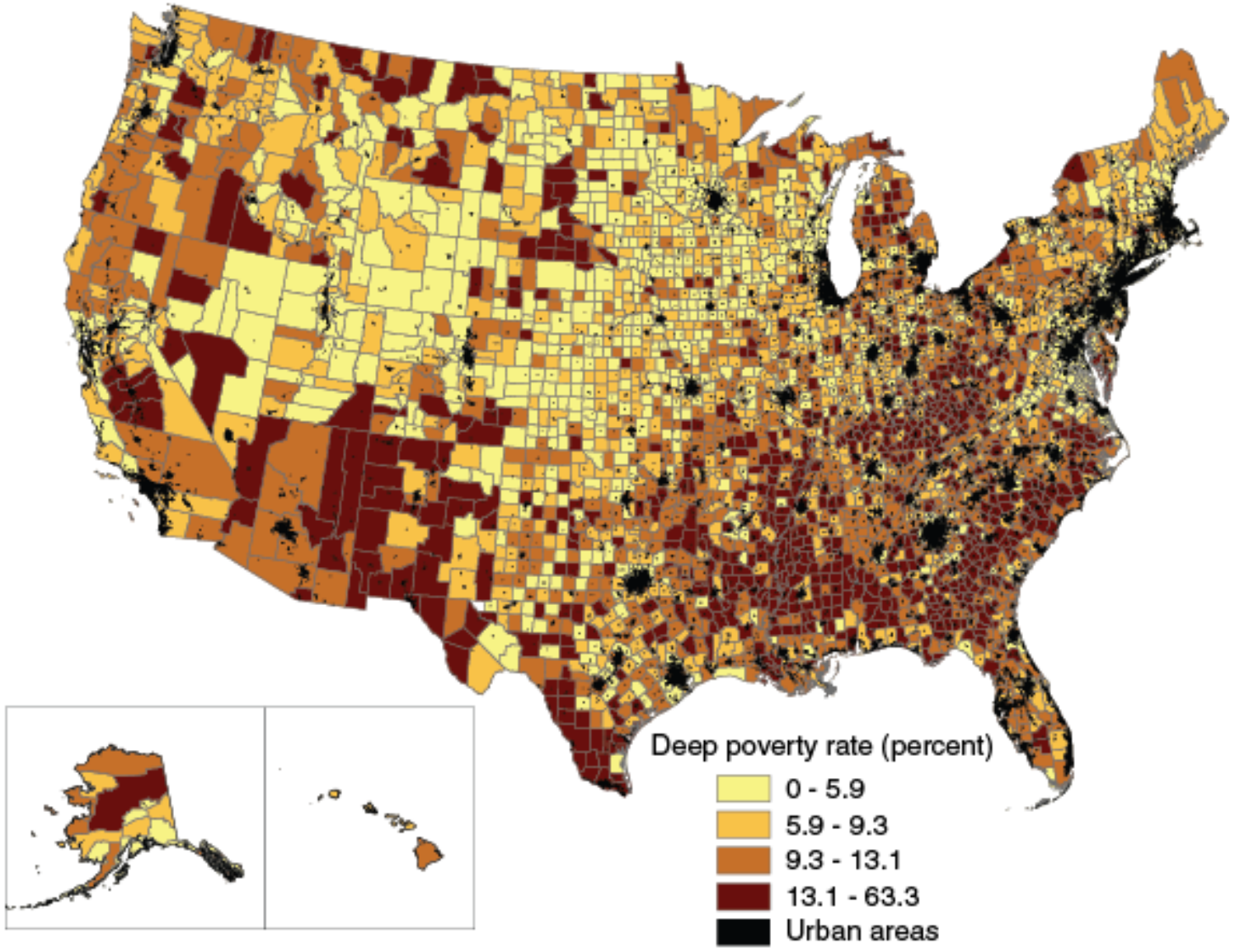
Childhood poverty initiative

- White House Rural Council – task force.
  - Through the White House Rural Council, HHS is coordinating efforts between the Administration for Children and Families, the Health Resources and Services Administration, and the Office of the Secretary to see what can be done to help provide health and human services to impoverished rural children.

- One in four rural children currently live in poverty—the highest rate since 1986—and the gap between rural and urban child poverty rates continues to rise.

- Ninety-five percent of persistent poverty counties are non-metro counties.

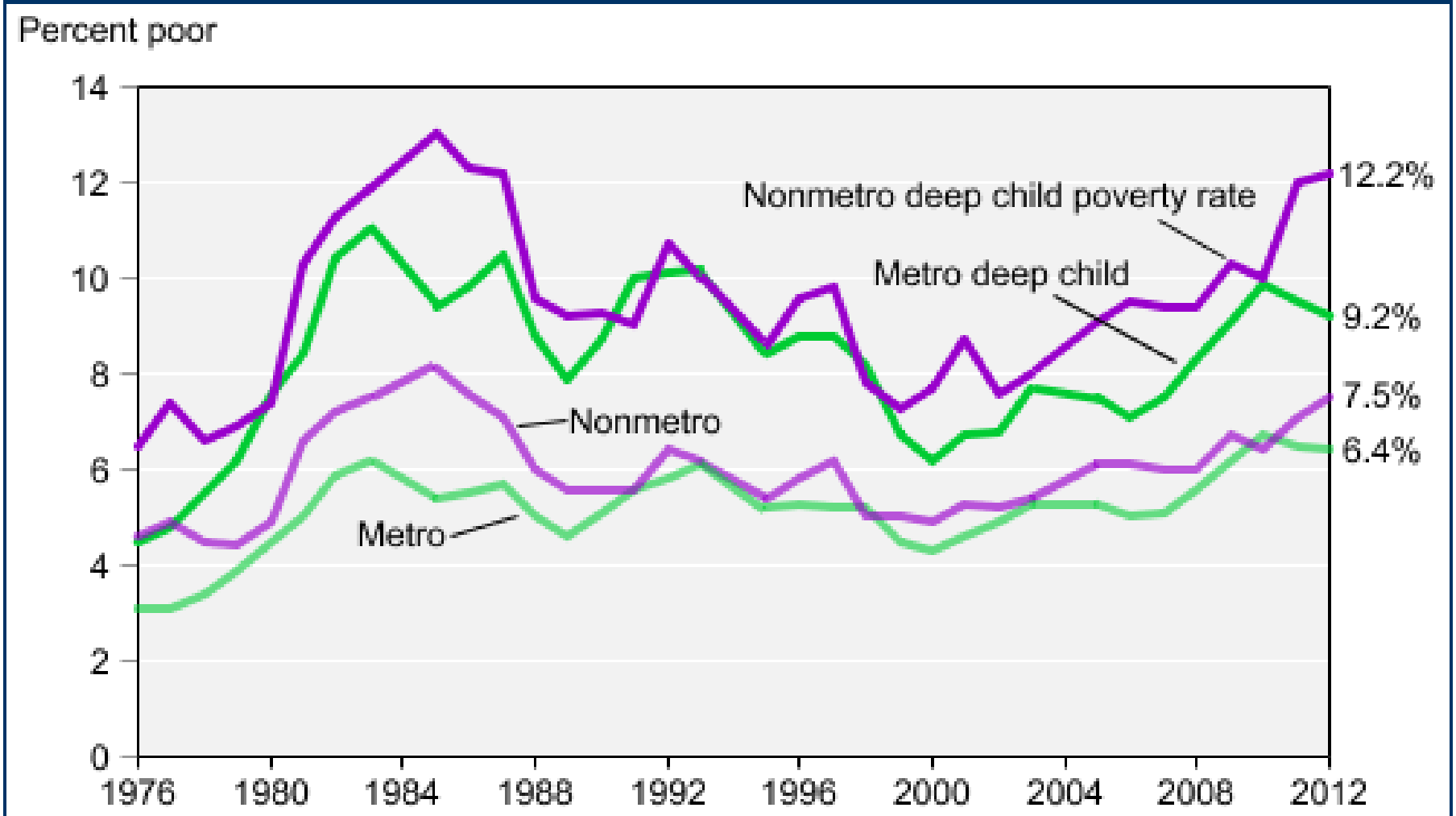
Deep poverty* for children, 2008-2012



*Deep poverty is defined by income below 50 percent of the Federal poverty level.

Source: USDA, Economic Research Service using data from the U.S. Census Bureau, American Community Survey 5-yr estimates, 2008-2012.

Deep poverty (and deep child poverty) rates by metro/nonmetro residence, 1976-2012



Note: Metro status of some counties changed in 1984, 1994, and 2004. Metro and nonmetro rates are imputed for those years.
Source: USDA, Economic Research Service using data from U.S. Census Bureau and U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey (March Supplements and 2013 Annual Social and Economic Supplements).

Improving Access to Quality Medical Care Webinar Series

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Your opinion is valuable to us.
Please participate in this brief survey:

www.surverymonkey.com/s/SWTRCWebinarSurvey

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