

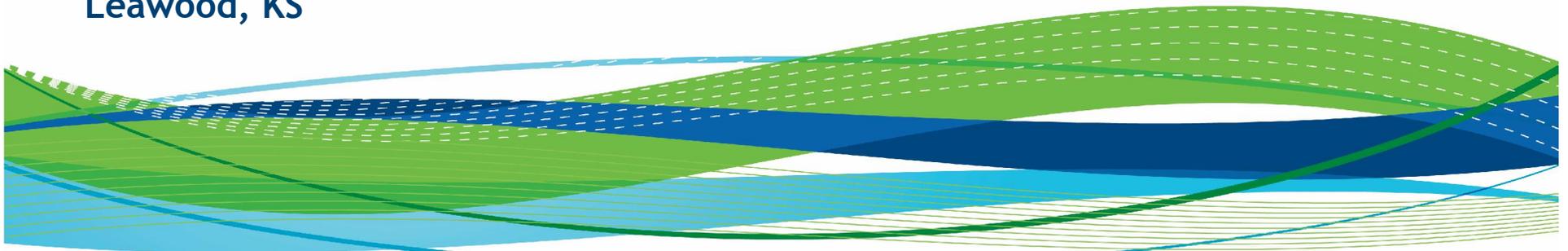


Your voice. Louder.

Critical Access Hospital Administrators Meeting

Little Rock, AR

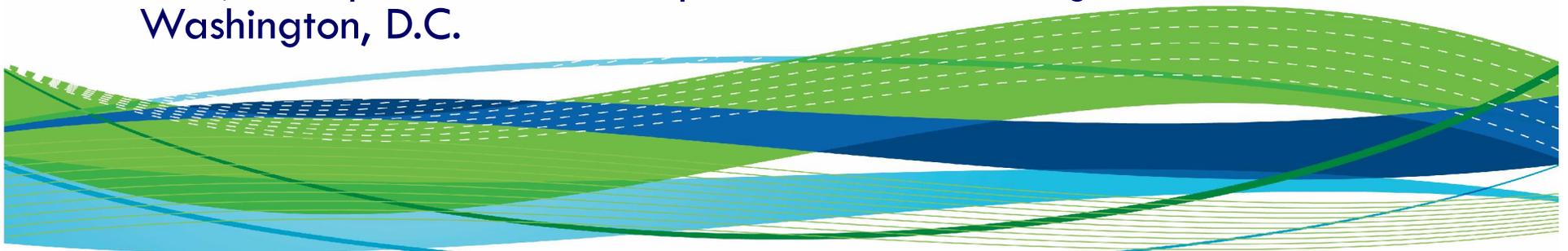
Brock Slabach, MPH, FACHE
Sr. Vice-President
National Rural Health Association
Leawood, KS



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.

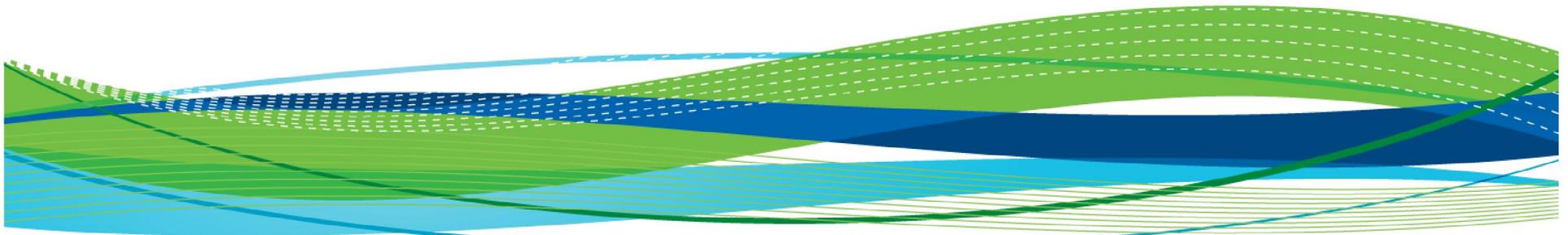


Rural disparities/challenges



Your voice. Louder.

- War on Poverty in the 60's
- Rural Health Clinics –just turned 36 (1978), >4,500 RHC's nationwide
- Community Health Centers, created in the War on Poverty
- 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.

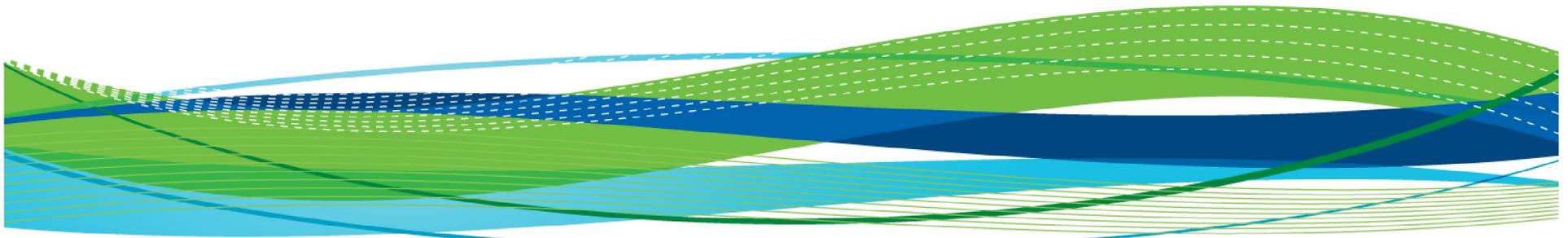


Problems still exist...



Your voice. Louder.

- *Health equates to wealth* according to Univ. of Washington Study, July 2013
- 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.

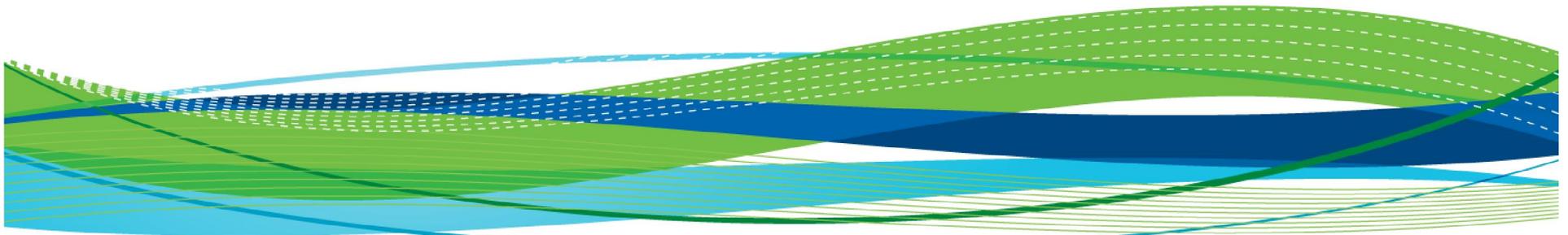


Medicare Cuts Enacted

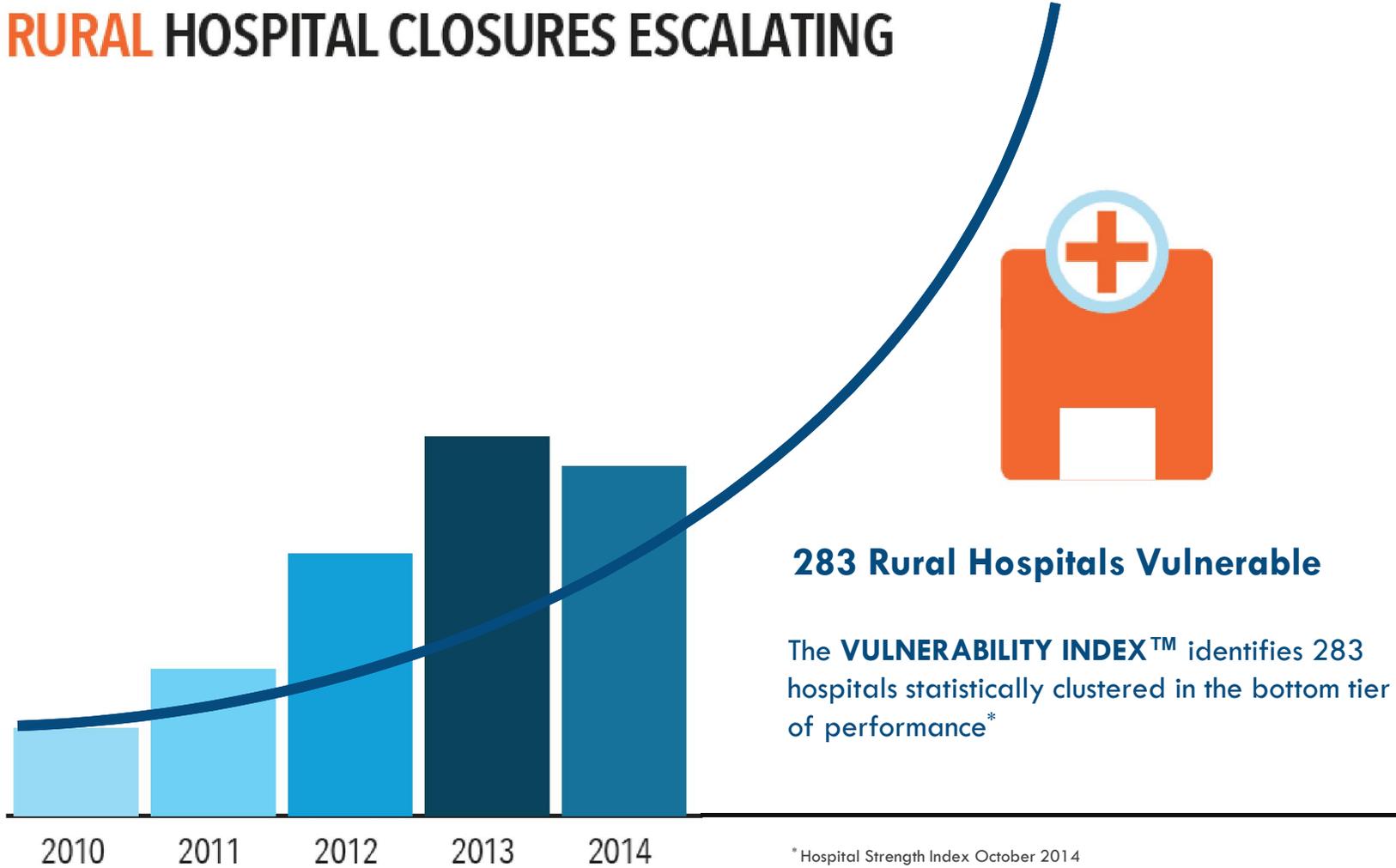


Your voice. Louder.

- 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

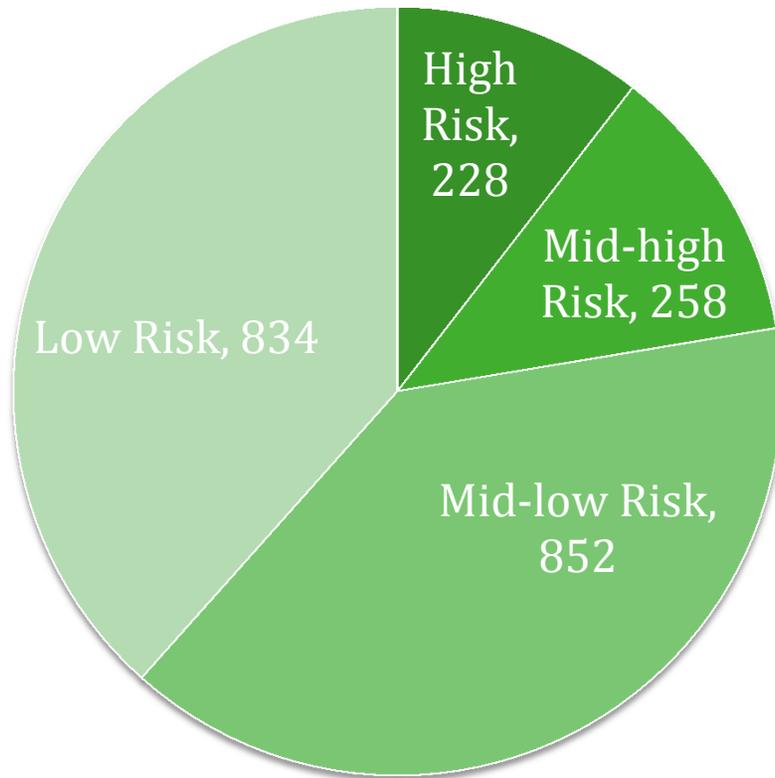


Vulnerability Index: Rural Health Safety Net Vulnerable
RURAL HOSPITAL CLOSURES ESCALATING

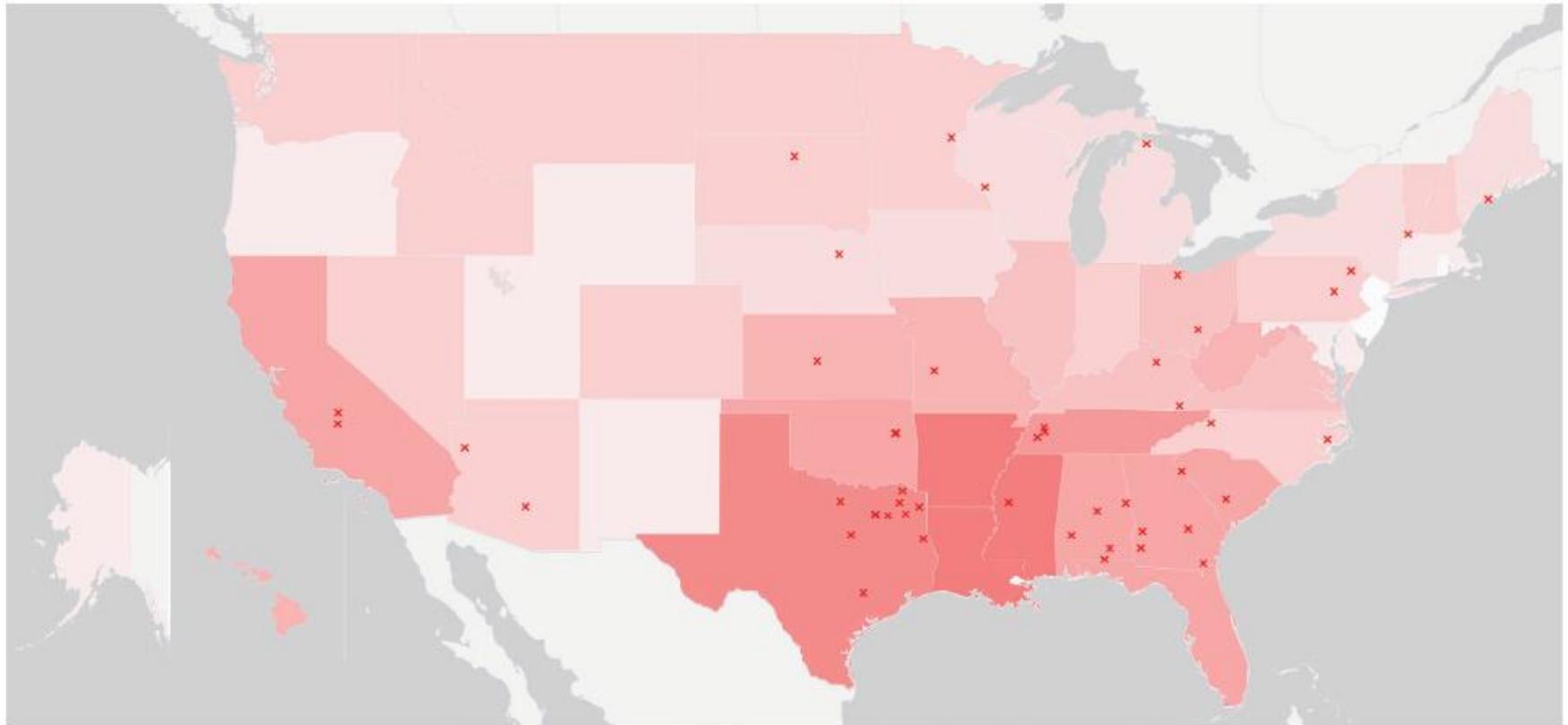


UNC At-Risk Estimates

Hospitals by Risk Level (2013)



Vulnerability Index: Rural Closures and Risk of Closures



Hospital Closures Since 2010 X

Percent Vulnerable  35%

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

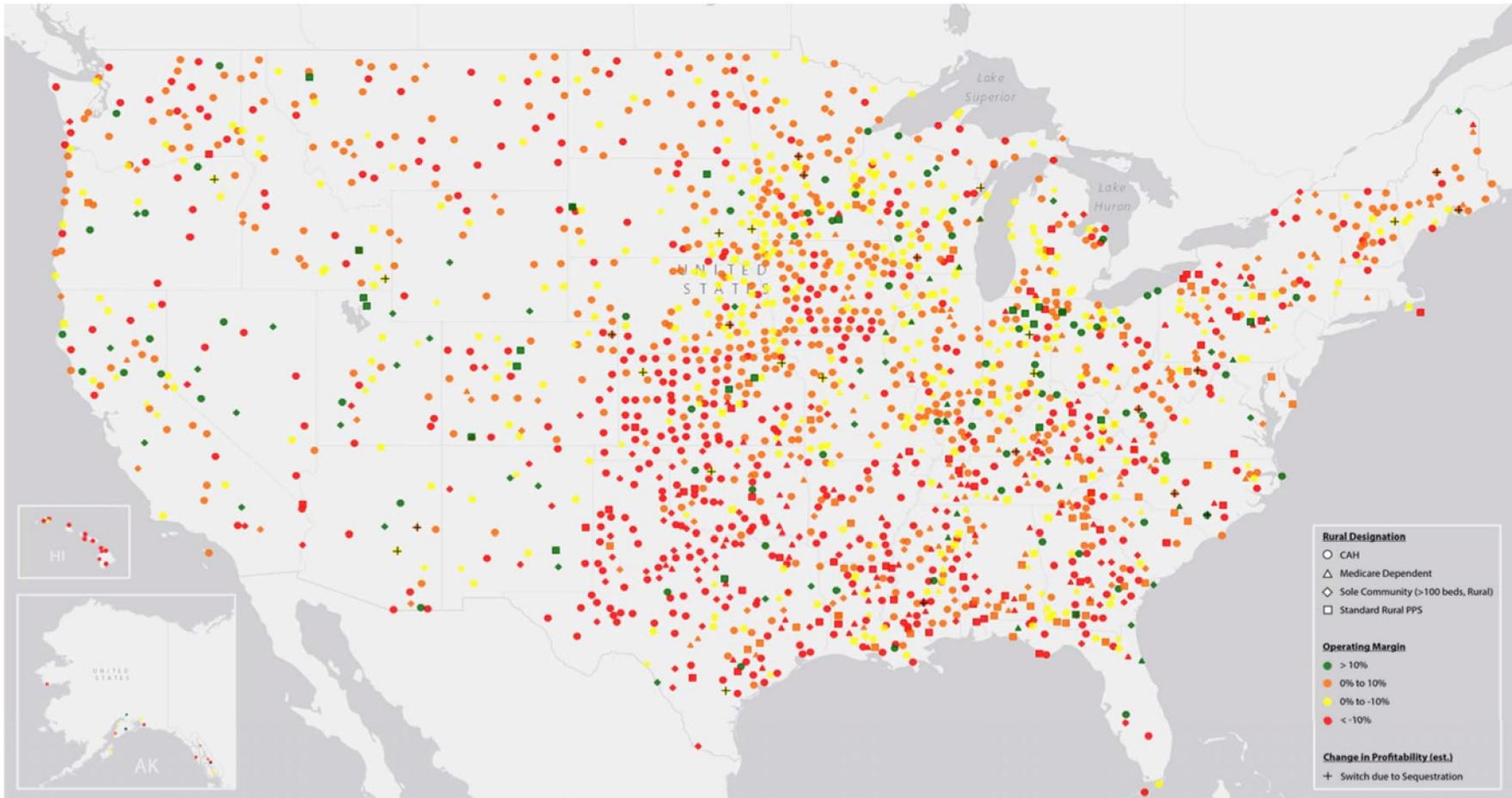


Powered by  **iVantage**[®]
HEALTH ANALYTICS

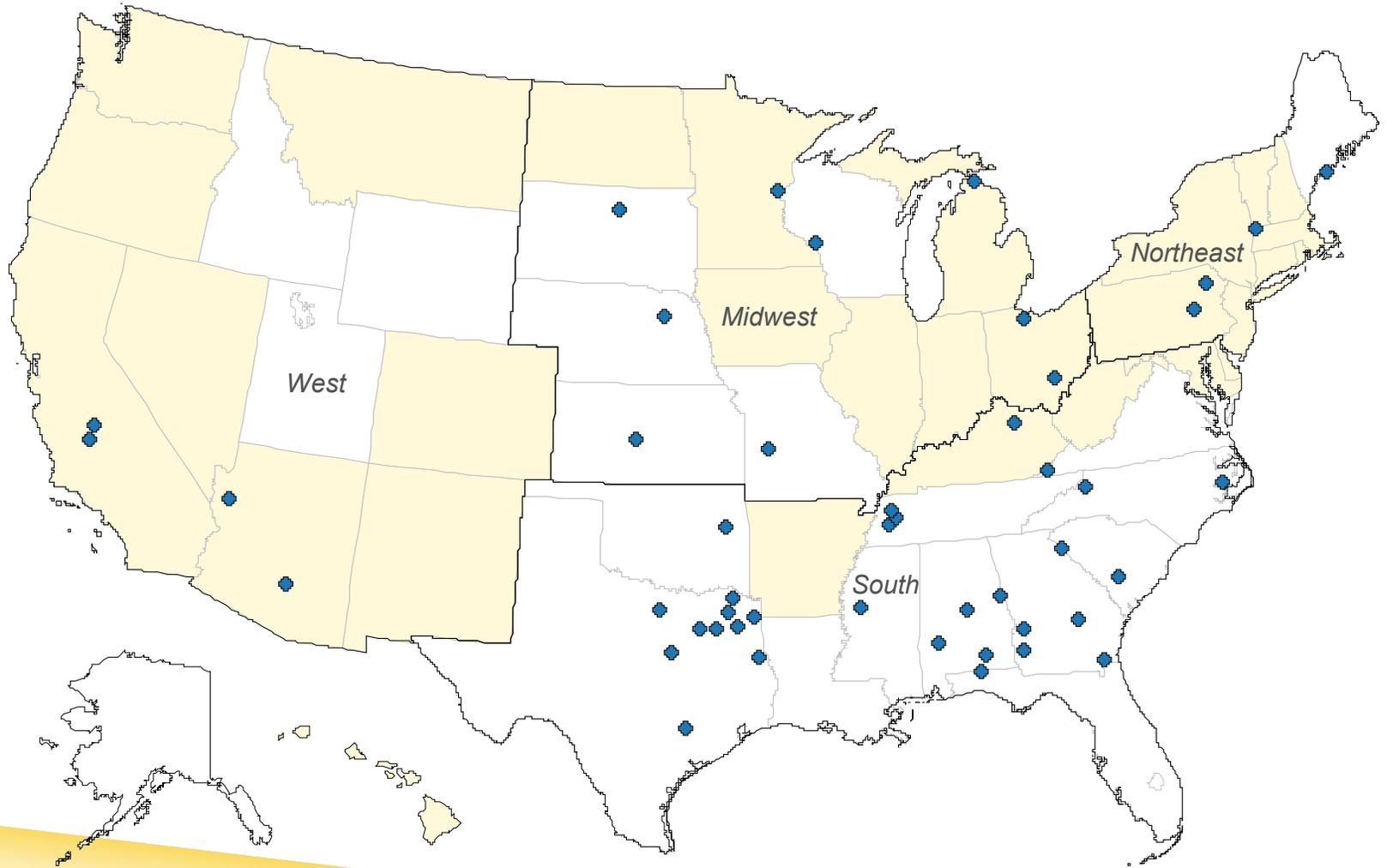
Sequestration Impact to Rural Hospital Profitability

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)



2010-14 rural hospital closures: Where were they?



2010-14 rural hospital closures: Why did they close? (As reported by news media)

Market Factors

- Small or declining populations
- High unemployment (as high as 18%)
- High or increasing uninsured patients
- High proportion of Medicare and Medicaid patients
- Competition in close proximity

Hospital Factors

- Low daily census, as low as 2.3 patients a day
- Lack of consistent physician coverage
- Deteriorating facility
- Fraud, patient safety concerns, and poor management

Financial Factors

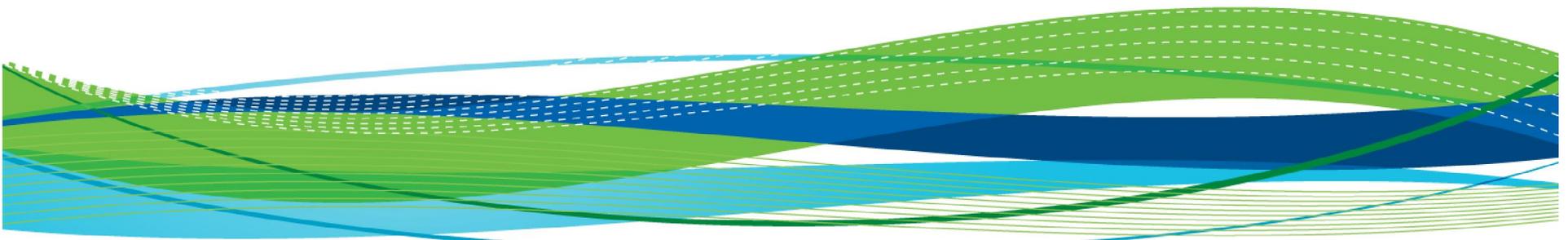
- High and increasing charity care and bad debt
- Severely in debt
- Insufficient cash-flow to cover current liabilities
- Negative profit margin



NRHA Response

Target solutions for three cohorts of rural hospitals:

- At-risk or soon to be at-risk
- Stable with strategically sound fundamentals
- High-performers or first movers



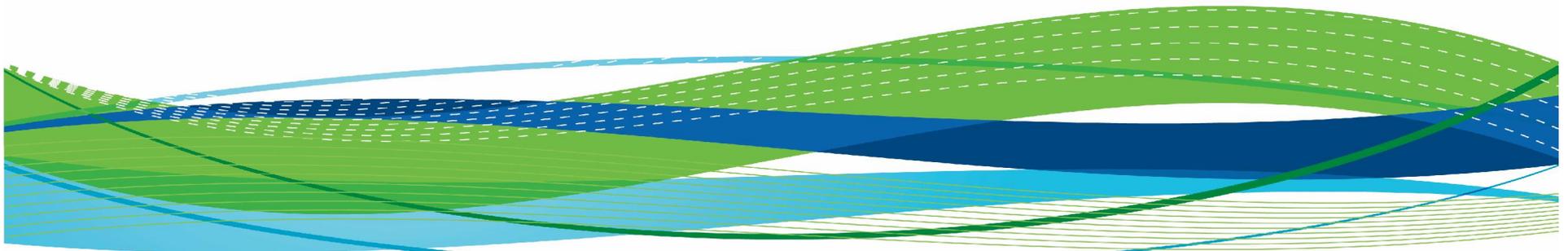
Two-Step Process:



Your voice. Louder.

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





The Save Rural Hospitals Act, HR 3225

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)

- I Innovation model for rural hospitals who continue to struggle.

Grassley Proposal

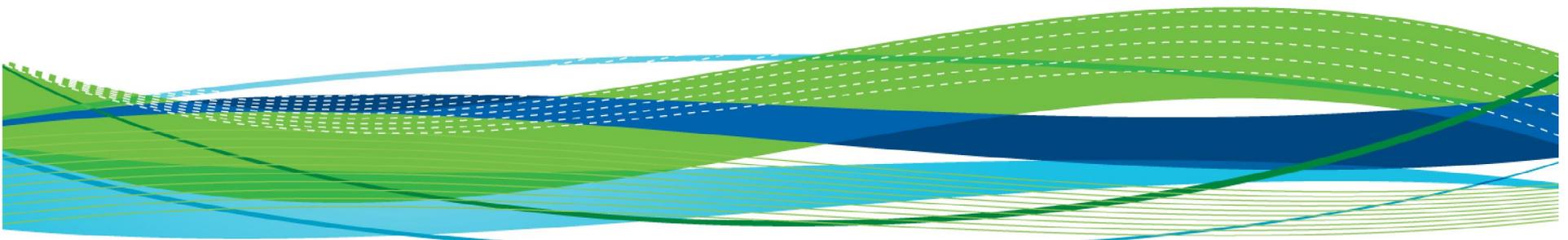


Your voice. Louder.

Title: Rural Emergency Acute Care Hospital Act
(REACH)

Features:

- Creates a new provider type: Rural Emergency Hospital (REH)





The Save Rural Hospitals Act

HR 3225: Sponsored by Sam Graves (R) MO and Dan Loeb (D) IA

Title 1: Rural hospital stabilization (Stop the bleeding)

Title 2: Rural Medicare beneficiary equity.

Title 3: Regulatory Relief (Stop the bleeding)

Title 4: Future of rural health care (Bridge to the Future)

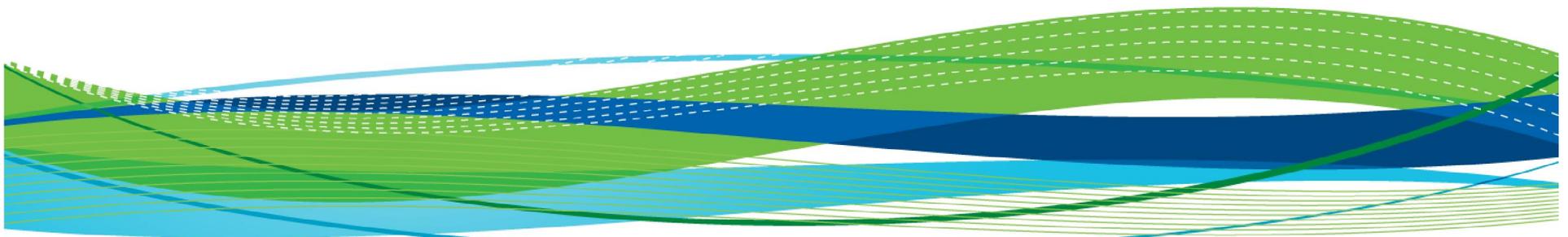
Save Rural Hospitals Act



Your voice. Louder.

Title I: Rural Provider Stabilization

- Eliminating Medicare sequestration for rural hospitals
- Reversing cuts to reimbursement of bad debt for CAHs and Rural PPS Hospitals
- Extending payment levels for low-volume hospitals (LVH) and Medicare Dependent Hospitals (MDH)
- Reinstating revised DRG payments for MDHs and SCHs
- Reinstating hold-harmless for hospital outpatient services for SCHs



Save Rural Hospitals Act



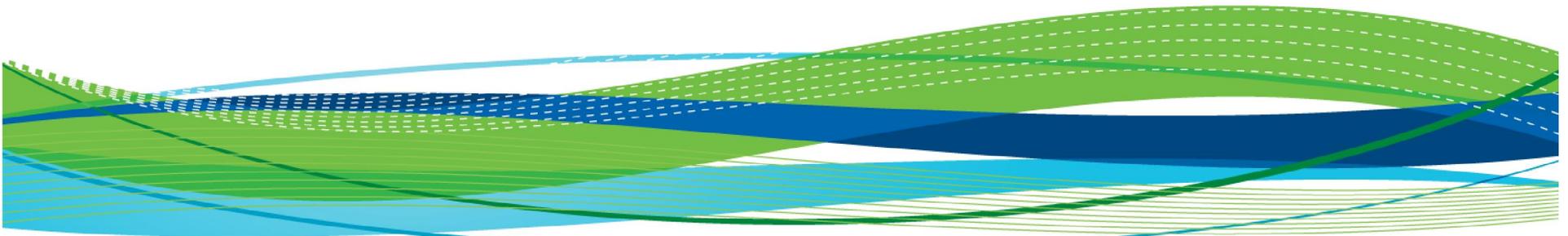
Your voice. Louder.

Title I: Rural Provider Stabilization

- Delays application of penalties for failure to be a meaningful EHR user
- Eliminating rural Medicare and Medicaid DSH payment reductions

Subtitle B—Other Rural Providers

- Making permanent increase Medicare payments for ground ambulance services in rural areas
- Extending Medicare primary care payments



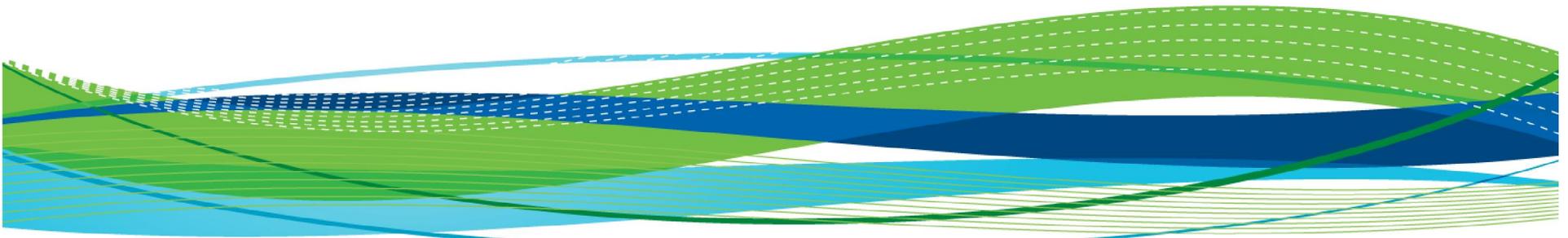
Save Rural Hospitals Act



Your voice. Louder.

Title II: Rural Medicare Beneficiary Equity

- Equalizing beneficiary copayments for services furnished by a CAH

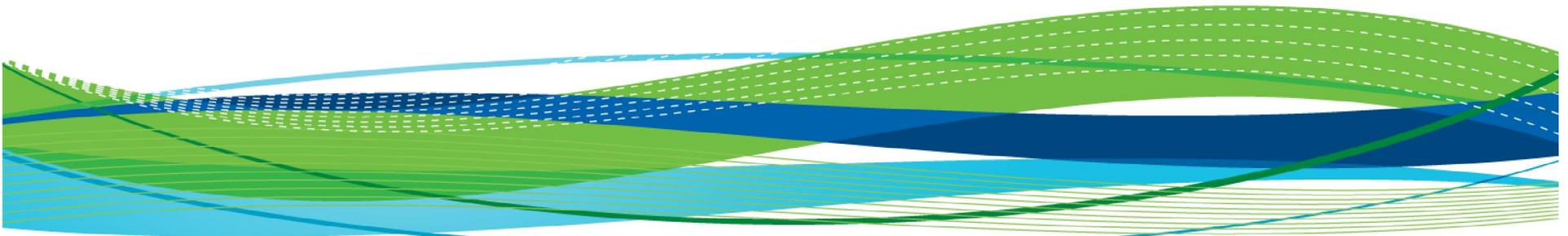


Save Rural Hospitals Act



Title III: Regulatory Relief

- Eliminating 96-hour physician certification requirement with respect to inpatient CAH services
- Rebasing physician supervision requirements
- Reforming practices of RACs under Medicare

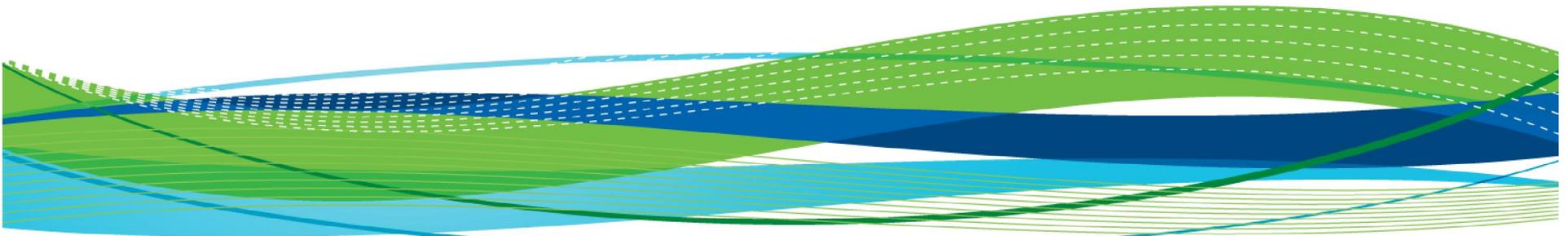


Save Rural Hospitals Act



Title IV: Future of Rural Healthcare

- Community Outpatient Hospital (COH) Program
- Grant funding to assist rural hospitals
- CMMI demonstration of shared savings in rural hospitals

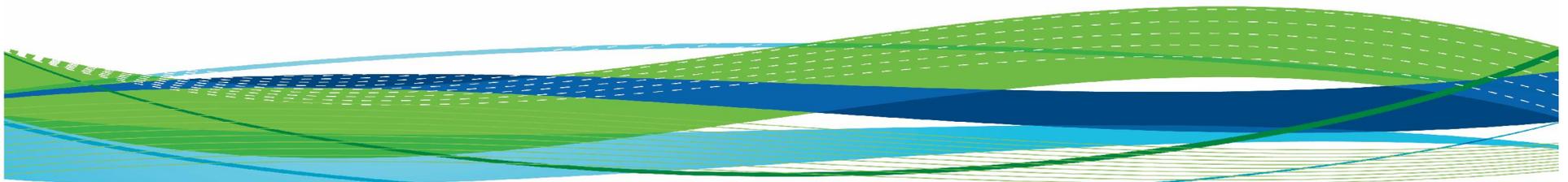


Why You Should Rally in Support of the Save Rural Hospitals Act, HR 3225



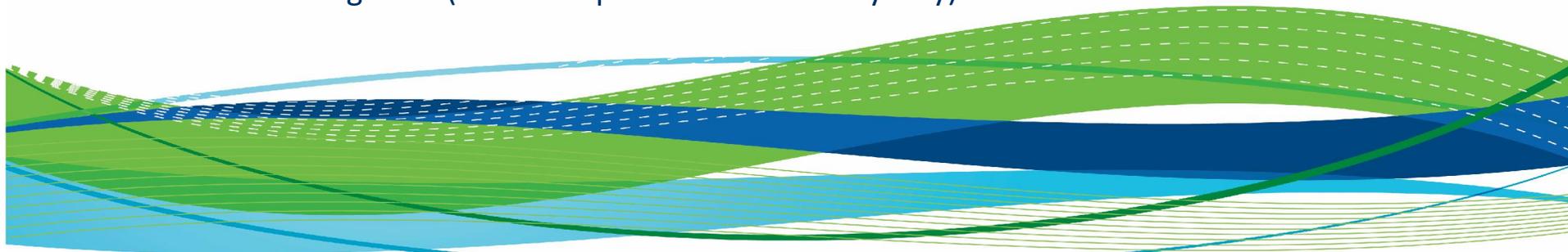
Your voice. Louder.

- Millions of dollars to ALL rural hospitals (for hospitals in all three cohorts of fiscal health;
- Significant regulatory relief;
- New grant dollars to meet challenges of federal health care demands (VBP, MU, bundled payments, ACOs, etc.); and
- A path forward for hospitals who continue to struggle.



Regulatory Update

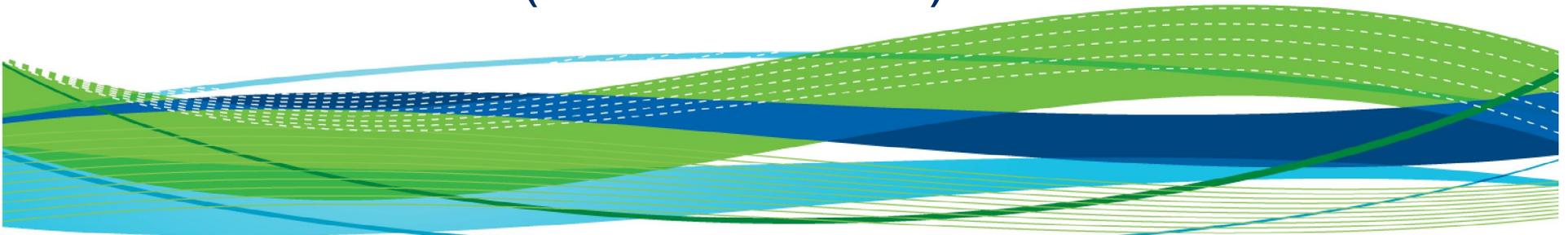
- **Outpatient PPS - submitted**
 - Negative 0.2% update
 - Changes to 2-midnight – continue to urge elimination
 - Wage index concerns
- **Home Health – submitted**
 - Negative 1.8% update - concerned about impact of rural
 - Wage index – geographic challenges
- **Physician Fee Schedule – submitted**
 - +0.5% (from SGR fix bill)
 - Care coordination – Advanced Care Planning
 - PQRS (and new MIPS) – urging simplicity and considering rural
- **Bundled Payments – Submitted**
 - Need to address low volume and rural providers
 - CAH swing beds (3 stars requires to waive 3 day stay)



340B Mega-Guidance



- Issued August 27, 2015
- Comments due October 27, 2015
- Very comprehensive, hits all major aspects of the program
- Important for 340B eligible entities review, send us comment
- [Mega-guidance Resource Center](#)
- 340B Intensive [Post-Conference](#), Friday, Oct 2 from 12:00 to 3:00 pm, Sheraton Kansas City Crown Center (lunch included)



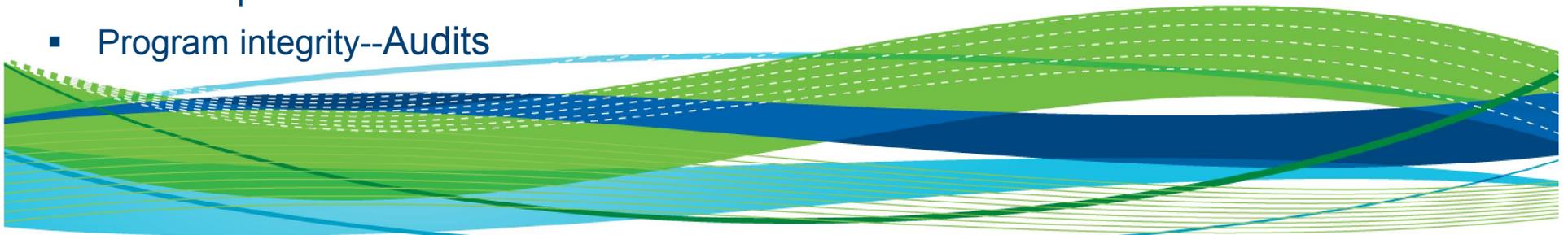
340B Mega-Guidance



Your voice. Louder.

Areas addressed include, but are not limited to 8 major parts of the published August 27th guidance:

- Covered entity eligibility
 - GPO prohibition
- **Covered outpatient drug definition/eligibility**
 - Bundled versus separately billed and reimbursed
- **Patient definition/eligibility**
 - 6 criteria
- Covered entity responsibility
 - Prohibition of duplicate discount
 - Record keeping
- **Contract pharmacy**
- Manufacturer responsibility
 - Recertification
- Rebate option for ADAP
- Program integrity--Audits



SGR Repeal and....



Your voice. Louder.

Incentivizes movement to alternative payment models (APM)

- Minimal FFS yearly increase next 10 years of 0.5%, then 0%
- Merit-based payment system (eventually -9% to +27% adjustment)—Based on quality, resource use and clinical practice improvement activities
- APMs (up to 5% bonus) based on APM level of participation—25% revenue year one (2018-19)
- 41% payment difference between highest and lowest performing physicians



SGR Fix



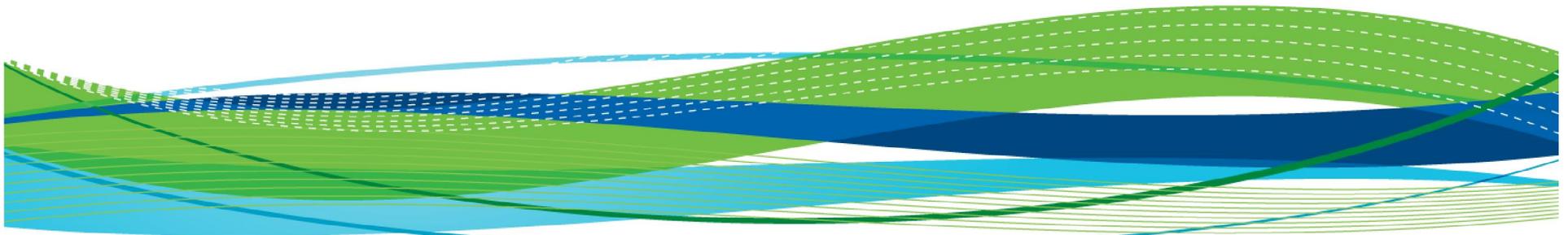
Your voice. Louder.

For Rural Doctors: 27-32% PFS Cuts

- Permanent SGR Repeal (\$276 billion permanent fix)
- GPCI Extension (\$500M)—Extends until Jan. 1, 2018

For Rural Hospitals:

- MDH (\$100M)—Extends until Oct. 1, 2017
 - 10-12% loss of Medicare revenue; need to make up 19% from private insurer.
- LVH (\$450M)—Extends until Oct. 1, 2017
 - approx. \$500,000 per hospital and can mean well-over \$1 million.
- Medicare Home Health Rural Add-On (extends 3% add-on until Jan. 1, 2018)
- Extension of therapy cap exceptions process (extends until Jan. 1, 2018)



SGR Fix



For Rural Ambulance Providers (\$100M) - Jan. 1, 2018

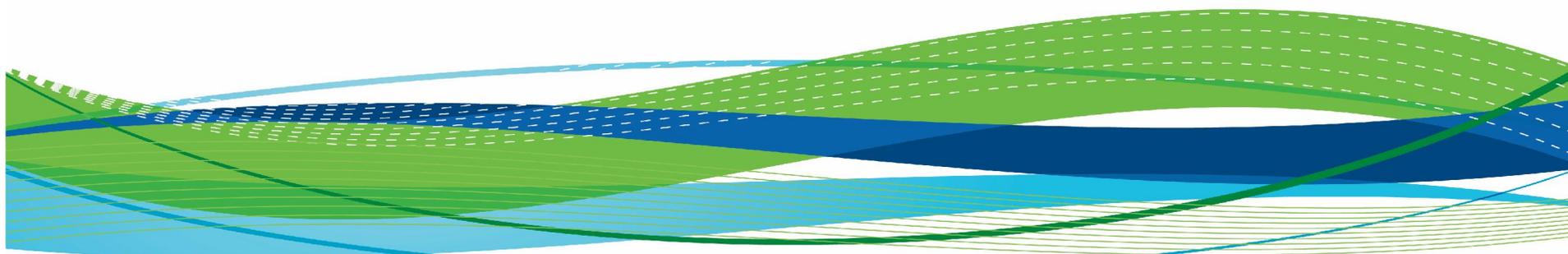
- 22.6% reductions

Two Year Extension:

Community Health Centers (CHC)

National Health Service Corps Fund (NHSC)

Teaching Health Centers



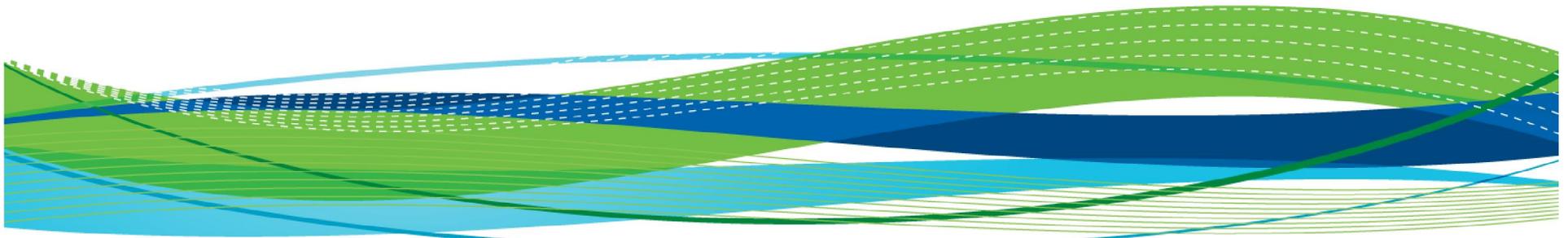
SGR Fix Implications



Your voice. Louder.

Bottom line:

- Leaves \$141B between 2015 and 2025 unpaid for or in other words, added to the deficit
- Physicians pushed along to APMs and a value-based system, impact on hospitals and volume?
- RHC cost-based reimbursement are exempt
- Physician alignment a key reality



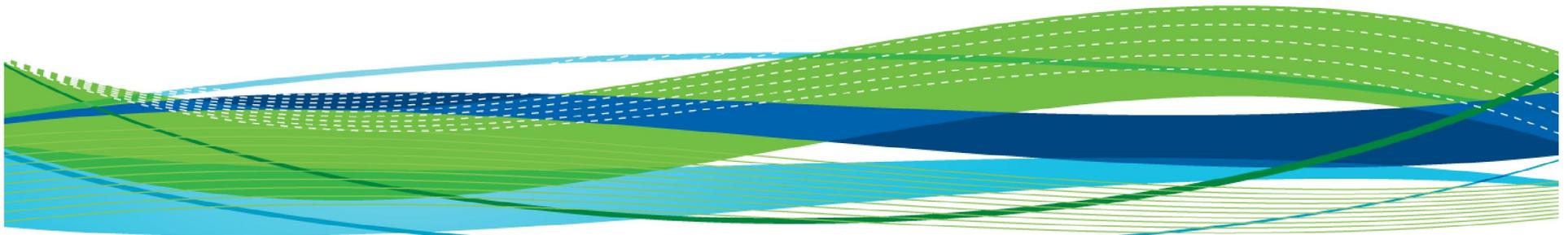
Sec. Burwell's Medicare Goals



Your voice. Louder.

- 30% of Medicare provider payments in APMs by 2016
- 50% of Medicare provider payments in APMs by 2018

- 85% of Medicare fee-for-service payments to be tied to quality and value by 2016
- 90% of Medicare fee-for-service payments to be tied to quality and value by 2018



CMS Payment Goals



Your voice. Louder.

Alternative Payment Models (APM)

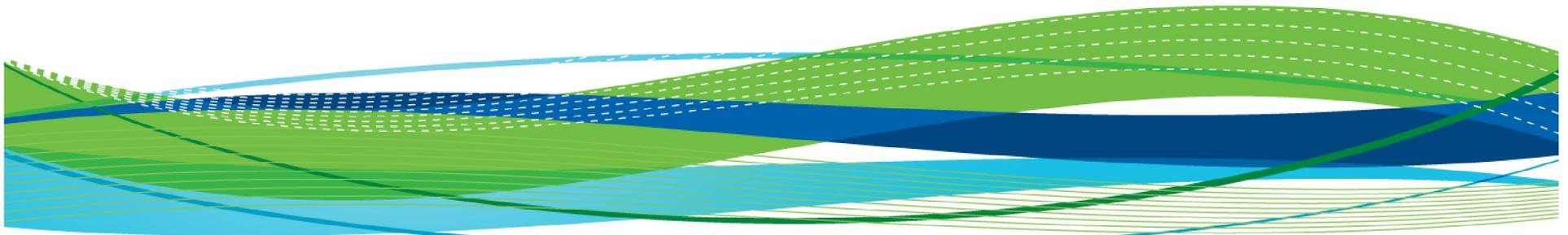
- Shared Savings Models
- Bundled Payments
- Patient Centered Medical Homes

Remaining Fee For Service Linked to Value/Quality

Aggressive Timeline

- Favors: Large Systems, population health management experience and deep pockets

Will Accelerate Provider Affiliations



So What?



Your voice. Louder.

- FFS/CBR payment → Value Payment
 - Primary care physicians become revenue centers
 - High cost procedures, specialists and hospitals become cost centers
- Insurance Strategies
 - Reference Pricing and Narrow Networks
- Consumer Driven Healthcare
 - High Deductibles and price transparency
- These fundamental healthcare changes will impact our hospital's financial viability and survival

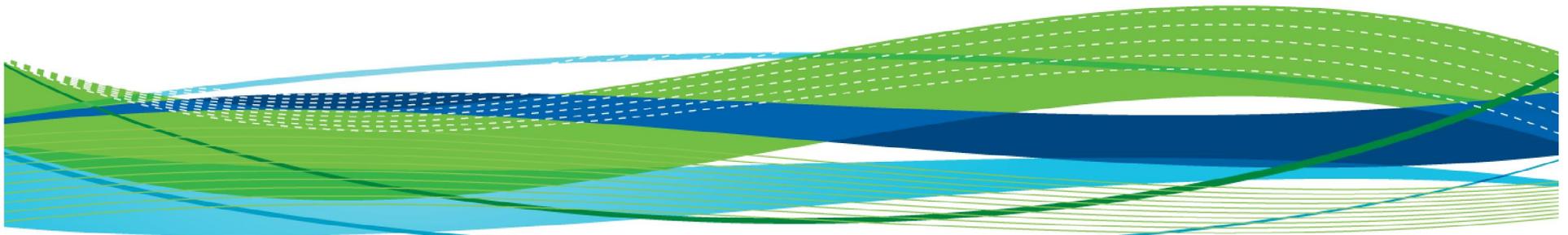


Converging Forces



Your voice. Louder.

- Price Reduction threats and volume reduction pressures
- Expanding insurance coverage but narrower networks
- Increasing quality of care measures and accountabilities
- Widespread provider and payer affiliations

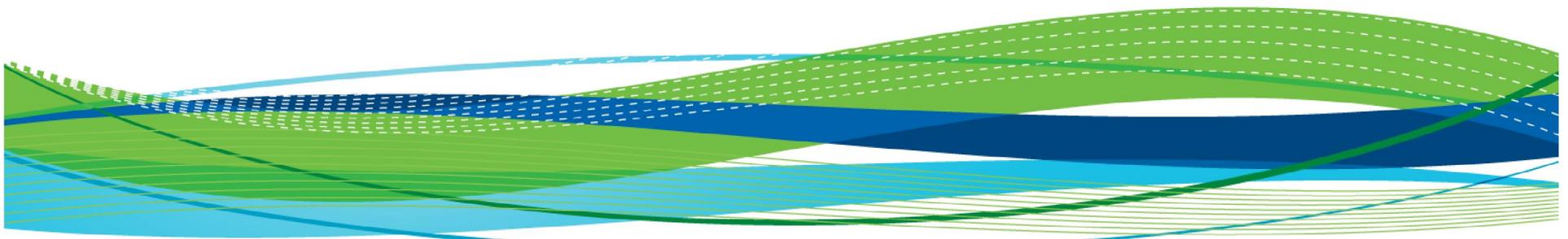


Follow the Money

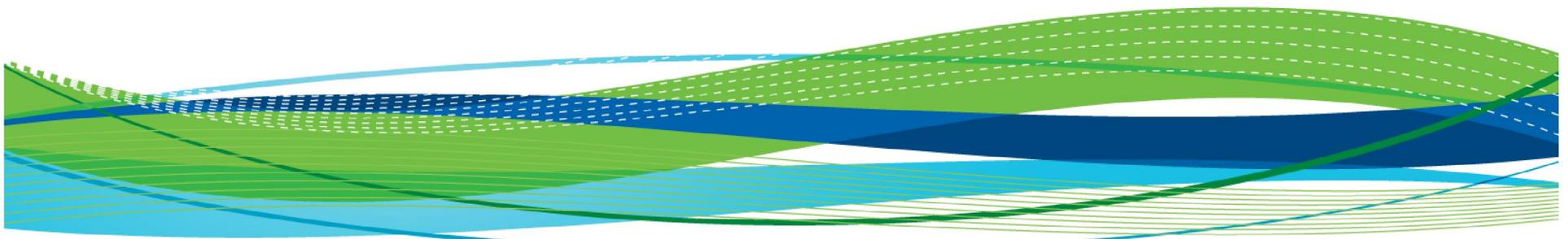


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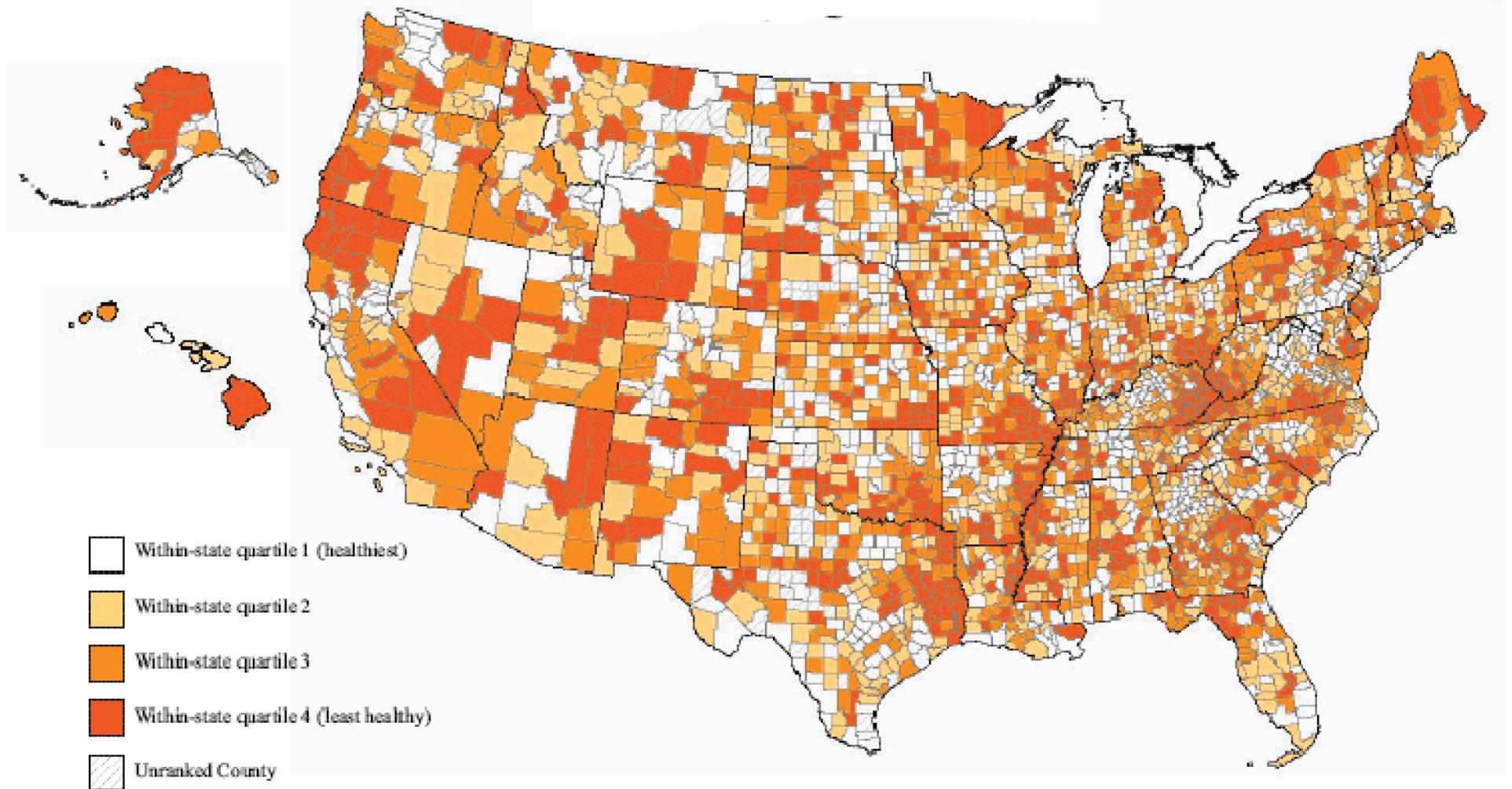
- How we deliver care is how we are paid for care
- Healthcare reform is changing BOTH payment and delivery
- Bottom line: reform involves transfer of risk from payers to providers



Transformation to Population Health Management



County Health Rankings



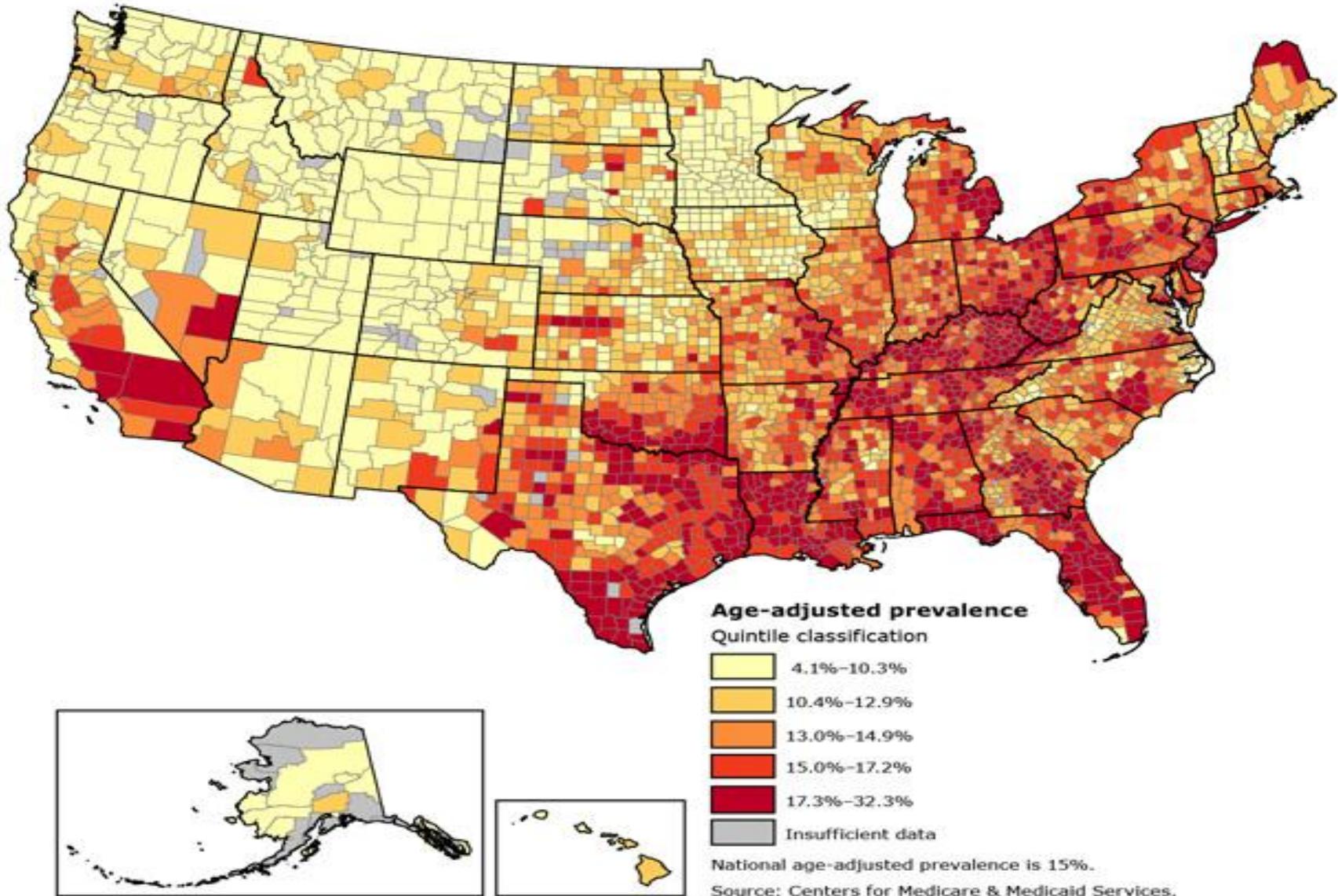
* Counties are ranked within states and split into quartiles with equal numbers of counties in each quartile.
Source: University of Wisconsin Population Health Institute, 2012.



<http://www.countyhealthrankings.org/>

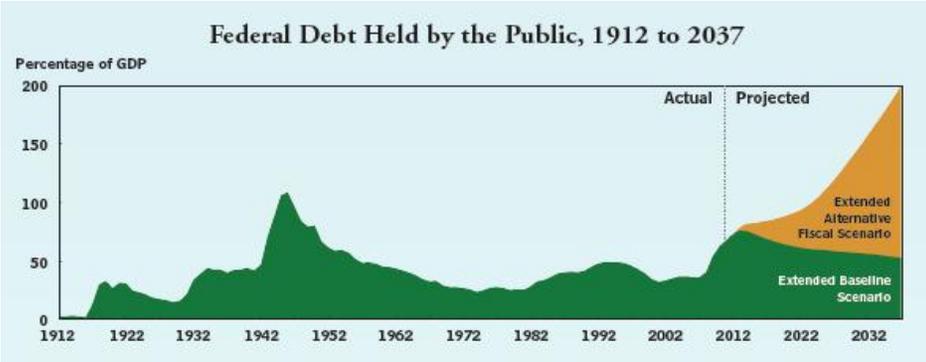
Prevalence of Medicare Patients with 6 or more Chronic Conditions

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

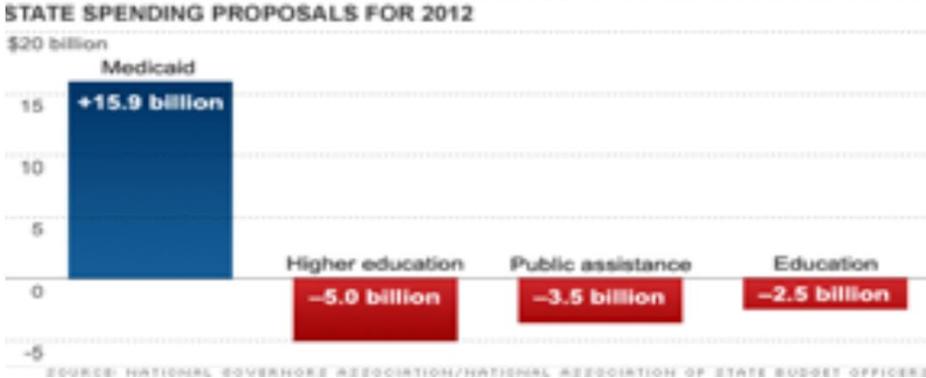


Market Pressures Increasing

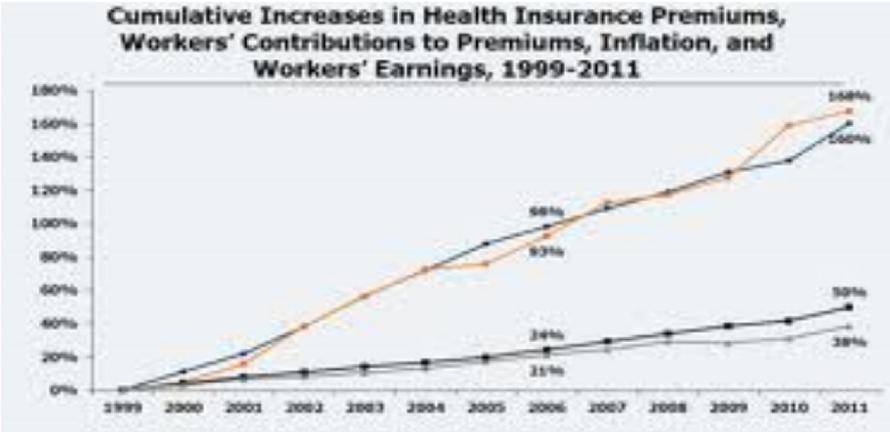
Federal



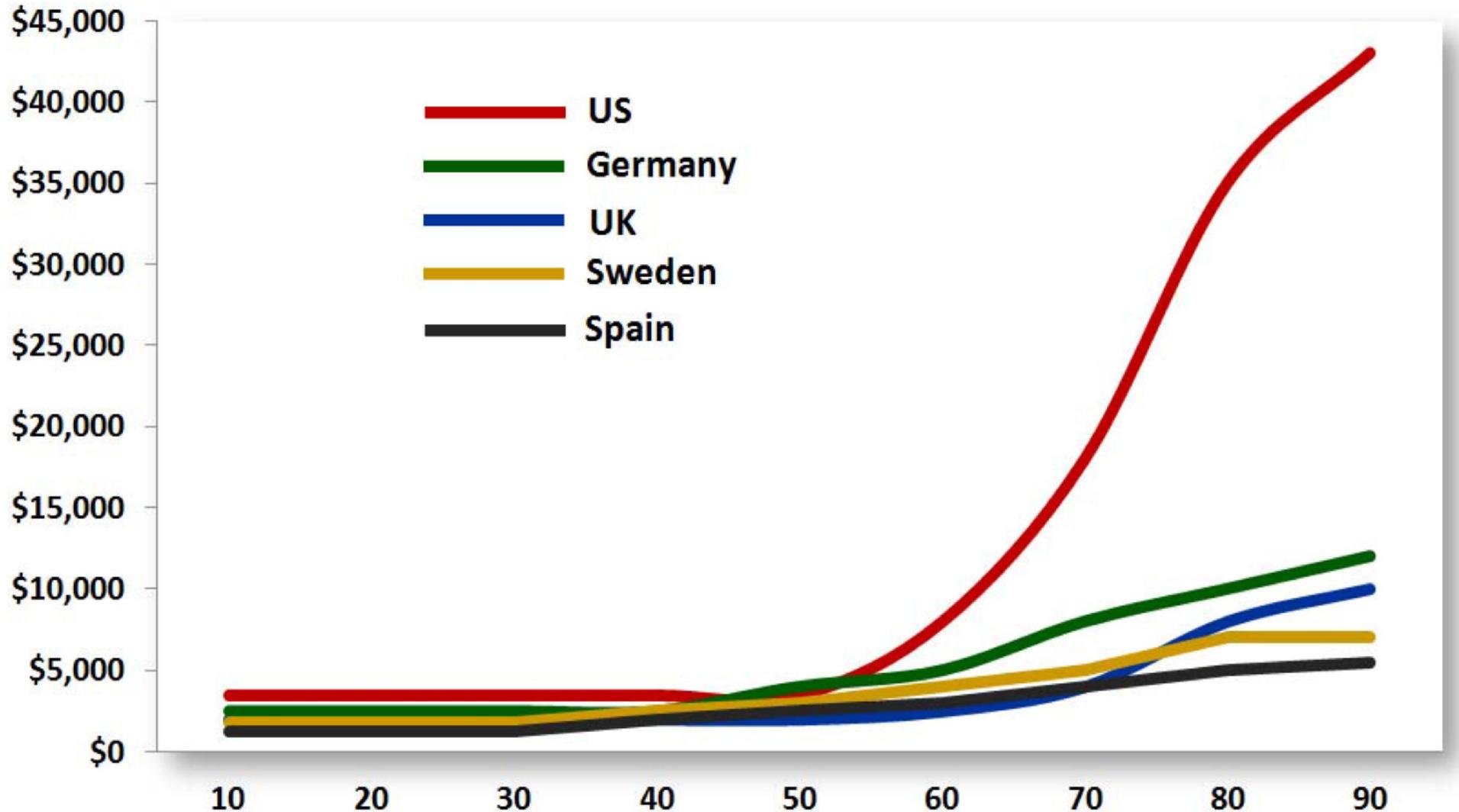
State



Employee/Commercial

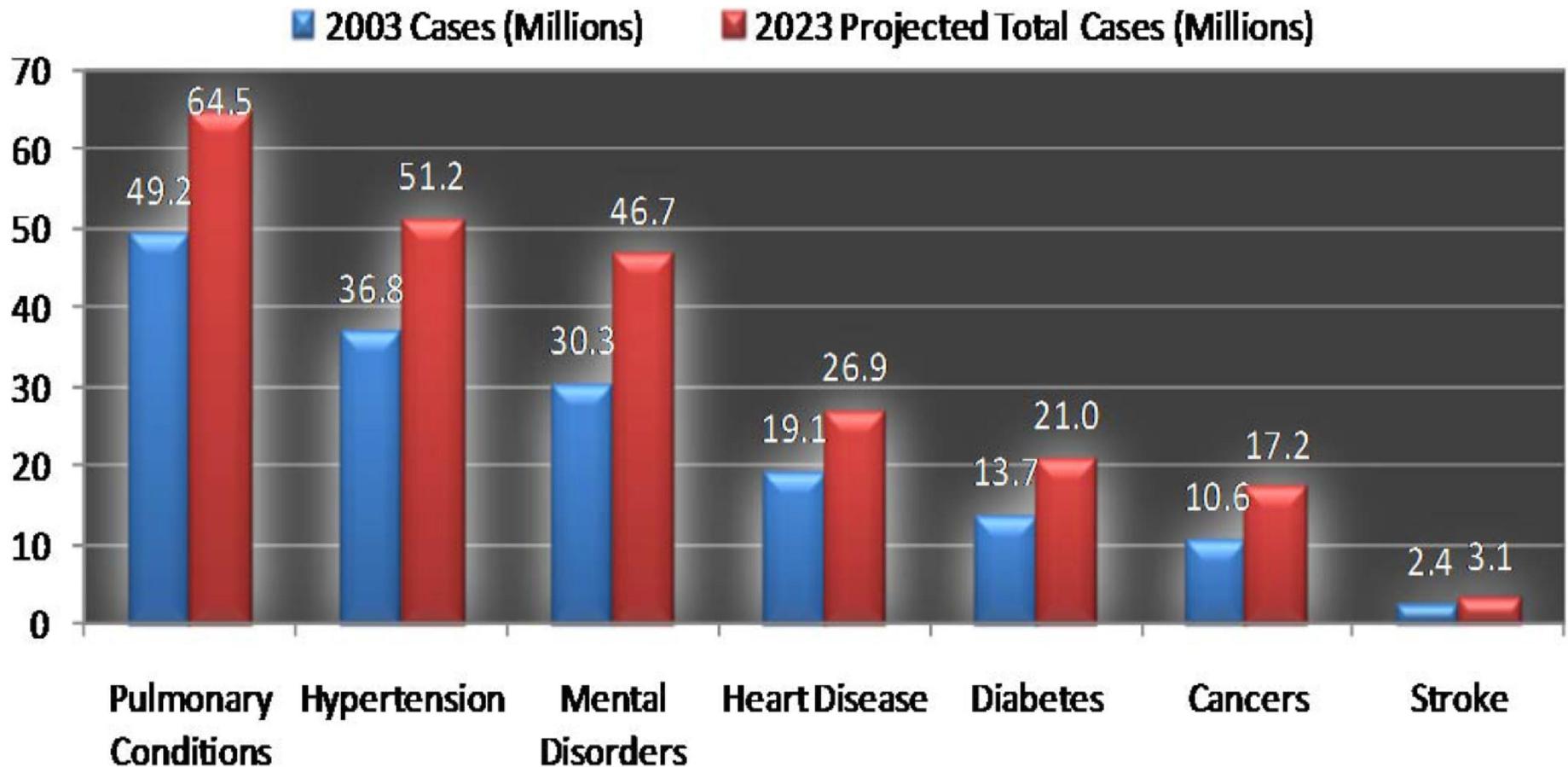


Industrialized Countries: Annual Spending by Age



Source: <http://blogs-images.forbes.com/danmunro/files/2014/04/hccostsbyage.png>

Chronic Disease Growth Projections



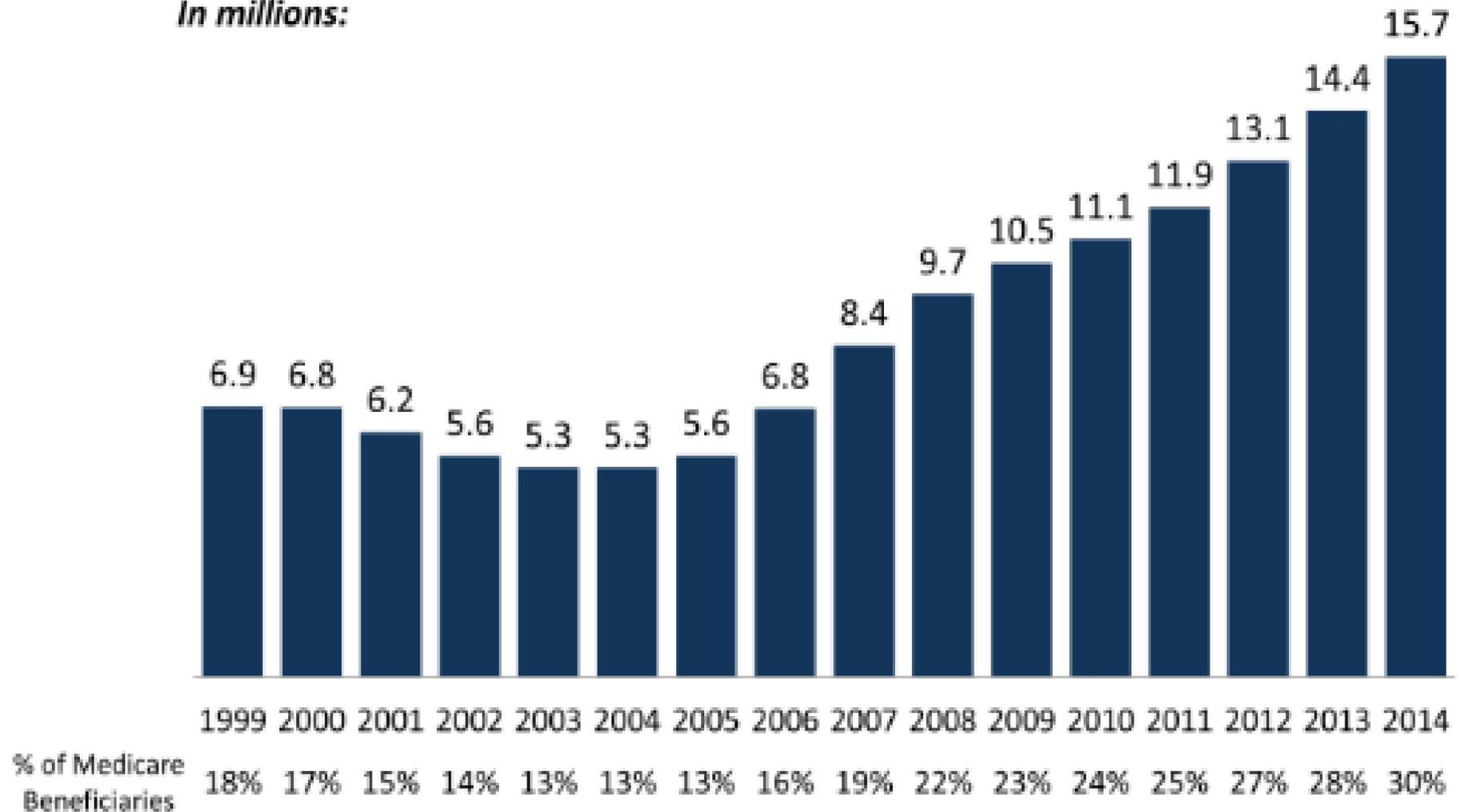
State of Healthcare 2010

Source: State of Healthcare 2010

Exhibit 1

Total Medicare Private Health Plan Enrollment, 1999-2014

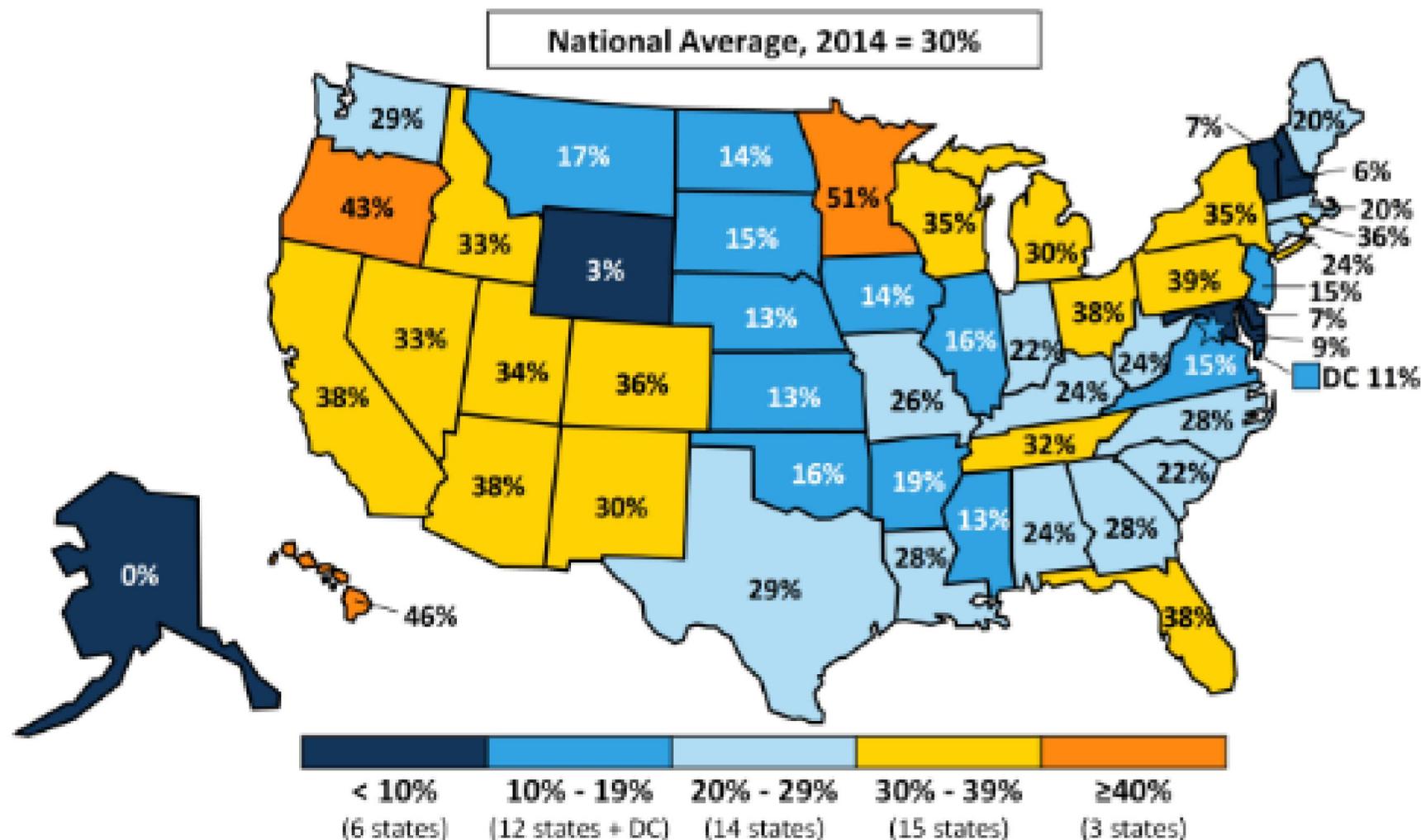
In millions:



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.

SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
 SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2014.

Healthcare Transformation



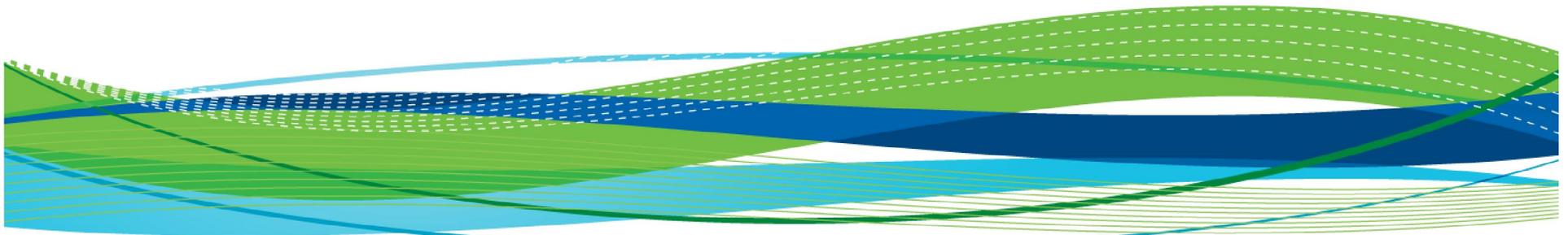
Your voice. Louder.

**Current
Fee for Service
System**

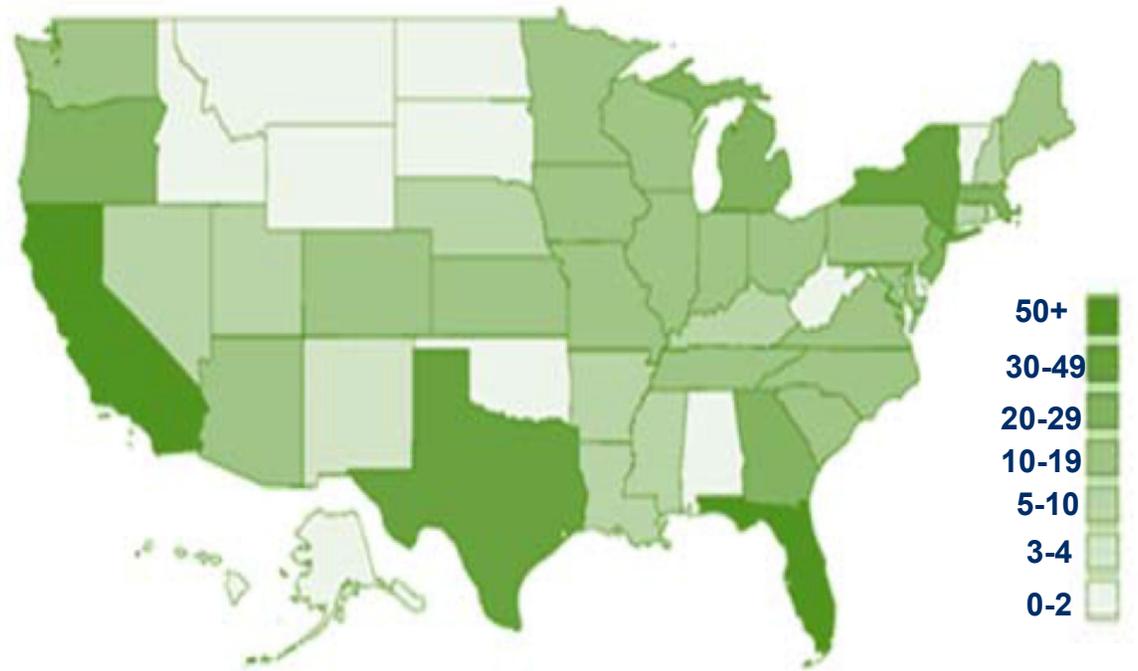


**Value Based
Payment Model**

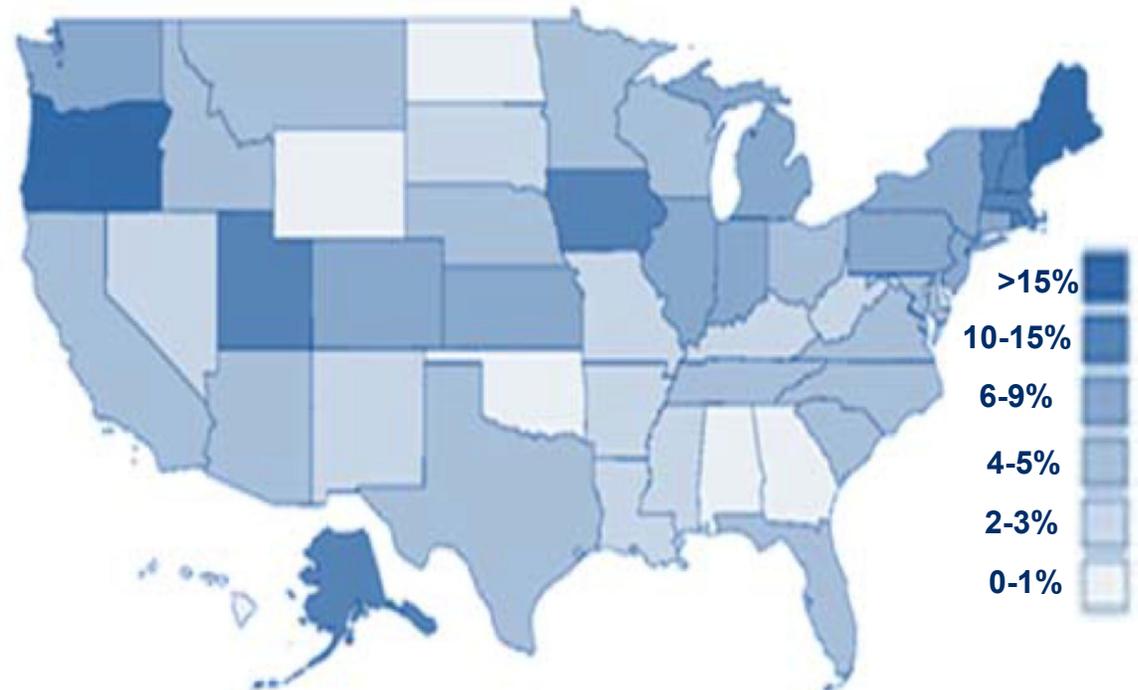
**Integrating and coordinating Care Across Continuum
Aligning Incentives for Value and Quality
Reducing the Cost Curve**



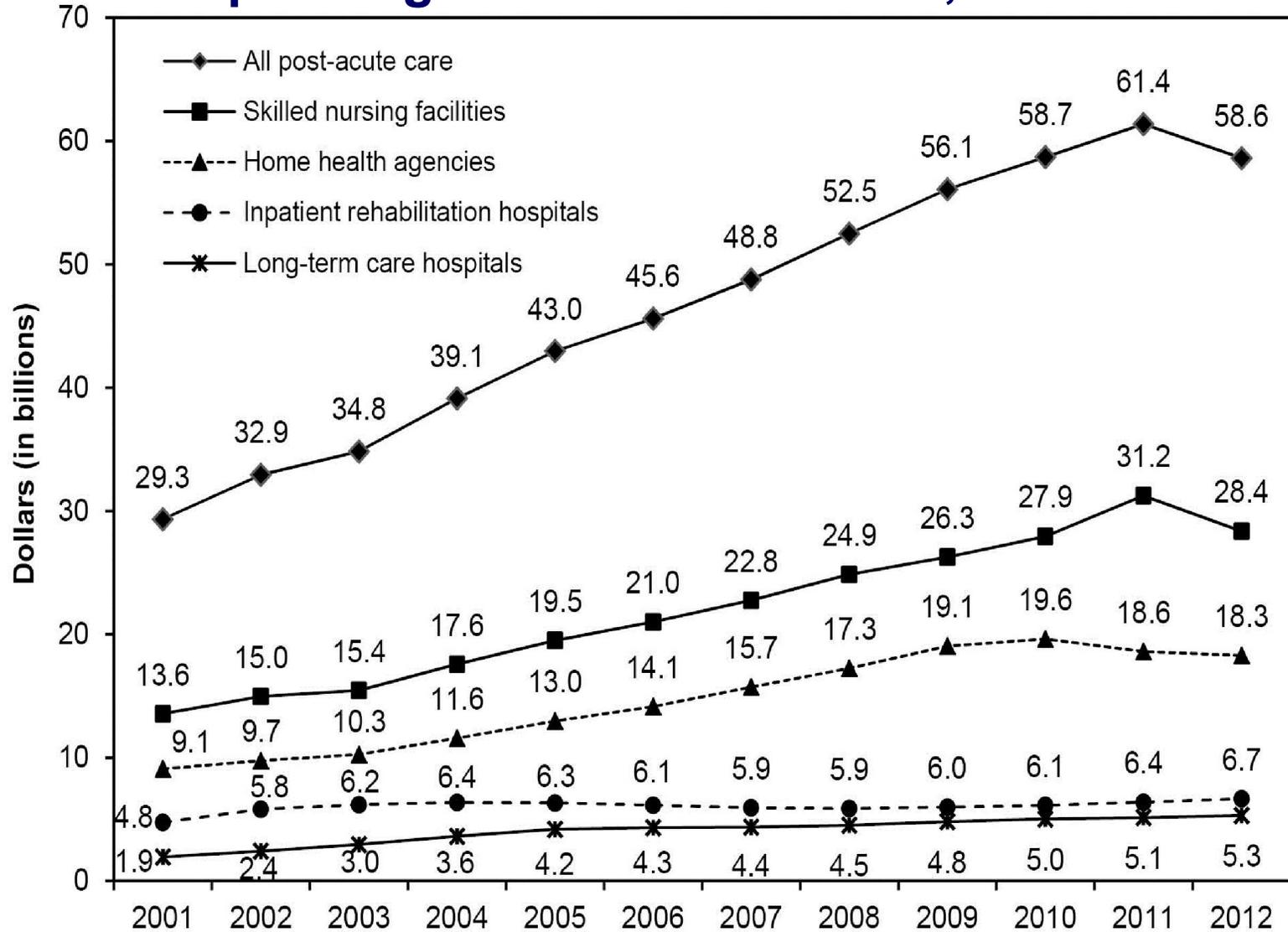
Number of ACOs



Percent of Population Covered by an ACO



Medicare Spending on Post-Acute Care, 2002-2012



Source: MedPAC, *A Data Book: Health care spending and the Medicare program*, June 2014

First Things First



Your voice. Louder.

Care Redesign

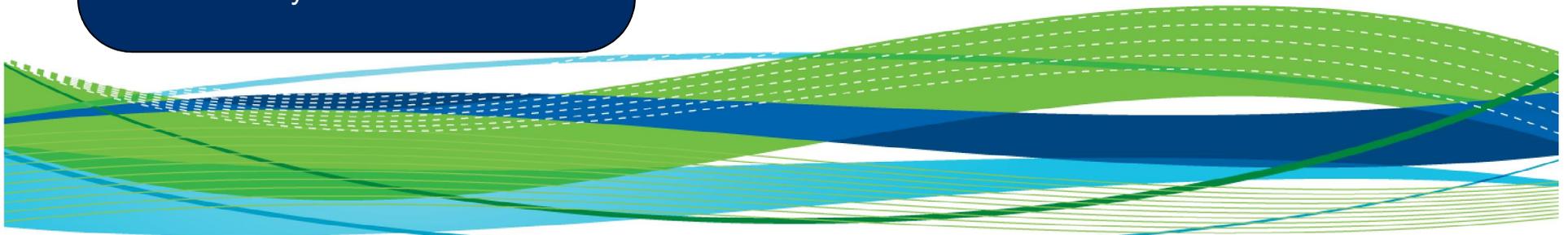
- PCMH
- Clinical Integration
- Care Management
- Post-acute Care
- EHR
- Data Analytics

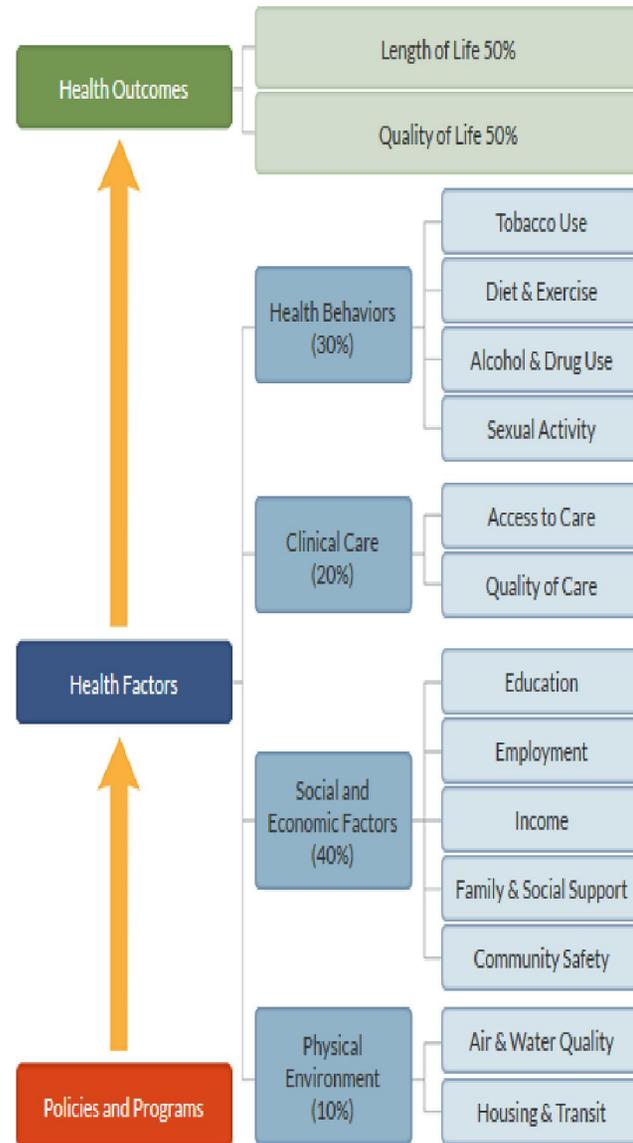
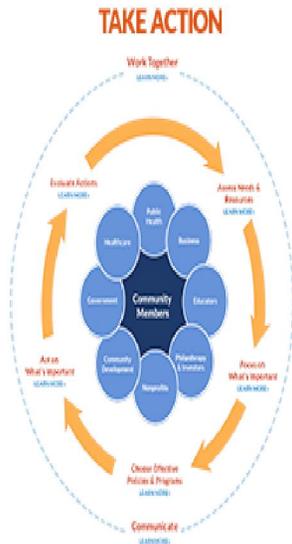
Care redesign must not outpace
Changes in payment

New Payment Arrangements

- Care Transformation Costs
- Care Management Payments
- Shared Savings
- Episodes of Care Payments
- Global Payments

Population
Health
Transformation





County Health Rankings model © 2014 UWPHH

Determinants of Health

Four Stages to Population Health



Your voice. Louder.



- **Education**
- **Assessment**
- **Gap Analysis**
- **Operational Plan**

- **Primary Care**
- **PCMH**
- **Clinical Integration**
- **Care management network**
- **Network development**
- **Health informatics**

- **Defined population**
- **Payor partner**
- **Post-acute**

- **Employee health plan**
- **Commercial arrangement**
- **Medicare**
- **Medicaid**
- **Employer contracting**
- **Uninsured**

Source: Joseph F. Damore, Premier Health Alliance, March, 2015

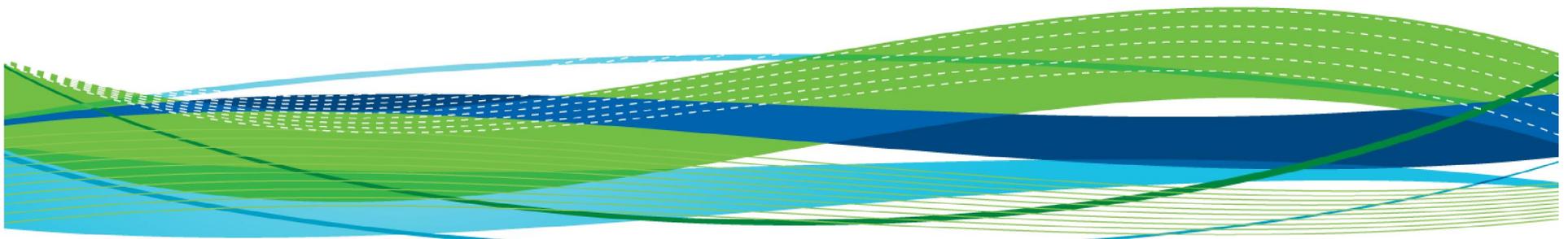


Volume to Value: Specifically....



Your voice. Louder.

- How do we set a glide path to delivering value when our revenue is primarily volume driven?
- What changes can we implement now to be successful in the future?
- Maybe a new set of tools?



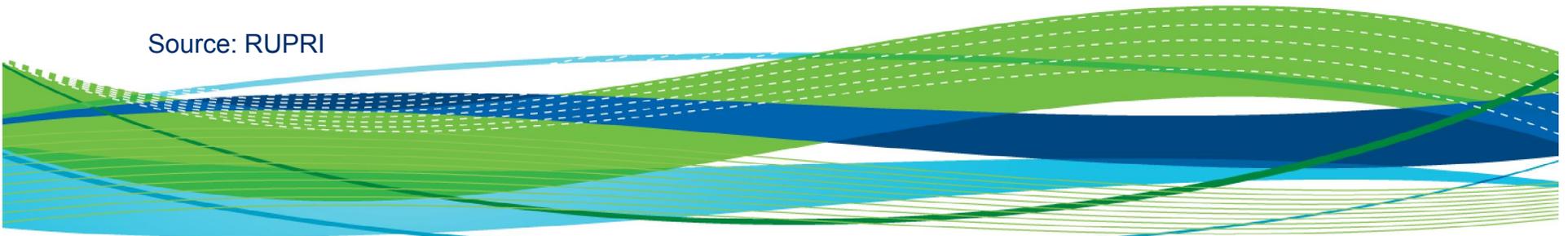
Rural Hospital Tool Box



Your voice. Louder.

1. Optimize Fee for Service
 2. Enhance Efficiency
 3. Improve Patient Care
 4. Engage Physicians
- Develop Patient Centered Medical Homes...(DSR)
 - Get Paid for Quality/Value...(PR)
 - Coordinate Care
 - Establish a Referral Network
 - Engage Your Community
 - Consider Regionalization

Source: RUPRI

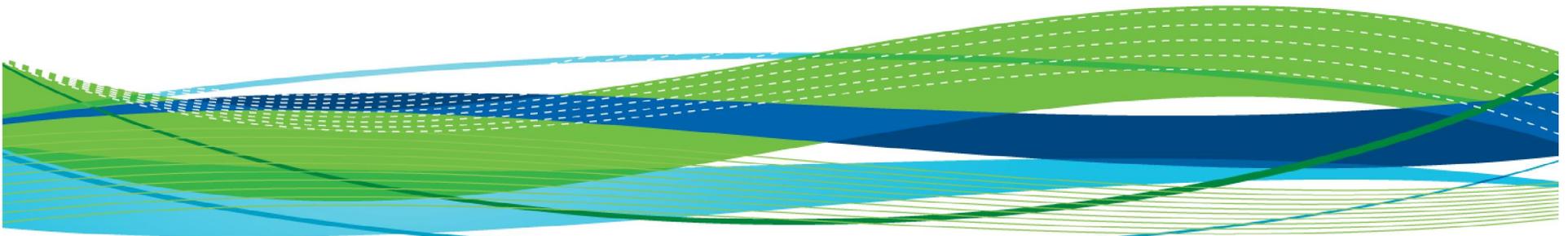


APM Readiness Checklist



Your voice. Louder.

- Rural Health Value Project, part of RUPRI, checklist for you to evaluate your readiness for APMs.
- Takes about 90 minutes for you and your team to review and answer.
- Points out gaps in readiness and a foundation for action.

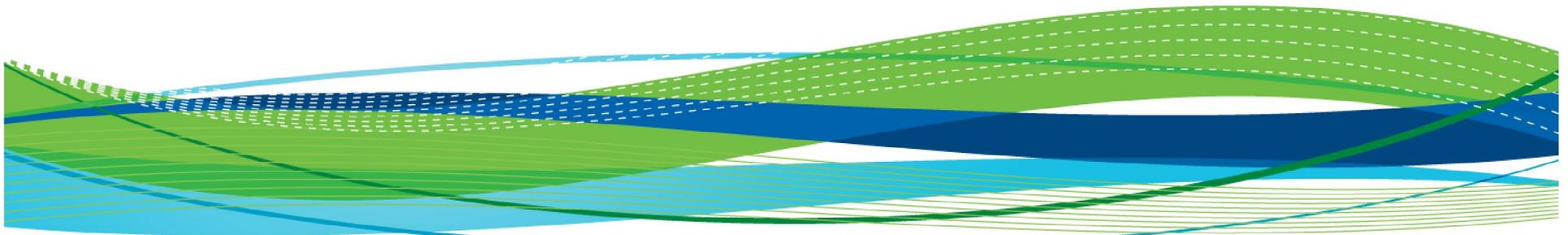


1. Optimize Fee For Service



Your voice. Louder.

- Revenue Cycle Management
- Expense Management
- Market Share
- PQRS
- Payer and Purchasing Contracts (GPO)
- Inventory Management
- Appropriate Volume



2. Efficiency

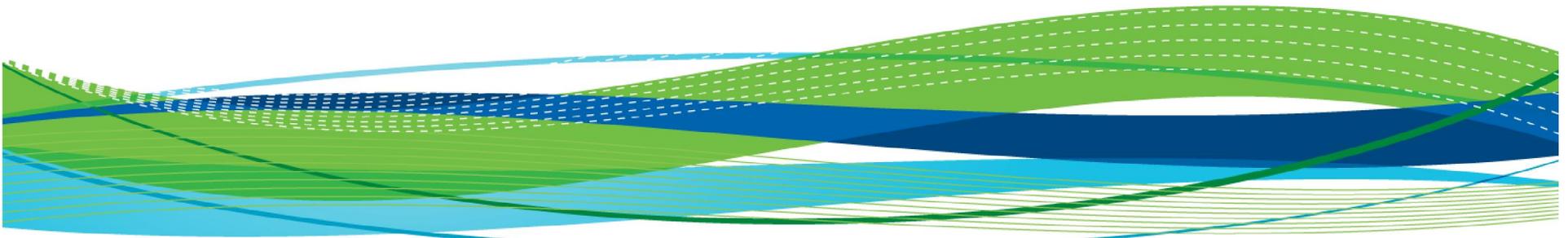


Your voice. Louder.

- Lean
- Six Sigma

Speed plus Accuracy =

Satisfied Employees, Better Delivery,
Better Quality and Satisfied Customers

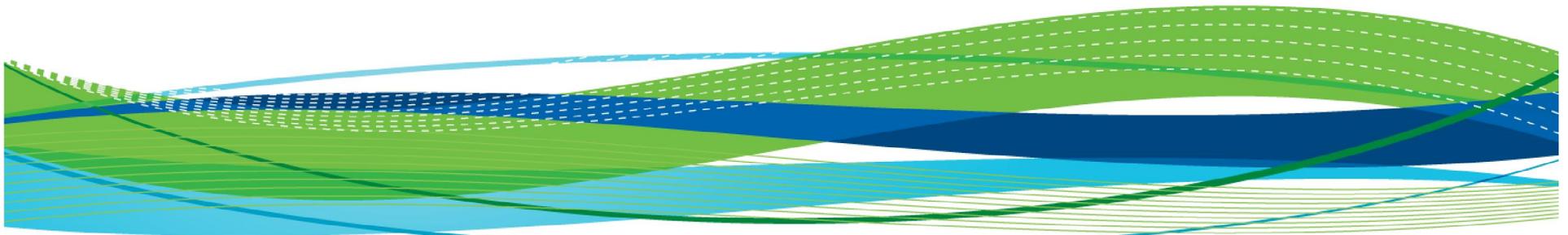


3. Improve Patient Care



Your voice. Louder.

- Clinical Quality, Patient Safety, and the Patient Experience
 - Always is > than the mean, always improving
 - Leadership priority
- Quality/Safety Performance
 - Outpatient: 33 ACO Measures
 - Inpatient: Hospital Compare
- Communicate to Improve
 - Public Reporting (CAH Website)
 - Every Meeting
 - Charts
 - Unbind the Data
- Direct Contracting for Care (cut out the middle and share savings)
 - Your own employees (self-funded plan)
 - Business and Industry (Boeing Announcement example)

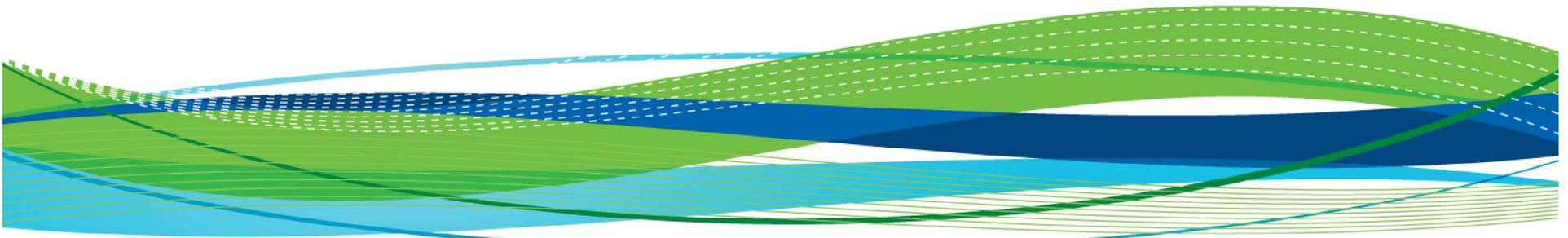


4. Engage the Physicians



Your voice. Louder.

The Hospital CEO's most important job is developing and nurturing good medical staff relationships

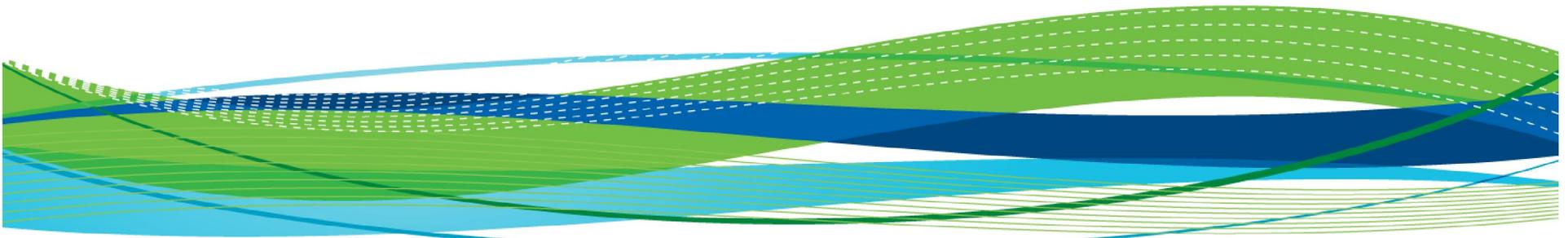


Journey to Value: A Process not an Event



“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”

--Bill Gates, Jr.

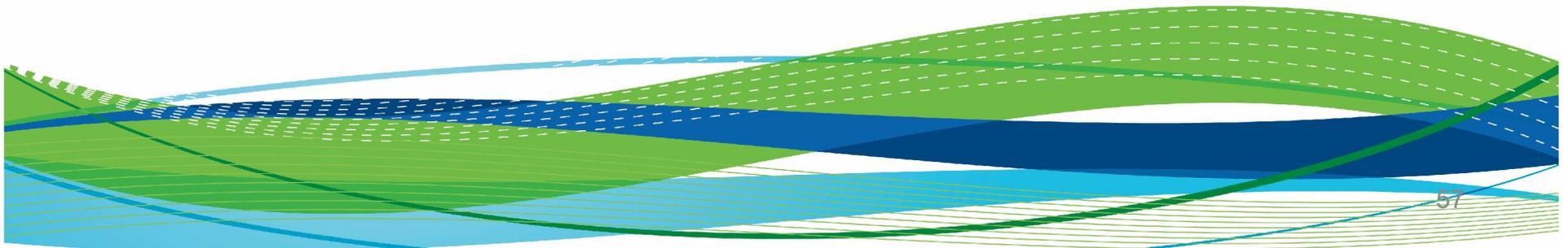




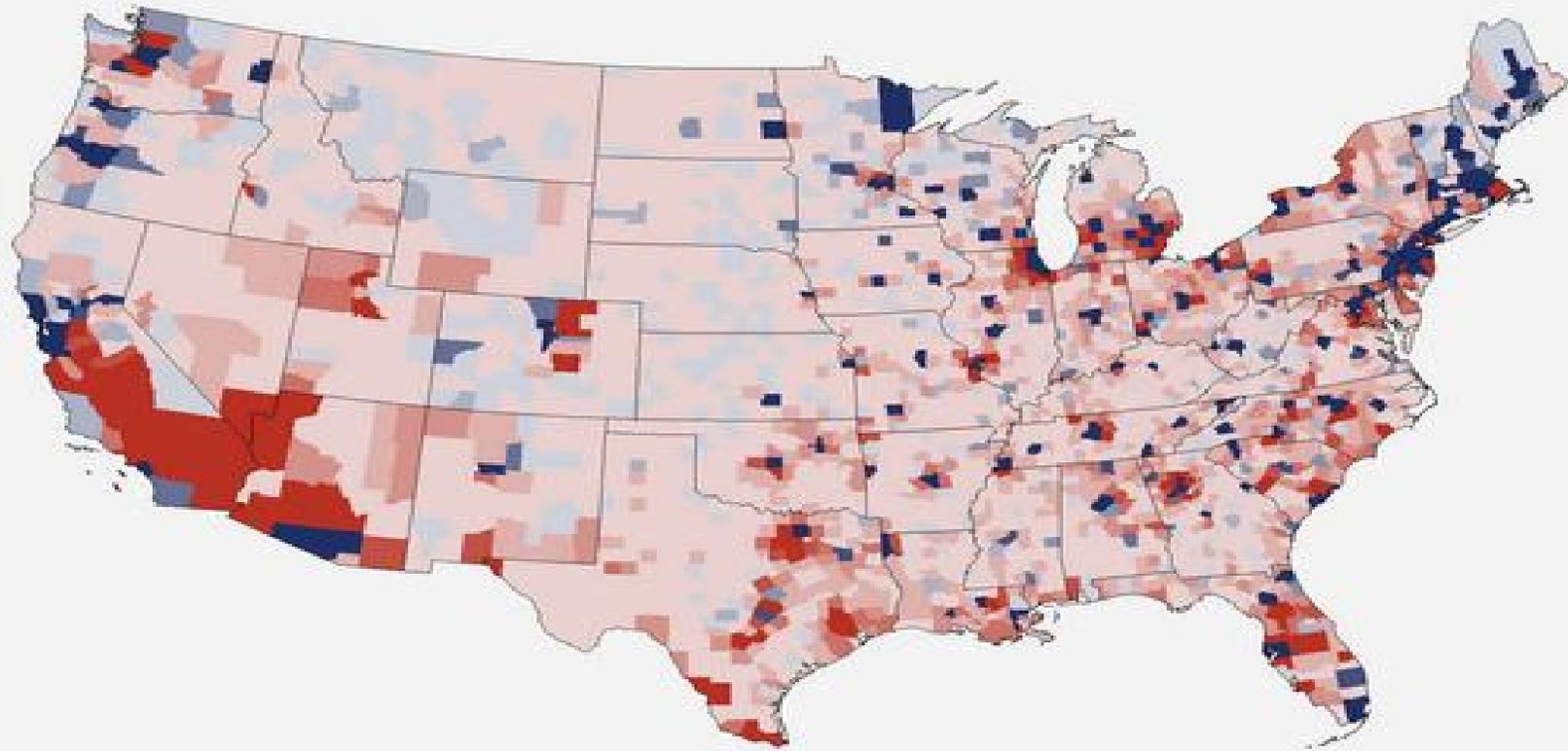
Your voice. Louder.

Key Issues

- Protection from burdensome and excessive policies
 - Physician Supervision
 - 96-Hour Certification Rule in CAH's
 - Two-midnight Policy
 - CAH vs PPS Outpatient Coinsurance: OIG Report
- Protect [340B Program](#)
- ACO Regulations for CAH and rural providers
- Public Health—Ebola, Enterovirus D68, HIV/AIDS
- HPSA/MUA/MUP Data Collection Changes
- Workforce



Nationwide Shortage and Surplus of Primary Care Physicians

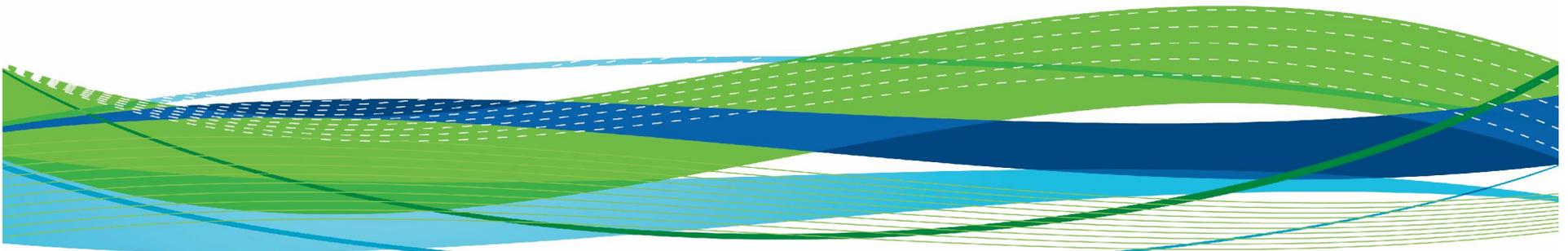


Key Issues



Your voice. Louder.

- NQF Rural Quality Task Force
- Veteran's access to rural providers
www.va.gov/opa/choiceact or (866) 606-8198
- Meaningful Use Stage 2 and now 3
- Rural Health Clinic (RHC) Program
- Federally Qualified Health Center (FQHC)
- Population Health
- Tele-health Opportunities
- CMS Request Letters to CAHs on Validating distance





Your voice. Louder.

Questions?

THANK YOU

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