National Rural Health Association

Delta Region Community Health System Development
May 8, 2020

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#ruralhealth

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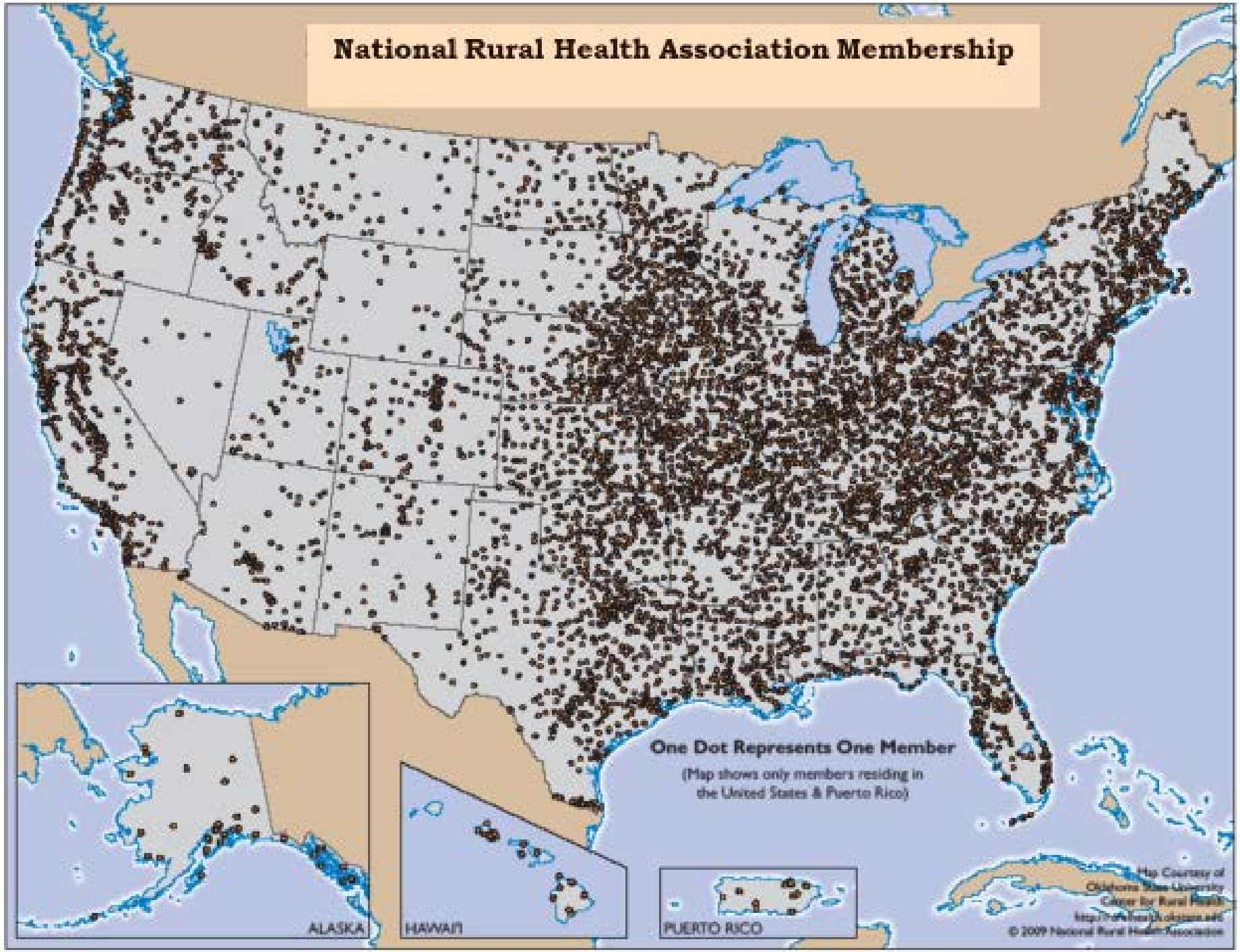
Senior Vice President


National Rural Health Association Membership
One Dot Represents One Member
(Map shows only members residing in the United States & Puerto Rico)
ALASKA
HAWAI'I
PUERTO RICO
Map Courtesy of
Oklahoma State University
Center for Rural Health
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Destination NRHA

Plan now to attend these 2020 events.

Annual Conference	~~May 19-22~~	~~San Diego, CA~~
Rural Hospital Innovation Summit	~~May 19-22~~	~~San Diego, CA~~
	June 16-19	**Virtual Conference**
Rural Health Clinic Conference	Sept. 22-23	Kansas City, MO
Critical Access Hospital Conference	Sept. 23-25	Kansas City, MO

Visit RuralHealthWeb.org

for details and discounts.

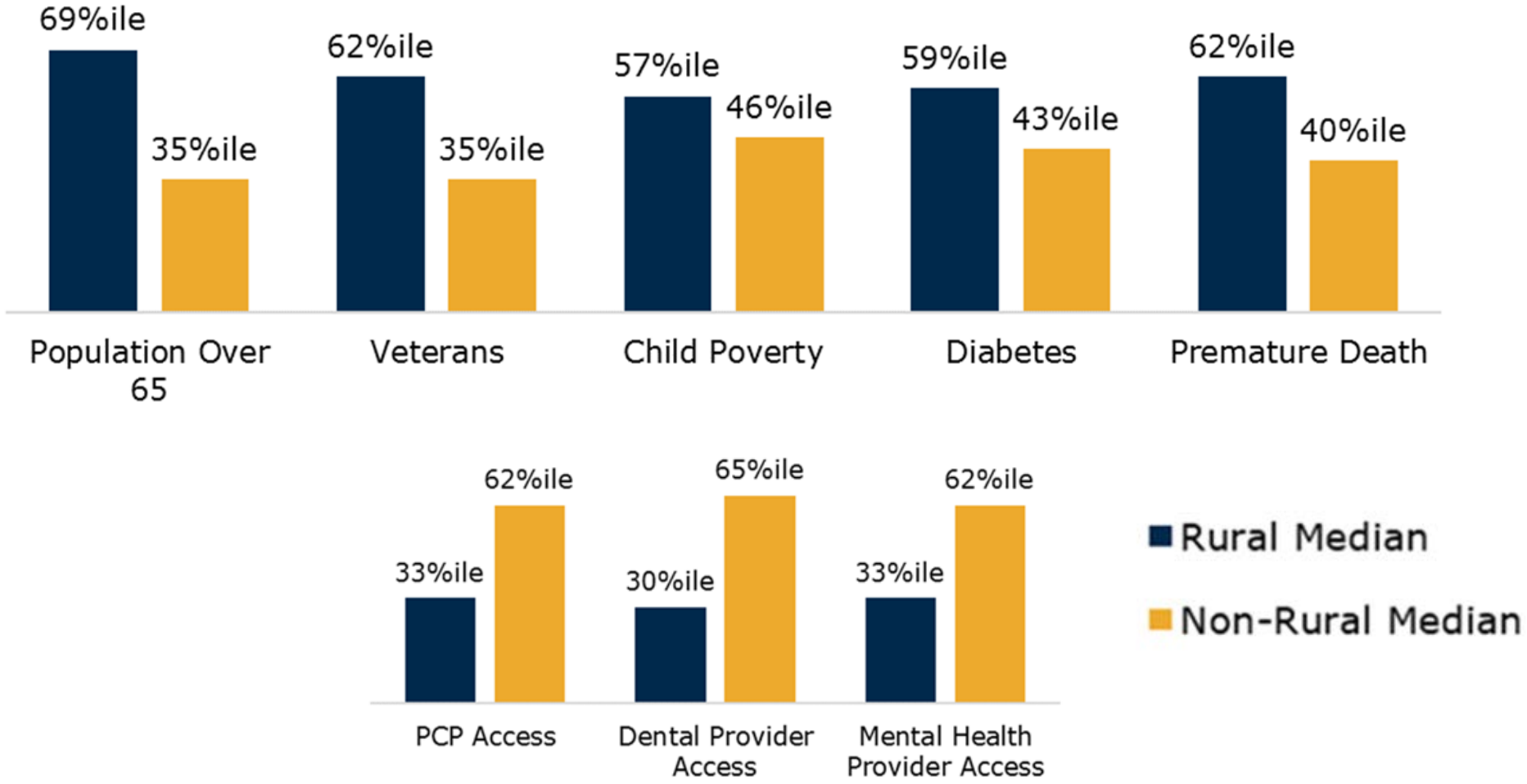
NRHA

Your voice. Louder.

Environmental Scan

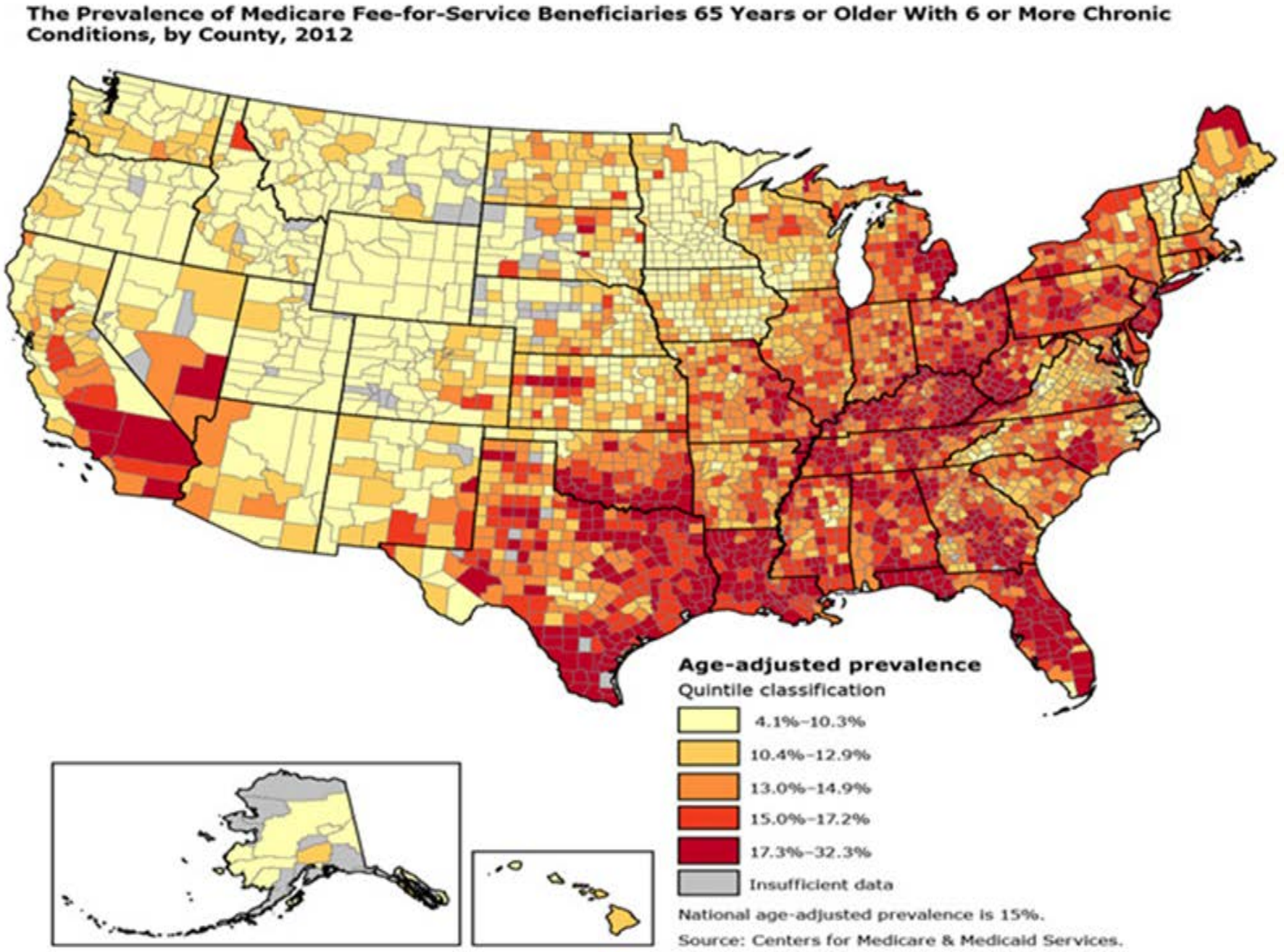
BEFORE CORONA (BC)

Summary: Rural Populations are Older, Less Healthy, Less Affluent and Have Limited Access to Multiple Types of Care

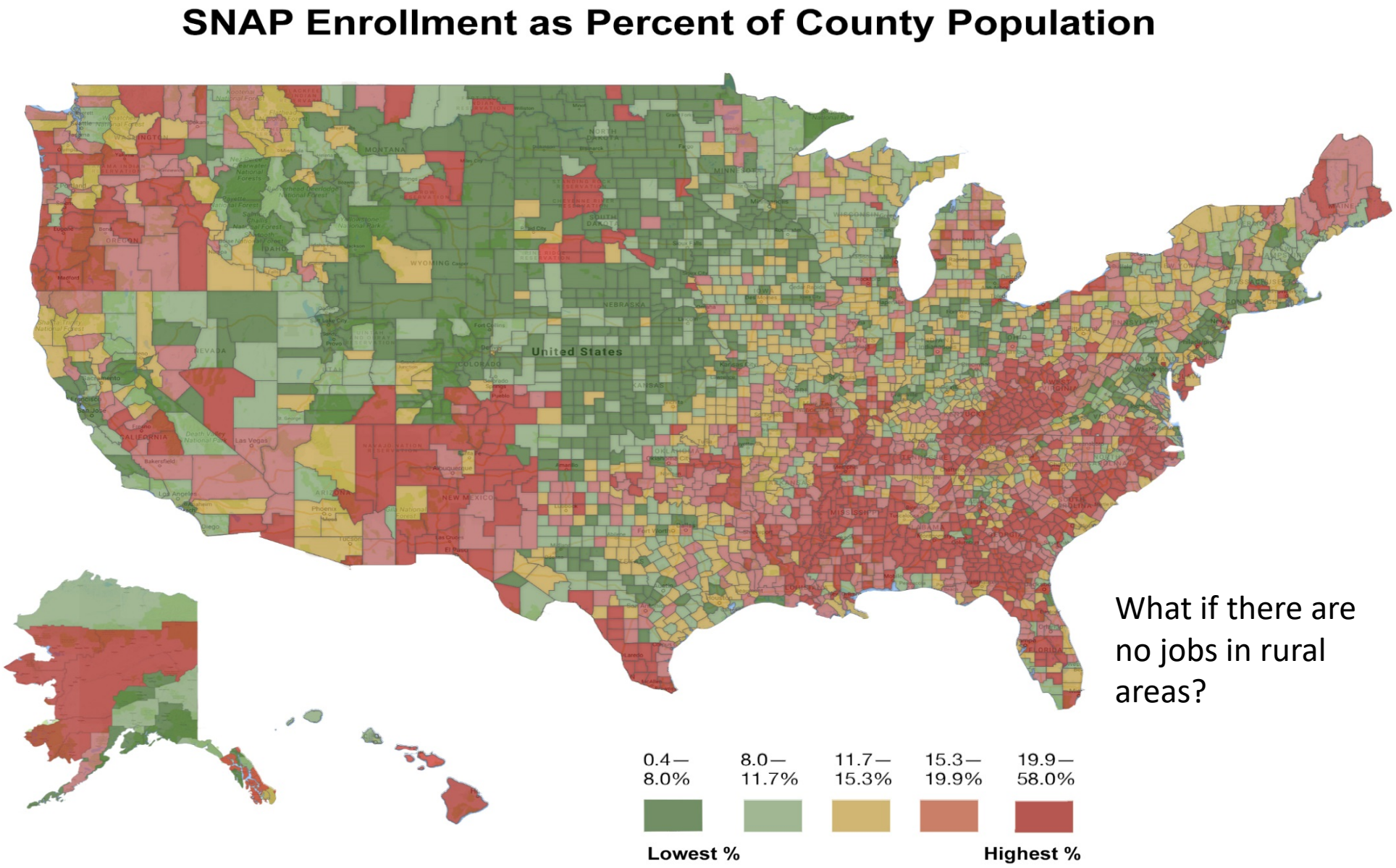


Source: iVantage Chartis Health Analytics

Prevalence of Medicare Patients with 6 or more Chronic Conditions

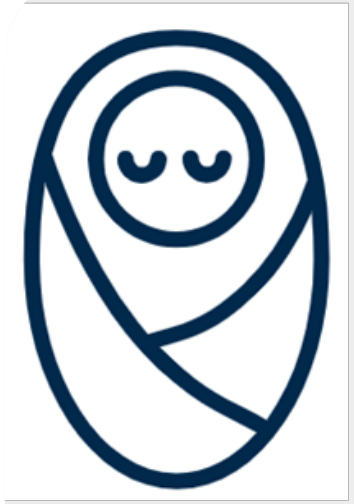


The geography of food stamps



What if there are no jobs in rural areas?

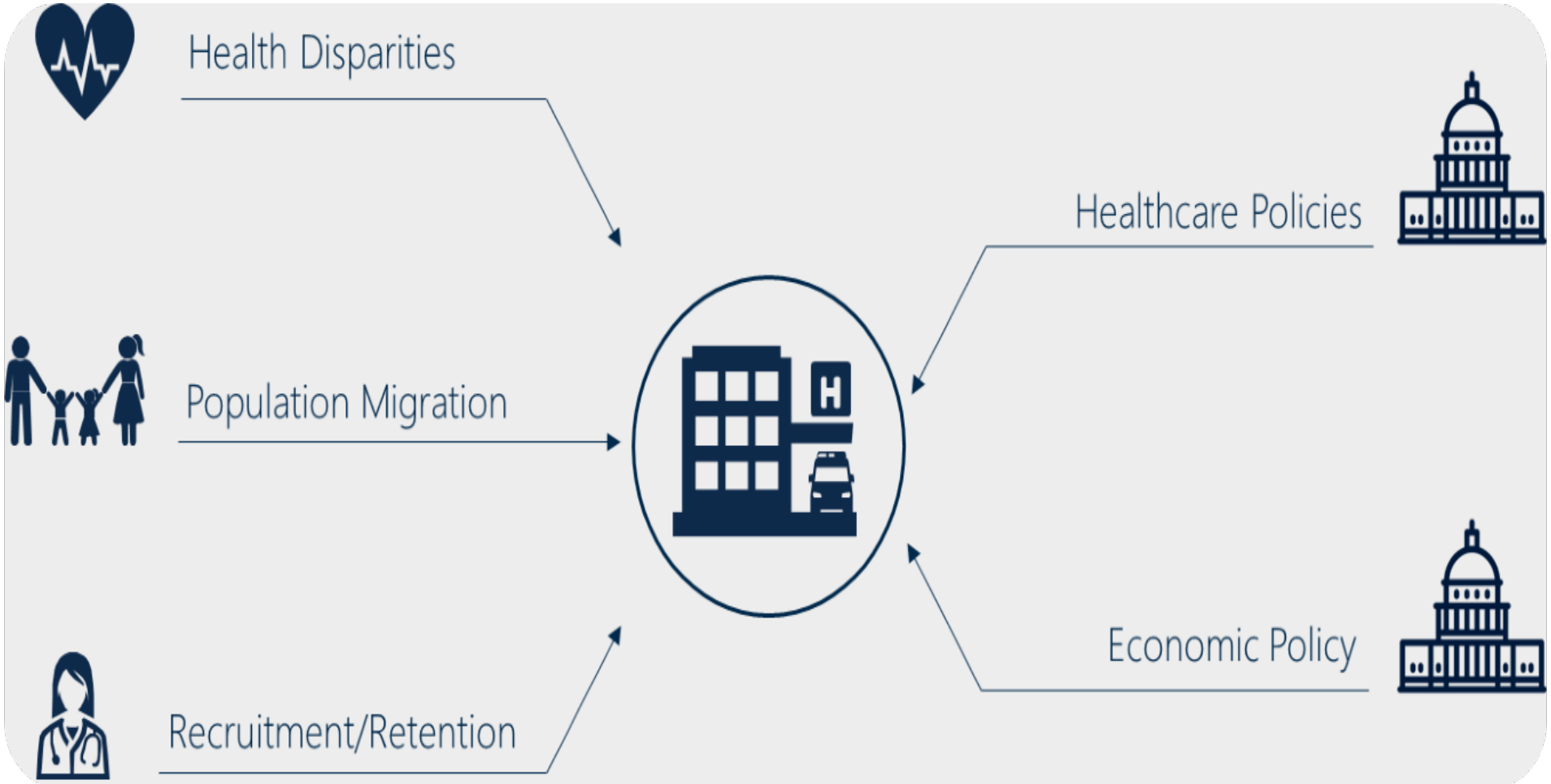
Rural Delivery Service Closures



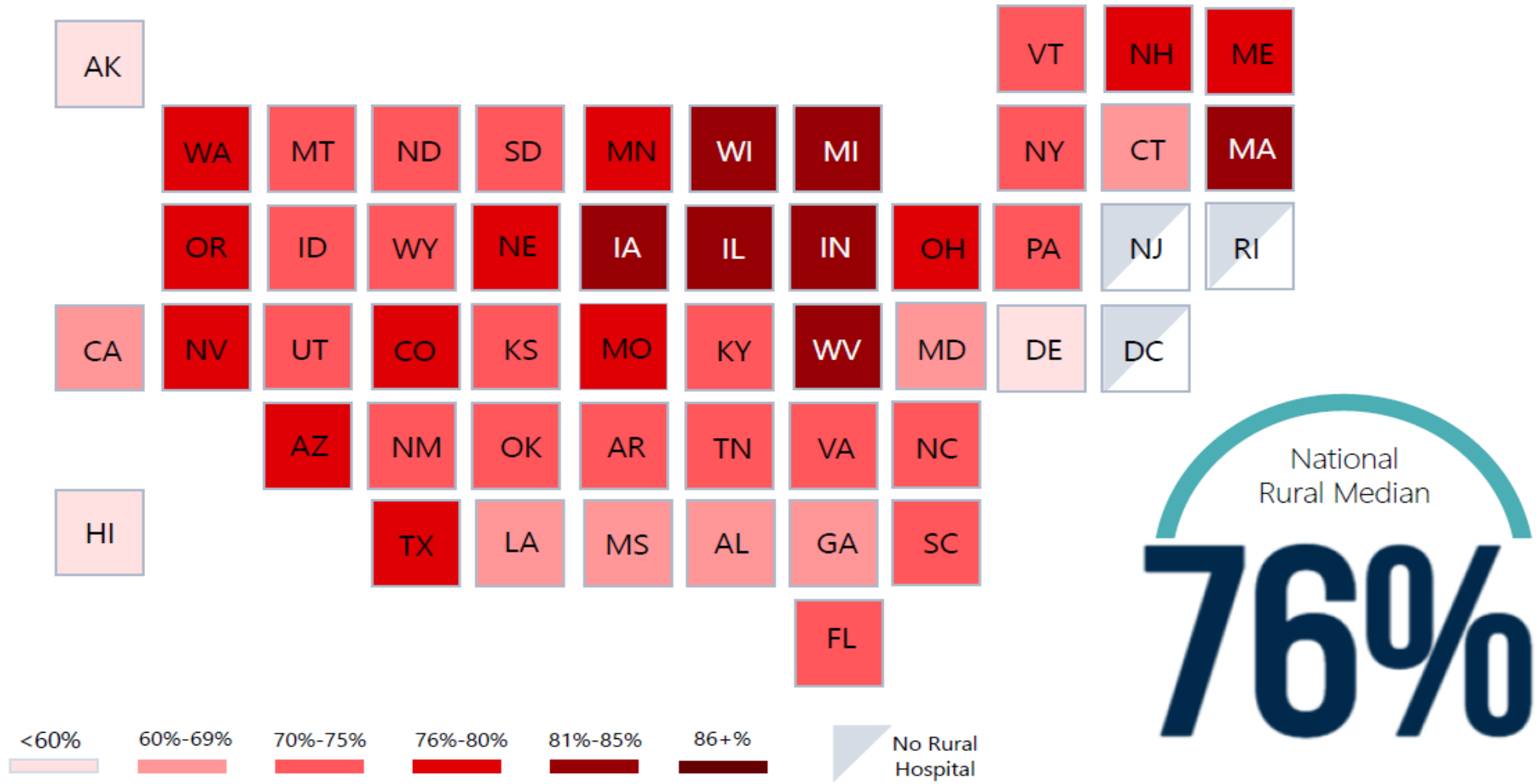
- Rural hospitals dropping OB since 2011: **134**
- Rural hospitals offering OB that have closed: **21**

Rural communities that have lost access to OB since 2011. **155**

Rural Hospital and Clinic Closure Crisis: Convergence of Multiple Pressure Points

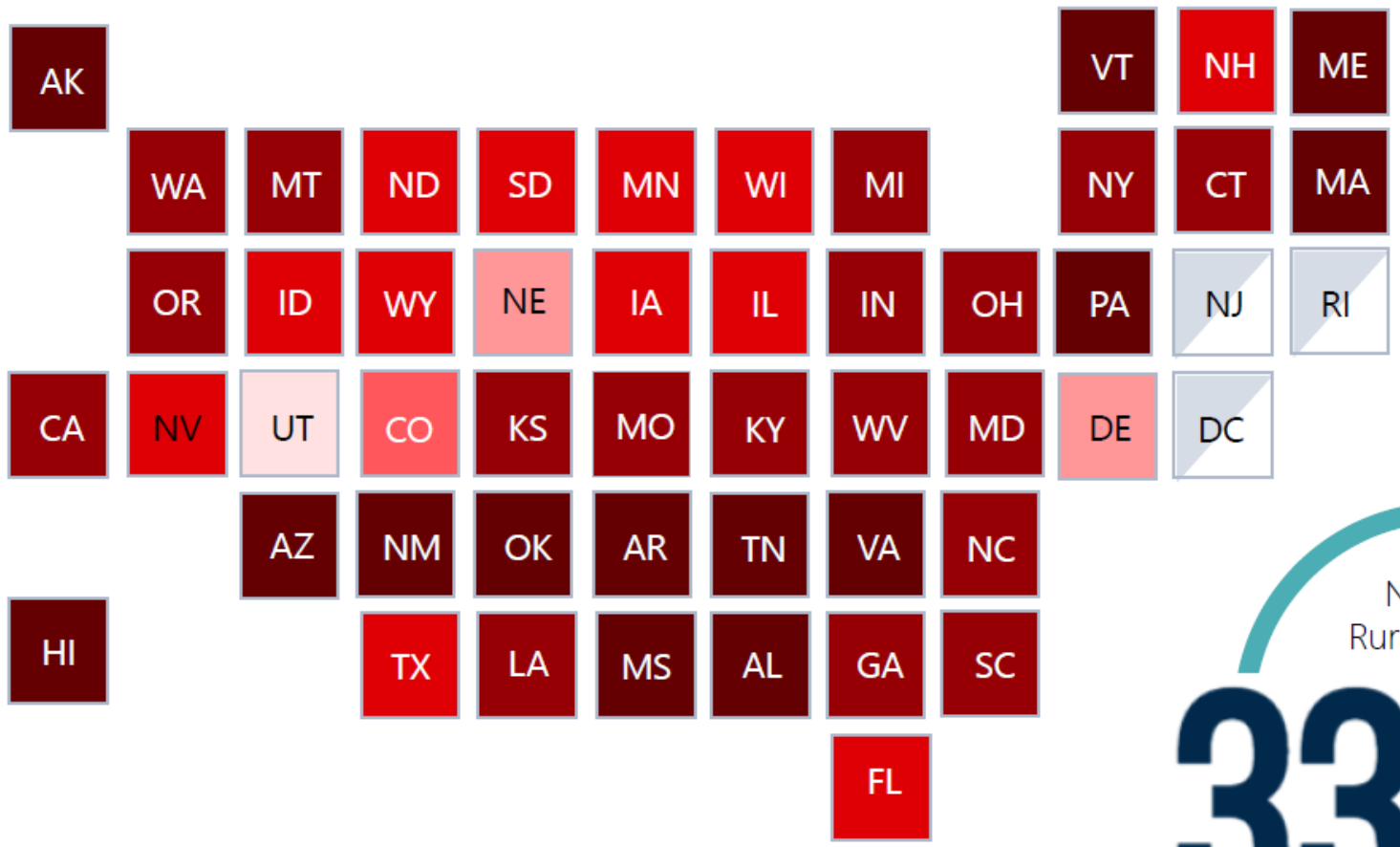


Rural Hospitals (All Rural)
% Revenue Associated with Outpatient Services



Percentage of revenue associated with outpatient service lines.

Rural Hospitals (CAH and RPPS)
Days Cash on Hand

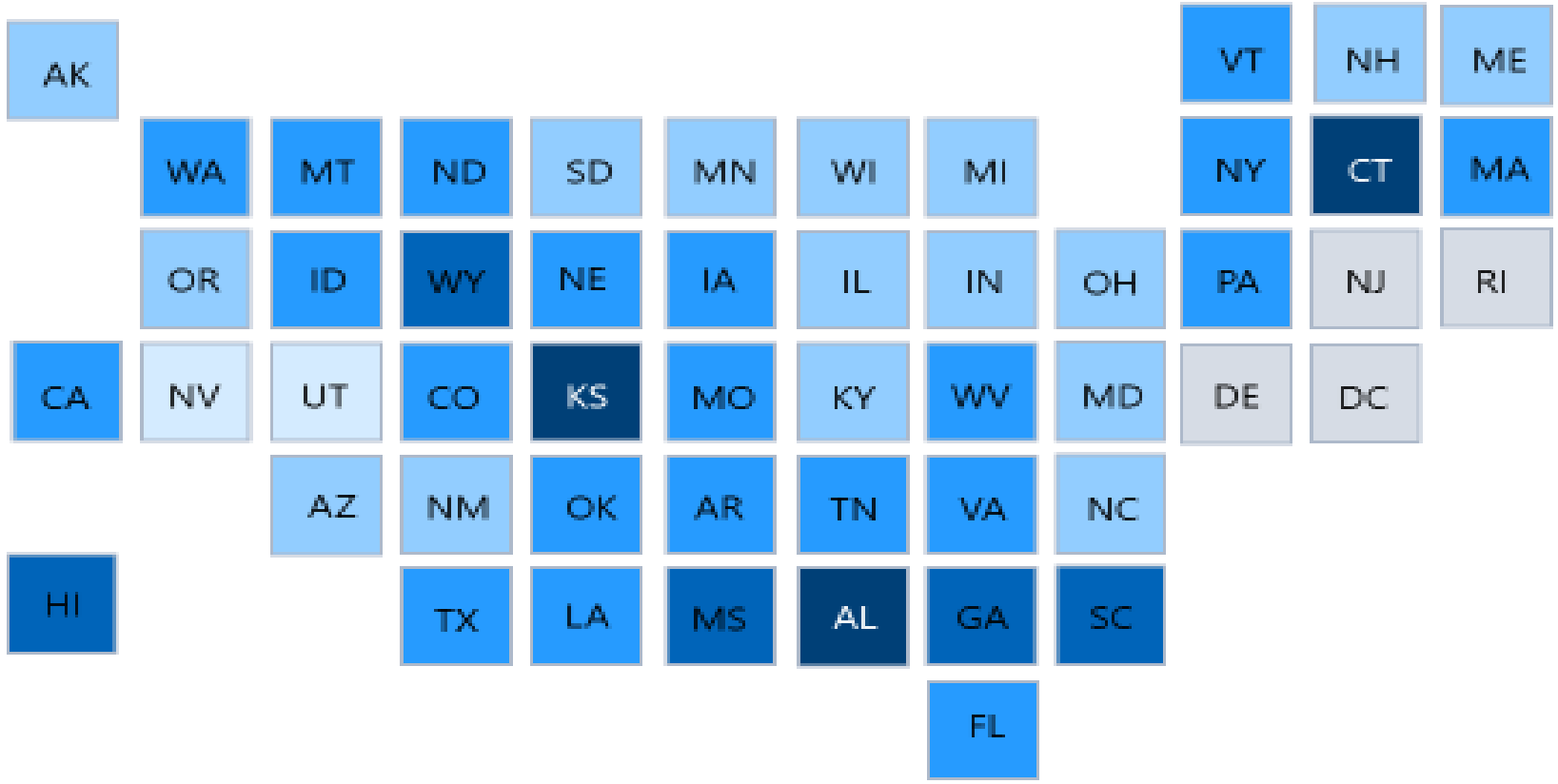


National Rural Median

33 DAYS

Median Days Cash on Hand for All Rural Hospitals within a State.

48% of all Rural Providers have a Negative Operating Margin

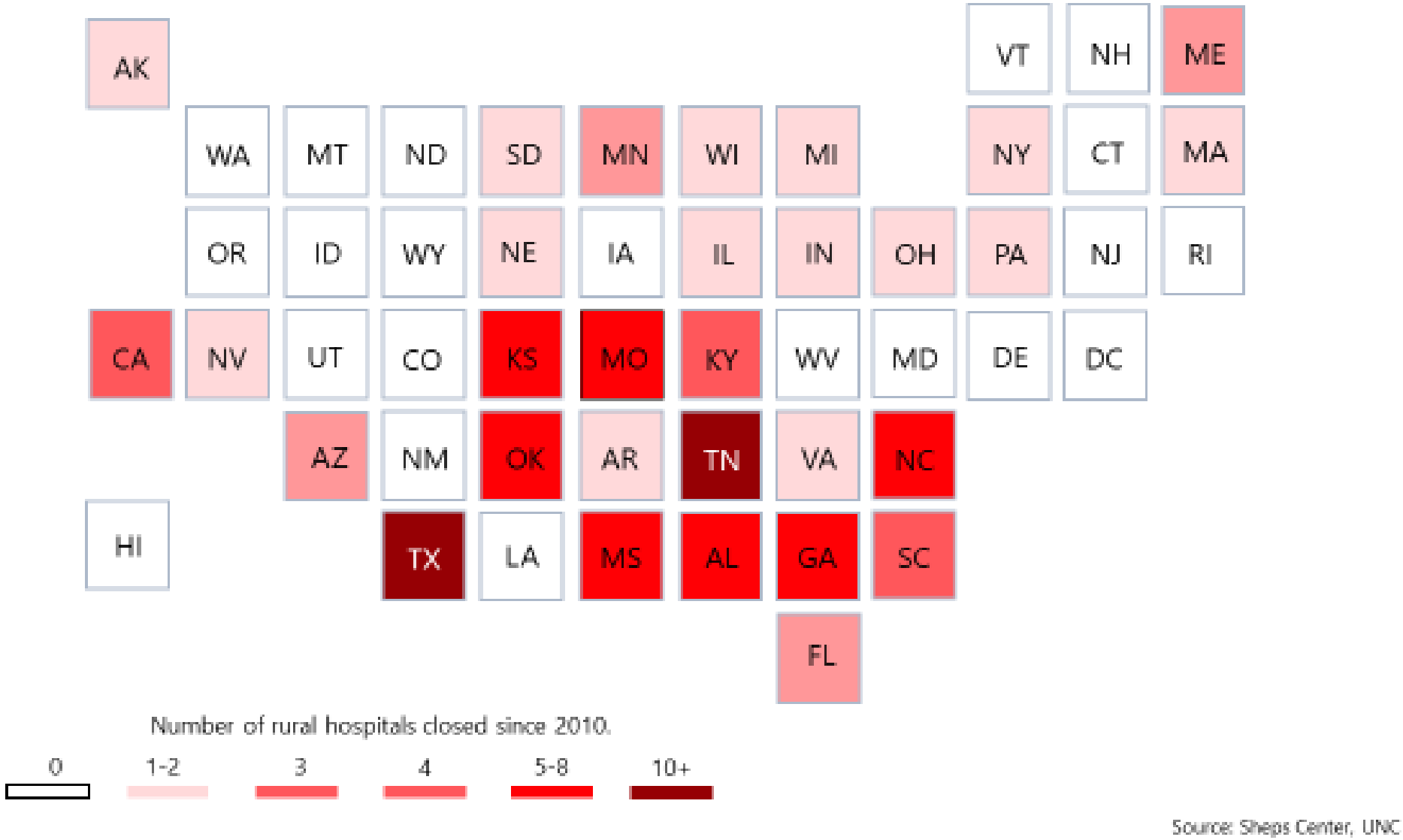


State-level percentage of rural hospitals with negative operating margin.

NA 0-20 21-40 41-60 61-80 81-100

Source: The Chartis Center for Rural Health, 2019.

Rural Hospital Closures – 128 and counting since 2010



Source: Sheps Center, UNC

Predictors of Hospital Closure

Your voice. Louder.

1. Area Deprivation Index	9. Operating Margin (Positive/Negative)
2. Average Age of Plant	**10. Percentage Capital Efficiency**
3. Average Length of Stay	**11. Percentage Change Total Revenue**
4. Case mix Index	12. Percentage Net Days in AR
5. Critical Access Hospital	**13. Percentage Occupancy**
6. Government Control Status	**14. Percentage Outpatient Revenue**
7. Medicare/Medicaid Discharges	**15. System Affiliation**
8. Number of Beds	**16. State-level Medicaid Expansion Status**

Bold text indicates those variables that are statistically significant

Source: Chartis iVantage

Regression model showed that…

- Being located in a Medicaid expansion state decreases the likelihood of closure by 62.3 percent
- Government Control Status was shown to decrease the likelihood of closure 70 percent
- System Affiliation was shown to decrease the likelihood of closure by nearly 50 percent
- A one percent increase in the percent change in total revenue can decrease the likelihood of closure by three percent
- A one percent increase in the proportion of outpatient revenue decreases the likelihood of closure by four percent

Source: Chartis iVantage

Vulnerability by the numbers

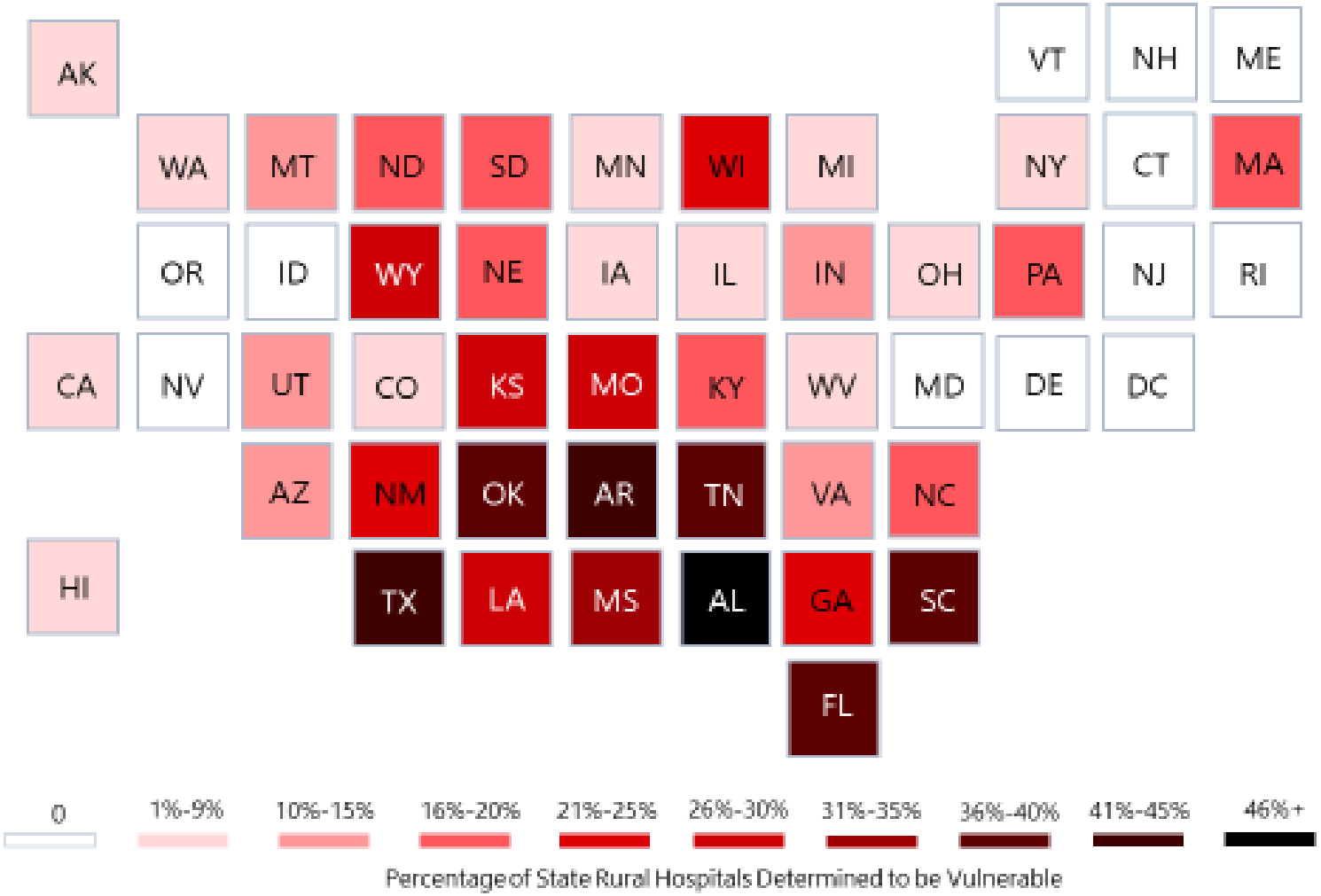
Your voice. Louder.

- 453 rural hospitals BC (i.e. Critical Access Hospitals and Rural & Community Hospitals) are vulnerable to closure based on performance levels which are similar to rural hospitals at the time of their closure
- Of these hospitals, 216 are considered “most vulnerable” BC
  - 97 of these are CAHs
  - 119 are PPS Hospitals
  - 75% or 162 are in states that have NOT expanded Medicaid
  - 76% or 165 do not have government control status

Source: Chartis iVantage

Chartis Vulnerability Analysis by State

Rural Hospital Vulnerability



Crisis in Rural Emergency Medical Services

Your voice. Louder.

- Communities across the country are seeing shortages of emergency services personnel.
- Rural areas are struggling to keep EMT services running because often they are made up of volunteers and part-time people.
- Estimate: up to one-third of all rural emergency services are in operational jeopardy.
- SIREN Act, a $5 million appropriation in Fiscal Year (FY) 2020 that supports rural fire and emergency medical services (EMS).
- An NRHA policy brief examines the issues for EMS services in rural areas
- Unlike fire and police departments, EMS agencies are not considered an essential, or required service in more than half of the USA.

NRHA

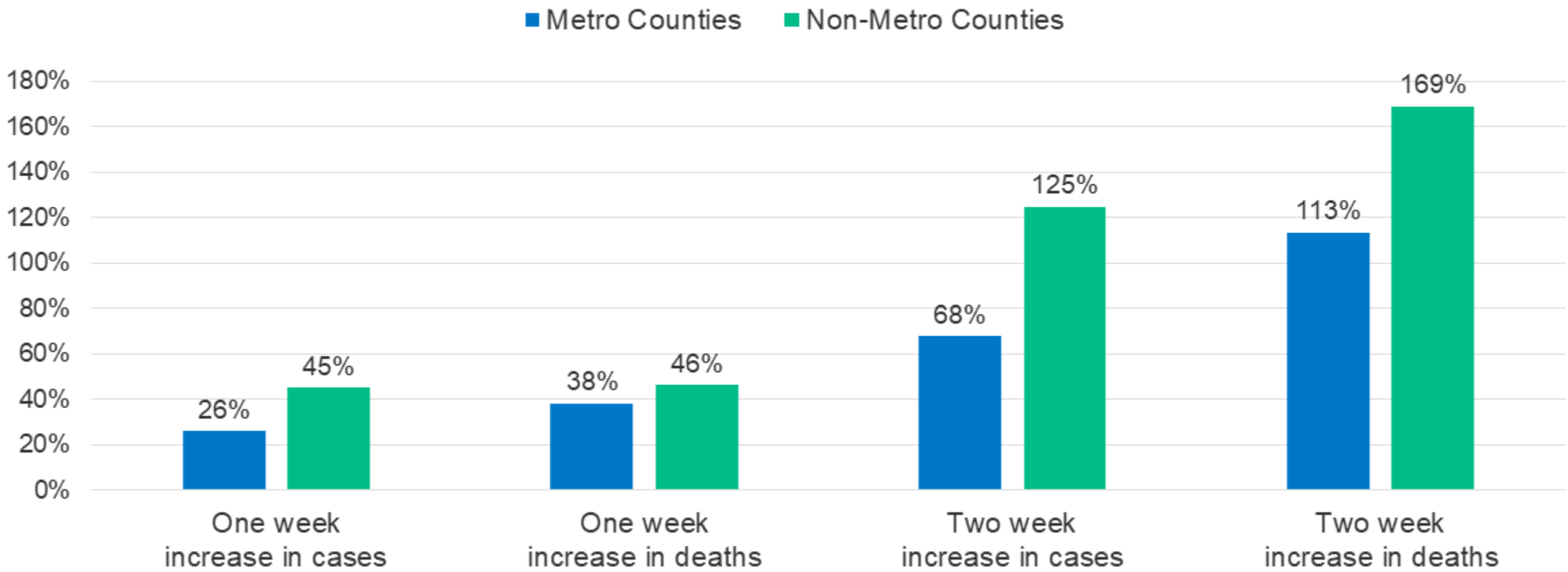
Your voice. Louder.

Environmental Scan

After CORONA (AC)

Figure 2

Rate of Increase in Coronavirus Cases and Deaths



NOTE: Data are as of April 27, 2020. Coronavirus cases and deaths not assigned to a county are excluded.

SOURCE: Center for Systems Science and Engineering (CSSE) at Johns Hopkins University; US Census Bureau; Federal Office of Rural Health Policy.

KFF
HENRY J KAISER FAMILY FOUNDATION


TRAVELERS CONTINUE
TO DRIVE ON BY
DO NOT STOP
OUR COMMUNITY IS
PREVENTING THE SPREAD
OF COVID-19

Rural Fractures Widen as Covid 19 Spreads

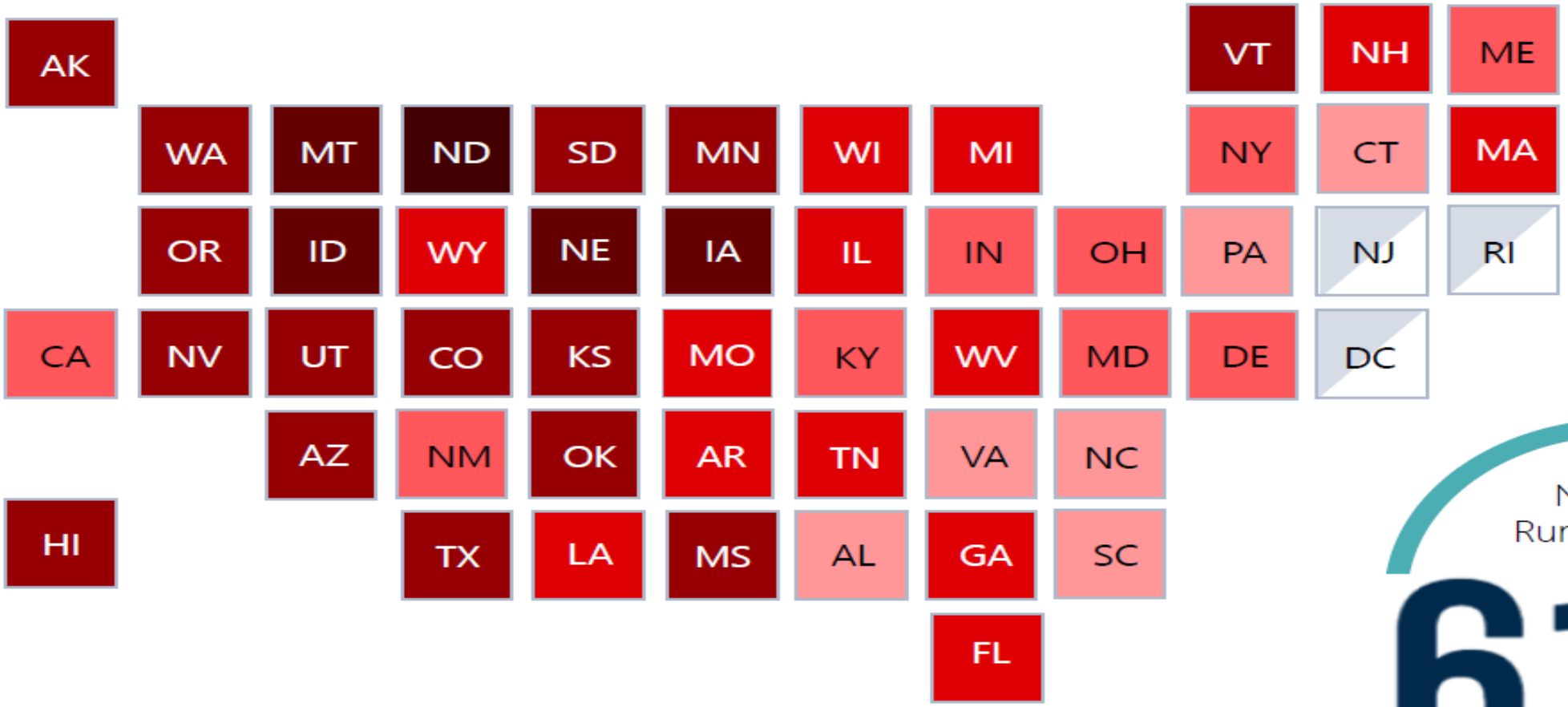
Your voice. Louder.

- Covid 19 has exploited the longstanding weaknesses of rural providers of care
  - Workforce
  - Technology/Supplies
  - Reimbursement/Finances
- Workforce shortages will be highlighted in the wake of Covid 19 spread
- Technology/Supplies
  - PPE
  - Ventilators
  - Testing
- Reimbursement/Finances: The Covid Paradox
  - CDC/CMS Recommendations to discontinue all elective/non-emergent care
  - Hospitals nationwide sitting idle as a result, hemorrhaging cash
  - Acute need for support in this period of emergency

Tyranny of Efficiency

- U.S. health care system over the last almost four decades has focused on efficiency due to:
  - Declining inpatient census
  - Growing share of the health care sector in the GDP
  - Technologies/drugs that decrease routine utilization creating excess provider capacity
- Results:
  - 1978 the US had over 1.5M hospital beds
  - 2016 the US had approximately 900,000 beds
  - Supply chains feature “just-in-time” efficiencies that operate best during routine operations
- After Corona:
  - A health care system designed for routine efficiencies are severely stressed
    - Workforce
    - Technology (vents)
    - Drugs

Rural Hospitals (All Rural)
% without Intensive Care Unit Beds (2018)



National Rural Median

61%

<20% | 21%-35% | 36%-50% | 51%-65% | 66%-80% | 81%-90% | 91%+

No Rural Hospital

Percentage of State Rural Hospitals without ICU beds. Minimum of 3 ICU beds per hospital.

Re-opening Elective/Non-Emergency Services

Your voice. Louder.

Key Elements to Control Community Spread

- Testing
- Tracing
- Treatment
- Vaccine

Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I

- Adequate facilities, workforce, testing, and supplies
- Adequate workforce across phases of care (such as availability of clinicians, nurses, anesthesia, pharmacy, imaging, pathology support, and post-acute care)
- In coordination with State and local public health officials, evaluate the incidence and trends forCOVID-19 in the area where re-starting in-person care is being considered

NRHA

Your voice. Louder.

Covid 19 Response

After CORONA (AC)

NRHA Response to Covid 19 Threats to Rural America

Your voice. Louder.

- NRHA Covid 19 Response Resource Center Online
- Partnering with federal agencies to clear regulatory barriers rural providers face and discover resources available to help
- Technical Assistance to rural providers of care on CMS Conditions of Participation (CoP) Waivers issued by President Trump
- Curating a membership listserv that has generated over 1,000 entries from rural providers of care nationwide
- Spreading best practices during crisis through resource sharing and problem solving
- Positioning NRHA as a trusted source of evidenced-based information in a time of crisis

CMS 1135 Waivers (partial list)

- SNF/Swing Bed waiver of 72 hour qualifying hospital stay
- Waived CAH bed limit of 25
- Waived CAH 96-hour average length of stay
- Telehealth waivers
  - RHC/FQHC distant site status during Public Health Emergency (PHE) in CARES Act
  - Encounter rate $92.03 per visit
  - Guidance issues by CMS on billing
    - Billed to Part B
    - Caution: costs associated with this service should be carved out of RHC cost reports and these encounters would NOT count toward provider productivity
    - Future waiver request to eliminate provider productivity screens
- Medicare Accelerated/Advanced Payment Program
  - CMS announced this will end soon
  - Billions of dollars forwarded to rural hospitals
  - NRHA advocacy agenda in Covid 4.0: forgiving funding forwarded under the provisions of this program

CARES Act Funding Provisions

Your voice. Louder.

- SBA Payroll Protection Program (PPP)
  - Exclusions: organizations that have declared bankruptcy
  - Controlling interest issues (systems) are excluded due to more than 500 employees
  - Governmental hospitals included based on 501(c)3 look-a-like provisions
  - Loan program open to clinics, associations and other community organizations, for-profit or non-profit
  - Must demonstrate at least 75% of funds are used for payroll purposes
  - Document “need” for the funds, NRHA in discussion with SBA and Treasury on definition of need
  - Covid 3.5 legislations added more money to this fund, it is going fast
  - Get with you banker ASAP to take advantage, money may run out by end of next week
  - SBA Extends Repayment Date for PPP Certification Safe Harbor to May 14
  - PPP does not include allowance for contracted services
  - SBA and NRHA are hosting a webinar on May 11 and 12 reviewing details of this program, check email for details/registration

CARES Act Funding Provisions, Continued

- Public Health and Social Services Emergency Fund (PHSSEF) or Provider Relief Fund
- $100B in Round 1
  - $50 billion general allocation will be allocated in proportion to each healthcare provider's share of 2018 total patient revenue
    - First $30B was distributed based on Medicare revenue only
    - Second tranche of $20B distributed based on total revenue and reconciled with the first phase.
  - Treatment of uninsured COVID-19 patients at Medicare rates. Providers can register for this reimbursement program beginning on April 27, 2020 and begin submitting claims in May 2020
  - $10B will be allocated for targeted distribution to hospitals in areas that have been particularly impacted by COVID-19
  - $2B for Low Income and Uninsured Patients
  - $10B targeted to rural hospitals, Rural Health Clinics and Federally Qualified Health Centers on 5/6/20
  - $400 million will be allocated for Indian Health Service facilities on the basis of their operating expenses.
  - Deposits made electronically by United Healthcare or Optum

HRSA Funding

- $150M Small Rural Hospital Improvement Program (SHIP) grants to support Covid Activity, approximately $90K per hospital—2 rounds on 4/1/2020 and 4/22/2020
- $1.32 billion in supplemental funding to community health centers (CHCs), including those providing care in rural areas (Sec. 3211)
- Reauthorizes HRSA grant programs that promote telehealth (Sec. 3212)
- Reauthorizes three rural health grant programs until 2025 — Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs. The reauthorization modernizes certain language (Sec. 3213)
- Establishes a Ready Reserve Corps to help ensure the nation has enough trained doctors and nurses to respond to COVID-19 and other public health emergencies (Sec. 3214)
- Allows reassignment of the NHSC to sites close to the one to which they were originally assigned, with the Corps member's voluntary agreement, in order to respond to the COVID19 public health emergency (Sec. 3216)
- Reauthorizes (until 2025) and updates Title VII of the Public Health Service Act (PHSA), which pertains to programs to support clinician training and faculty development, including the training of practitioners in family medicine, general internal medicine, geriatrics, pediatrics, and other medical specialties (Sec. 3401)
- Reauthorizes (until 2025) and updates the section of the Public Health Service Act related to education and training relating to geriatrics. It provides for grants, contracts, or agreements to health education programs for the establishment or operation of **Geriatrics Workforce Enhancement Programs**. (Sec. 3403)
- Reauthorizes (until 2025) and updates Title VIII of the PHSA, which pertains to **nurse workforce training programs**.
- Extends mandatory funding for programs crucial to rural areas: Community health centers; National Health Service Corps (NHSC); and Teaching Health Center Graduate Medical Education Program (THCGME) (Sec. 3831)
- Also provides $185 to HRSA to support rural critical access hospitals, rural tribal health and telehealth programs, and poison control centers (Title VII)

NRHA

Your voice. Louder.

Covid 19 Recovery

After CORONA (AC)

NRHA Covid 19 Recovery Plans

- Covid response is a marathon not a sprint
- Expecting Response phase to last 12-18 months
  - Testing, Tracing, Treatment and **Vaccine**
  - Continued stress on local epicenters of outbreaks and surges for care
  - Confounds re-opening strategies
- NRHA Developing Recovery Plan
  - Kevin Bennett, Chair, NRHAs Rural Health Congress is heading up the process
  - Critical to include rural in legislation addressing recovery, for example:
    - Public Health renaissance
      - Rural hospitals assisting with public health activities, pandemic response such as testing and contact tracing
    - New model(s) for rural providers—Incentives matter
      - Focus on reimbursement rather than structures (provider types)
      - A capitated system would have worked well in pandemic, for example

National Rural Health Association

Questions?

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