National Rural Health Association

Where We Want To Go: The Future of Rural Health

California State Rural Health Association

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#ruralhealth
September 21, 2023

Brock Slabach, MPH, FACHE
Chief Operations Officer

Destination NRHA

Plan now to attend these 2023 events.

Rural Health Clinic Conference	Sept. 26-27, 2023	Kansas City, MO
Critical Access Hospital Conference	Sept. 27-29, 2023	Kansas City, MO
Rural Health Policy Institute	Feb. 13-15, 2024	Washington, DC
Annual Conference	May 7-10, 2024	New Orleans, LA
Rural Hospital Innovation Summit	May 7-10, 2024	New Orleans, LA

Visit ruralhealth.us

for details and discounts.

National Rural Health Association

NRHA

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NRHA is a national nonprofit membership organization with more than 21,000 members, made up of a diverse collection of individuals and organizations with the common goal of ensuring all rural communities have access to quality, affordable health care.

Our mission is to provide leadership on rural health issues.

Why rural?

- Rural areas make up 80% of the land mass in USA
- Rural areas have roughly 17% of the US Population
- Rural areas provide the food, fuel and fiber to power our nation
- Access to high-quality health care is a requirement to keep these important resources available
- An exchange between urban and rural that must not be overlooked
- Historically, public policy has disadvantaged health care in rural communities

National Rural Health Association

Our Future Depends on our Advocacy

- Investing in a Strong Rural Health Safety Net
- Reducing Rural Healthcare Workforce Shortages
- Addressing Rural Declining Life Expectancy and Inequality

The Future of Rural Health

- Investment leads to healthier communities and workforce, which in turn attracts businesses and benefits the economy
- Core services available regardless of where you live
- Local rural health agencies established as a convenor
- Partnerships allow us to organize care as a community, reduce duplication of services and be more efficient
- Benefits rural areas that often have fewer resources

Rural Social Drivers of Health

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Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Pollution	Literacy	Food insecurity	Social isolation	Health coverage
Income	Housing	Language	Access to healthy food options	Community engagement	Provider availability
Expenses	Transportation	Early childhood education	SNAP	Discrimination	Provider linguistic and cultural competency
Debt	Public Safety	Vocational training		Stress	Quality of care
Medical Bills	Climate Change	Higher education			
Support	Walkability				

Adapted from KFF

Future: The Political Drivers of Health

The future of health equity begins and ends with the political determinants of health. --Leslie Erdelack

- Political drivers of health create the social drivers. Some examples:
  - Medicaid Expansion
  - GME Polices and specialties
  - Poor environmental conditions
  - Unsafe neighborhoods
  - Lack of healthy food options

- Defined: The Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities.

  --Daniel E. Dawes (2020)

Future: Commercial Drivers of Health

Defined as *systems, practices, and pathways through which commercial actors drive health and equity.*
Source: The Lancet, March, 2023

Four industries (tobacco, unhealthy food, fossil fuel, and alcohol) are responsible for at least a third of global deaths per year.
Source: The Lancet, March, 2023

- Commercial actors (CA) shape regulation and policies
- Favorable policies increase sales of possibly harmful products
- Policies enable CA to externalize the cost of harm
- Externalized costs met by states and individuals affected
- CAs enjoy large profits that propels a growing power imbalance

Capitol Hill Listens to You

Federal/State Officials value and want to hear YOUR input

- Capitol Hill values rural health advocate input.
- The Hill wants ***YOUR*** story.
- You and your legislators are neighbors.
- ***YOUR*** voice is important to help get meaningful legislation passed. As a provider and employer in a district, you understand how legislation will most impact a Member's constituency.

The real problem of humanity is the following, we have:

- paleolithic emotions
- medieval institutions
- godlike technology

Edward O. Wilson
https://www.nytimes.com/2019/12/05/opinion/digital-technology-brain.html

The Stories We Tell

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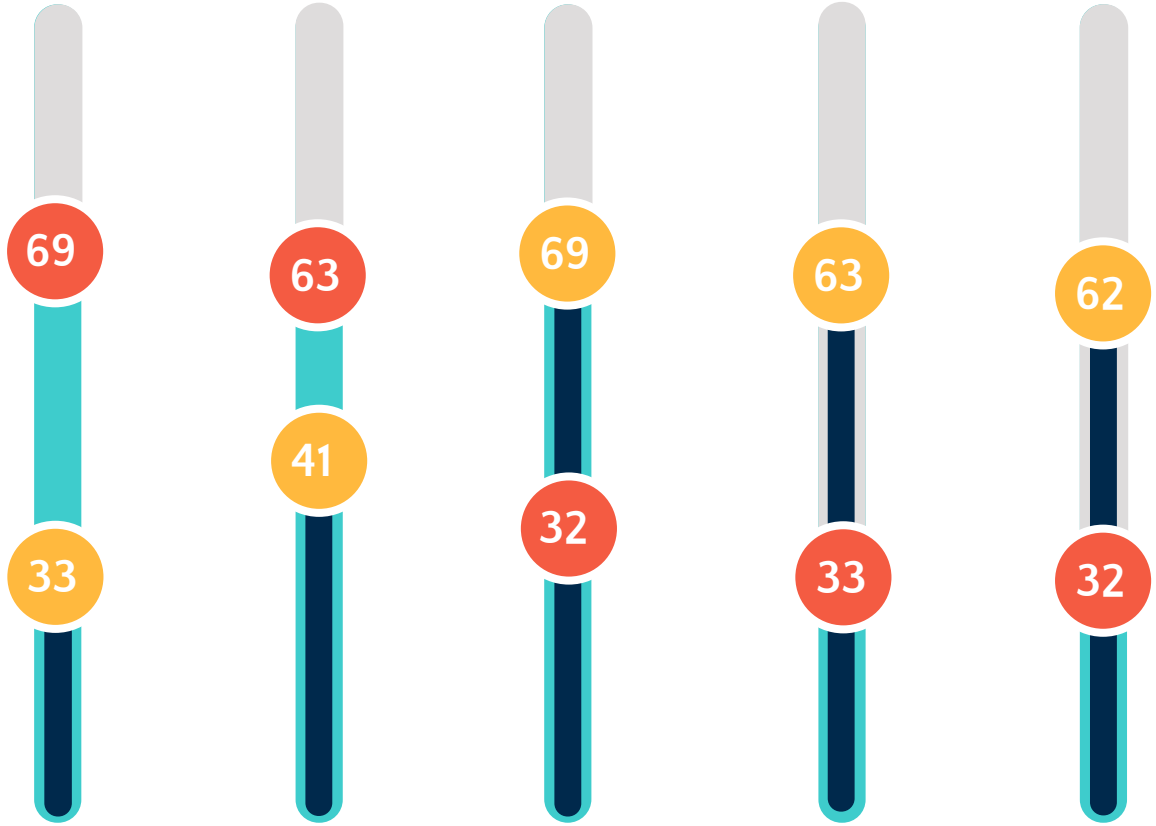
Population Health Disparity

Rural v. Urban

Rural

Urban

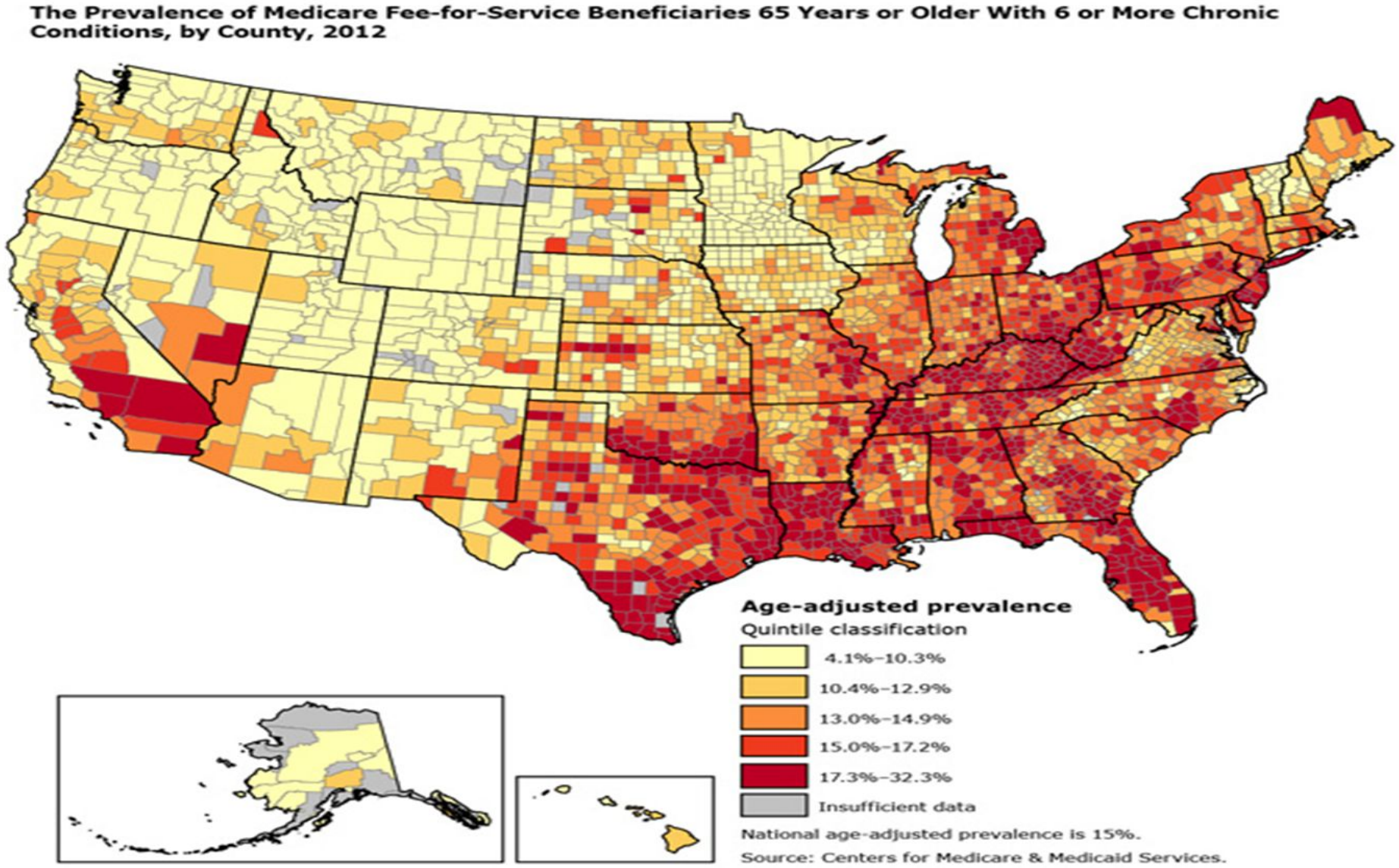
Percentile Ranking



Over 65 | Diabetes | Median HSHLD Income | Access to Primary Care | Access to Mental Health

Oral Health Disparities in Rural

Prevalence of Medicare Patients with 6 or more Chronic Conditions



The Geography of Food Stamps

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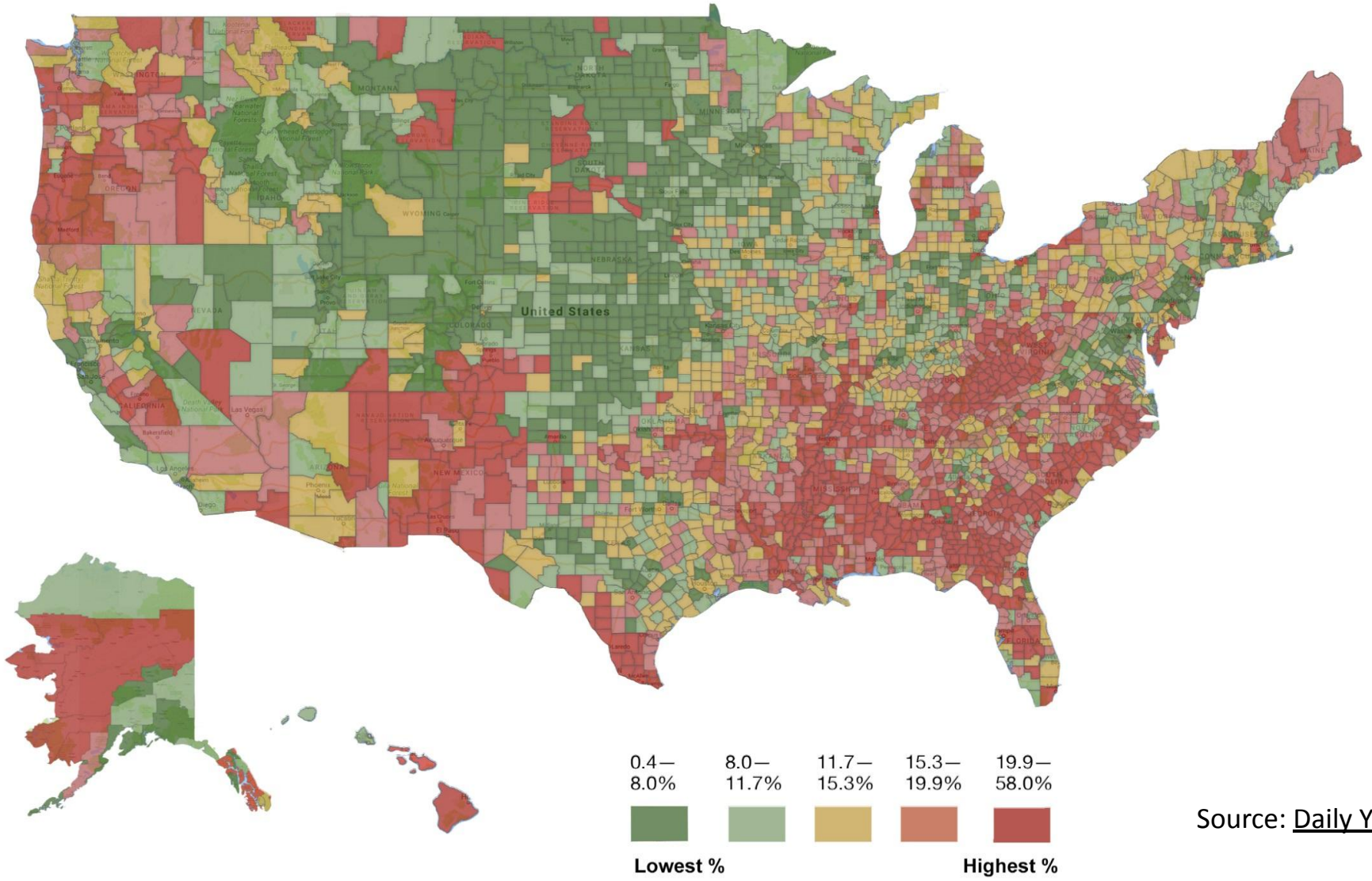
SNAP Enrollment as Percent of County Population

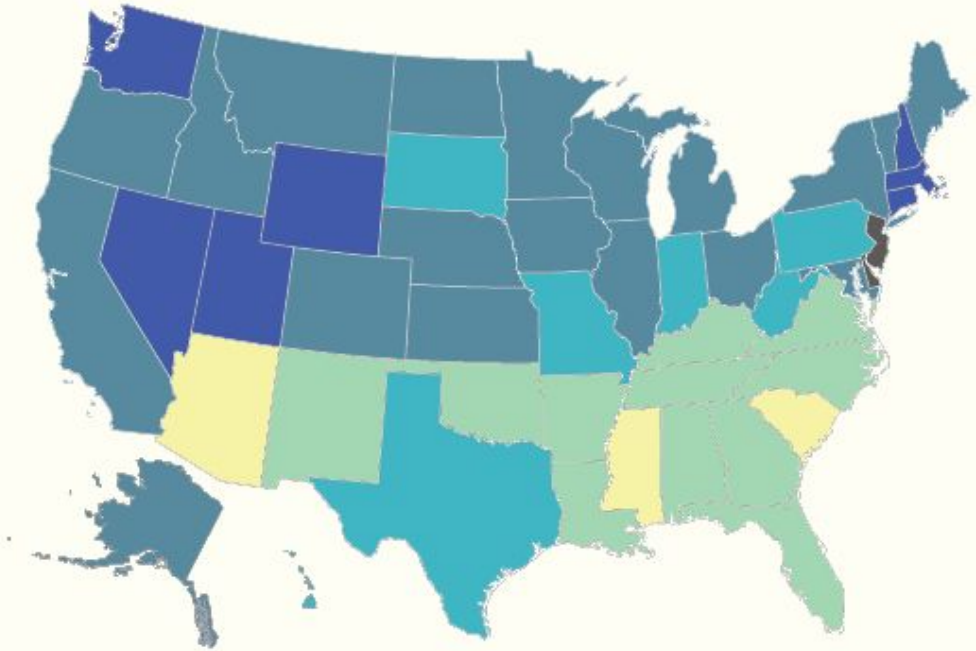


Source: Daily Yonder, 2018

The Digital Divide in Rural America

National Rural Health Association

RURAL HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS



Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year variable B28002. Rural refers to outside OMB-designated metropolitan areas.

HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS

Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

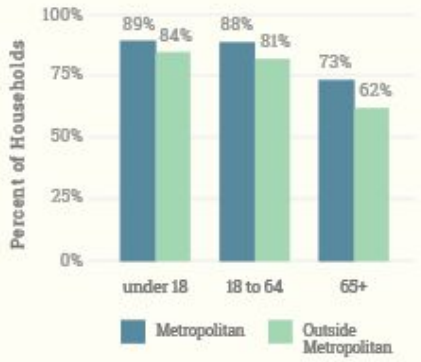
83% METROPOLITAN vs **73%** OUTSIDE METROPOLITAN

BROADBAND SUBSCRIPTIONS

BY INCOME

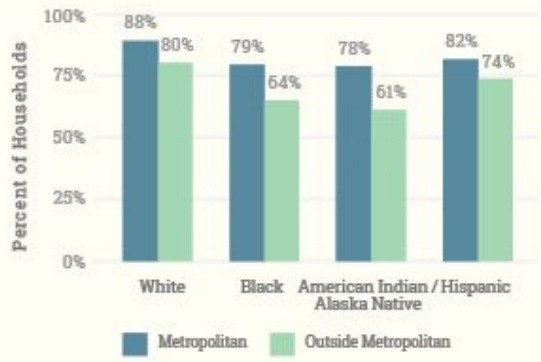
Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

BY AGE



Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

BY RACE / ETHNICITY



Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

Rural Hospital Closures

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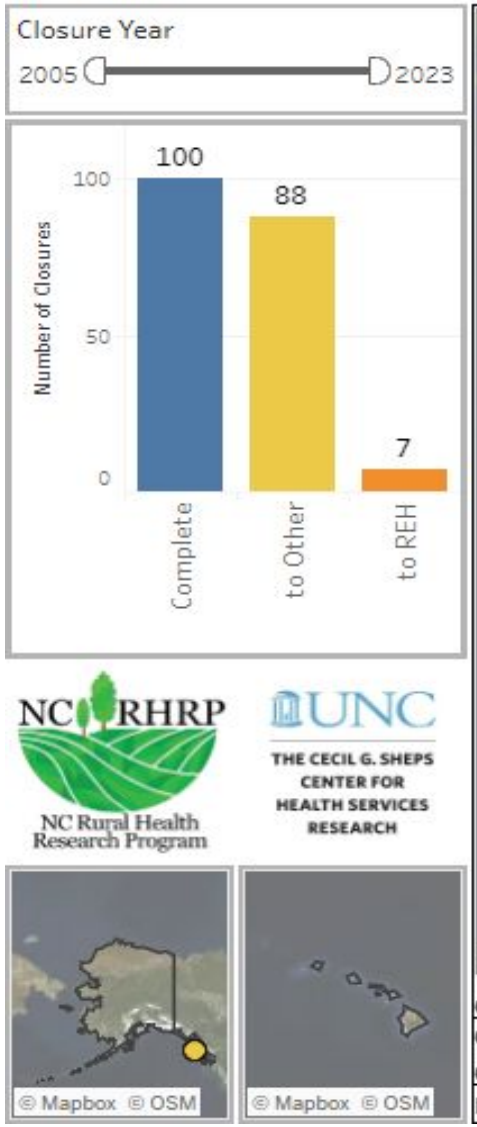
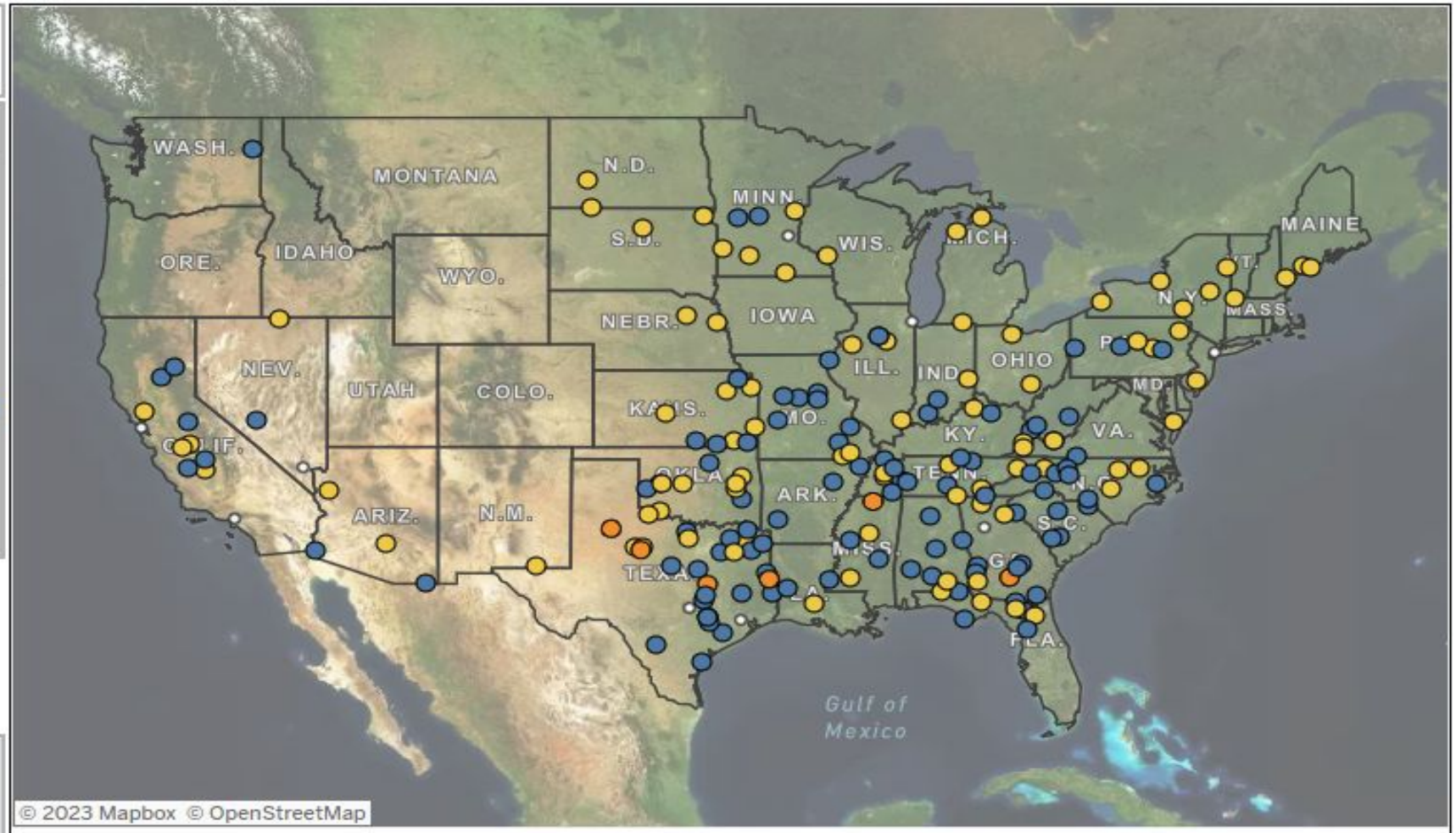
156 Closures since 2010





Complete Hospital Closure: Health care is no longer provided at this facility.
Converted to Rural Emergency Hospital (REH): Facility no longer provides inpatient care, but provides emergency and outpatient care.
Converted to Other: Facility no longer provides inpatient care, but provides some health care (e.g., urgent care, primary care, emergency care, long-term care).

Source: UNC Sheps Center for Rural Health

USDA/NRHA Rural Hospital TA Program

- Rural Hospitals that are current borrowers from USDA are eligible for full-range of services:
  - Strategic, Financial, Operational Assessment (SFOA)
  - Target services, for example:
    - Revenue Cycle
    - 340B
    - Cost Report Review
- Rural Hospital that are not current USDA borrowers:
  - Debt capacity/Market Analysis
- TA is free-of-charge to hospital
- Contact Brock Slabach or Tommy Barnhart at NRHA

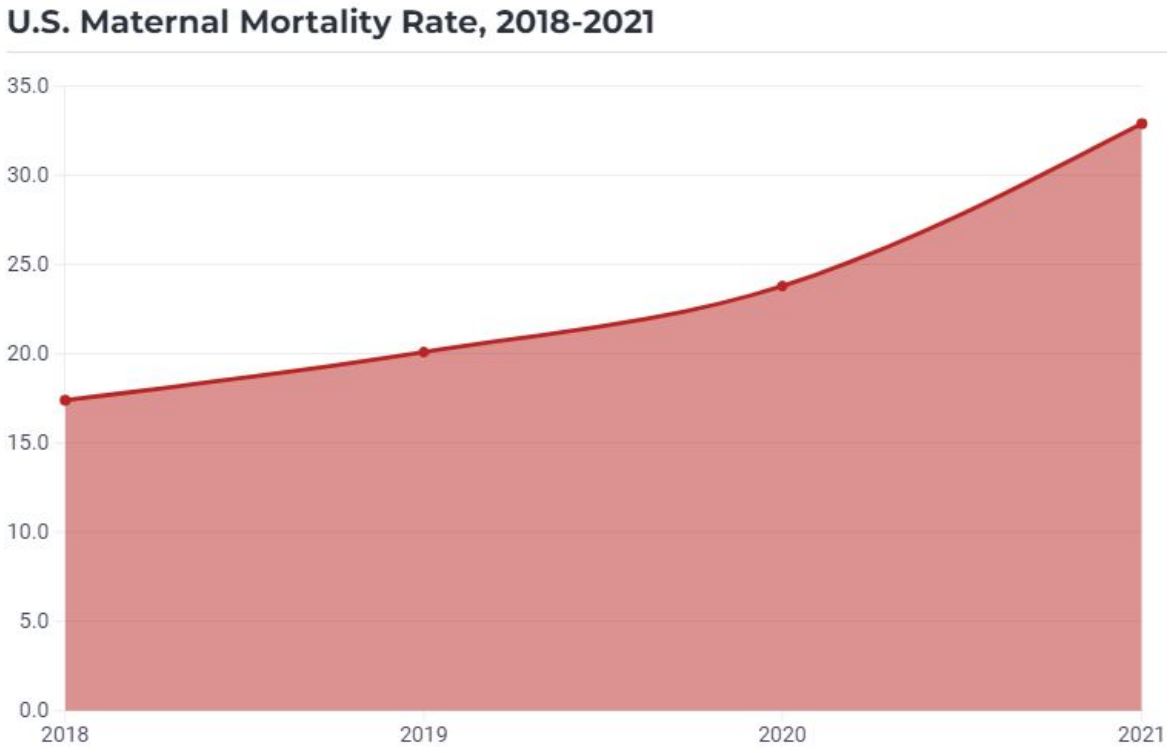
“Rural hospitals and the rural economy rise and fall together”

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

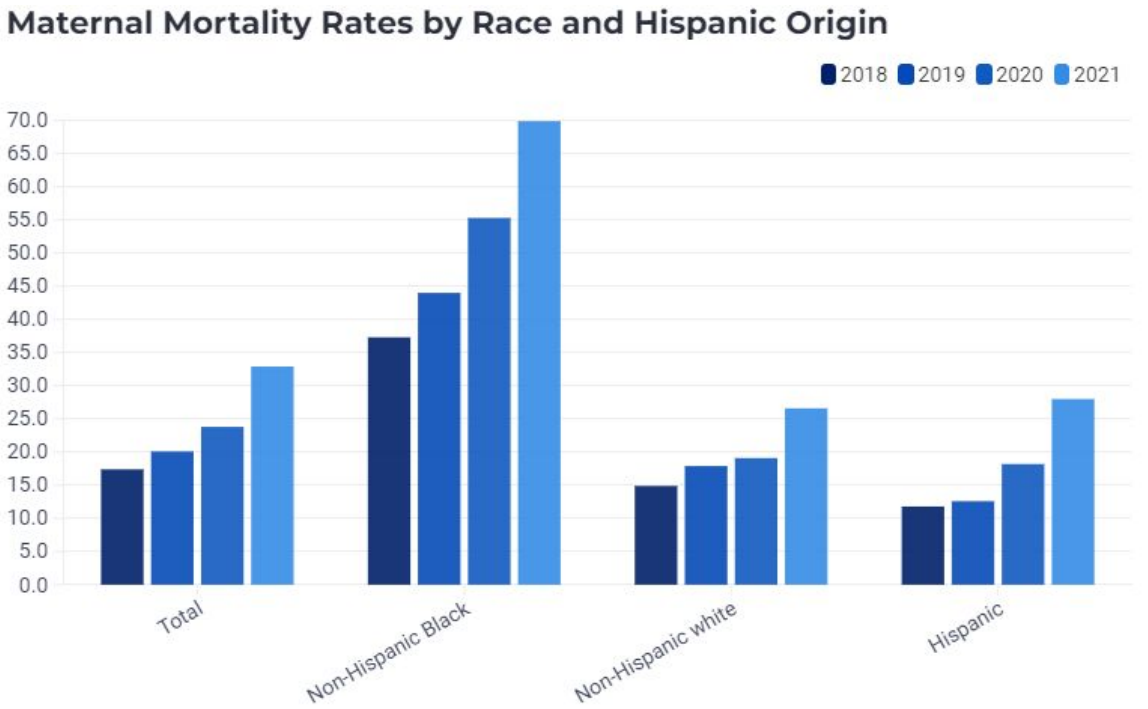
- Mark Holmes, professor, University of North Carolina

- 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)
- Medical deserts form in rural communities where hospitals close.

Maternal Mortality Crisis

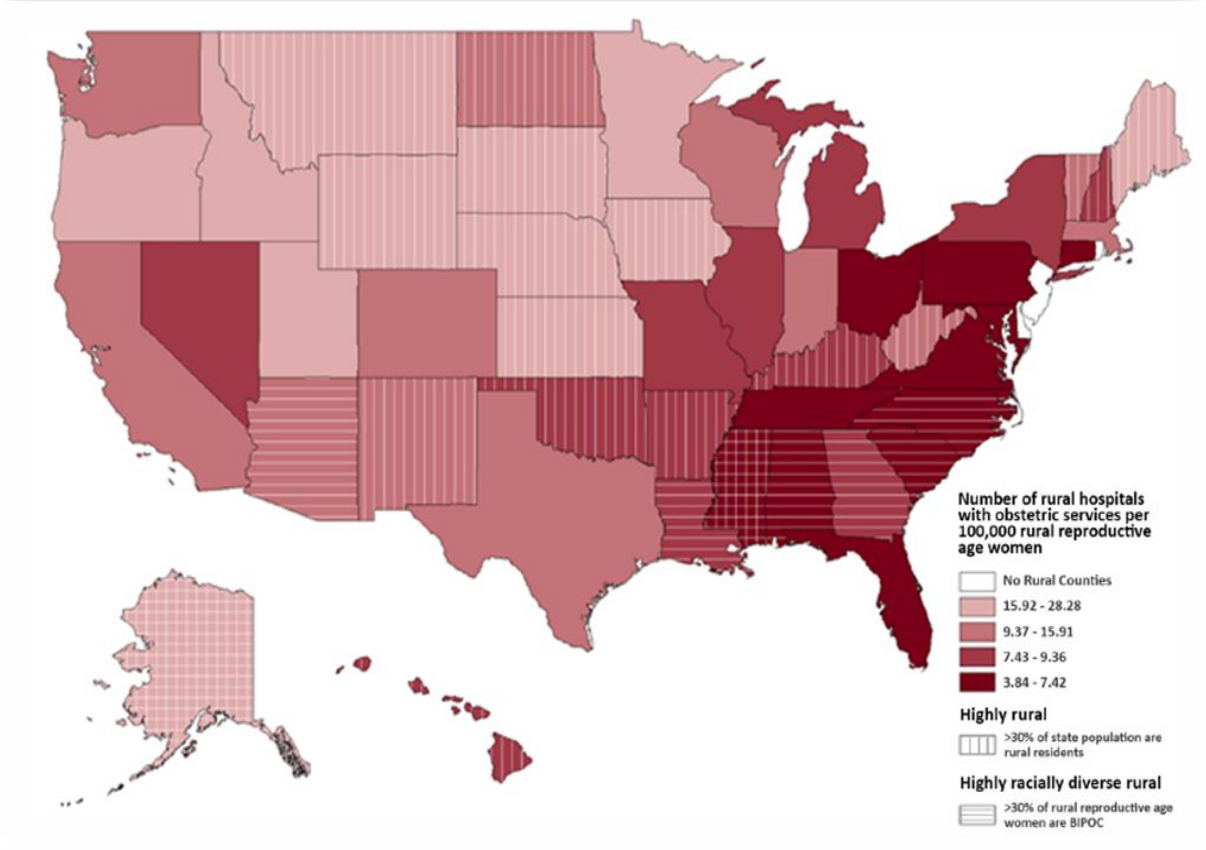


Source: National Center for Health Statistics
Chart: News Data Team at U.S. News
Maternal mortality rates are deaths per 100,000 live births.



Source: National Center for Health Statistics
Chart: News Data Team at U.S. News
Maternal mortality rates are deaths per 100,000 live births. Total includes deaths for race and Hispanic-origin groups not shown separately, including women of multiple races and origin not stated.

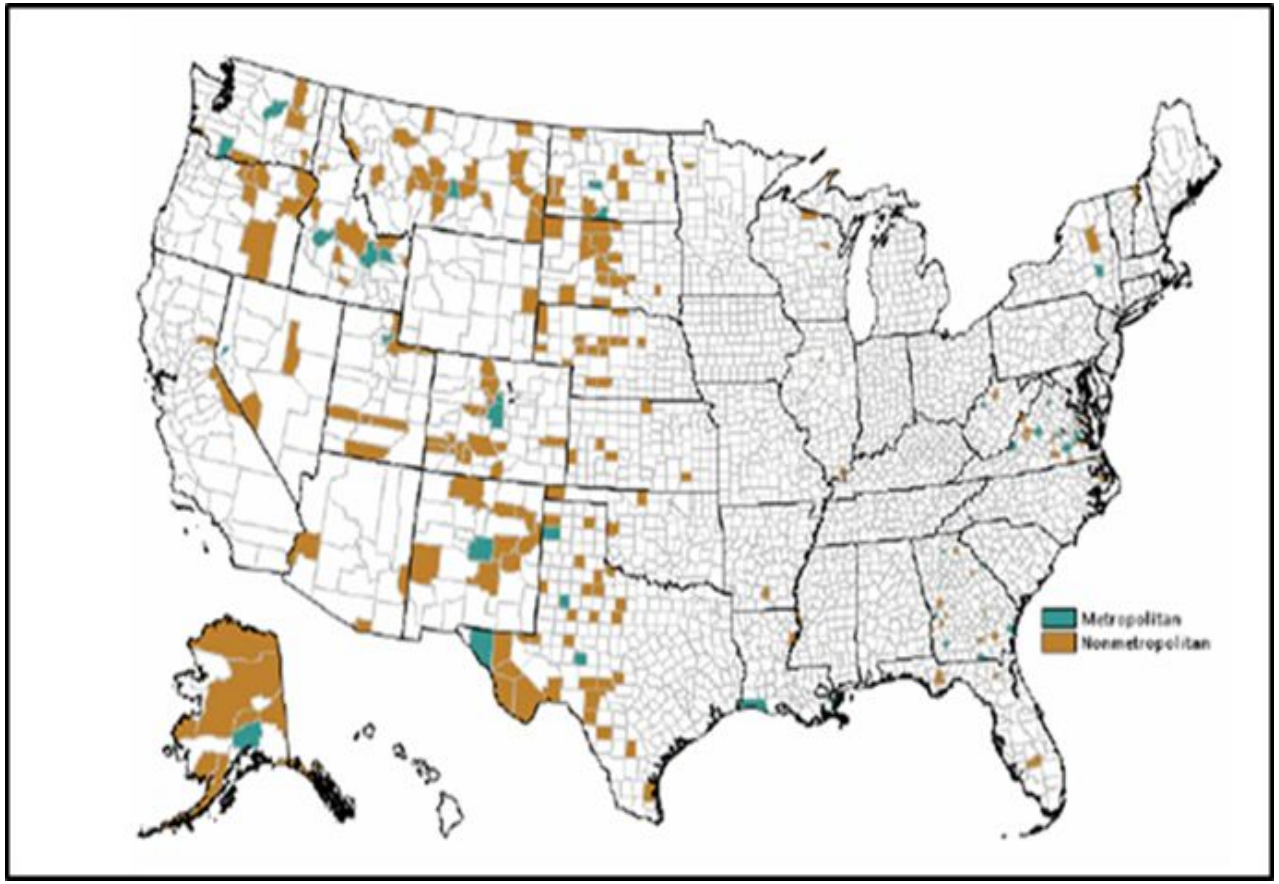
Maternity Deserts Nationwide



- 56% of rural counties lack hospital-based OB services
- Substantial state and regional variability
- Loss of hospital-based OB services is most prominent in rural communities:
  - With a high proportion of Black residents
  - Where a majority of residents are Black or Indigenous have elevated rates of premature death

- https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Hospital%20System%20Participation%20and%20Services.pdf

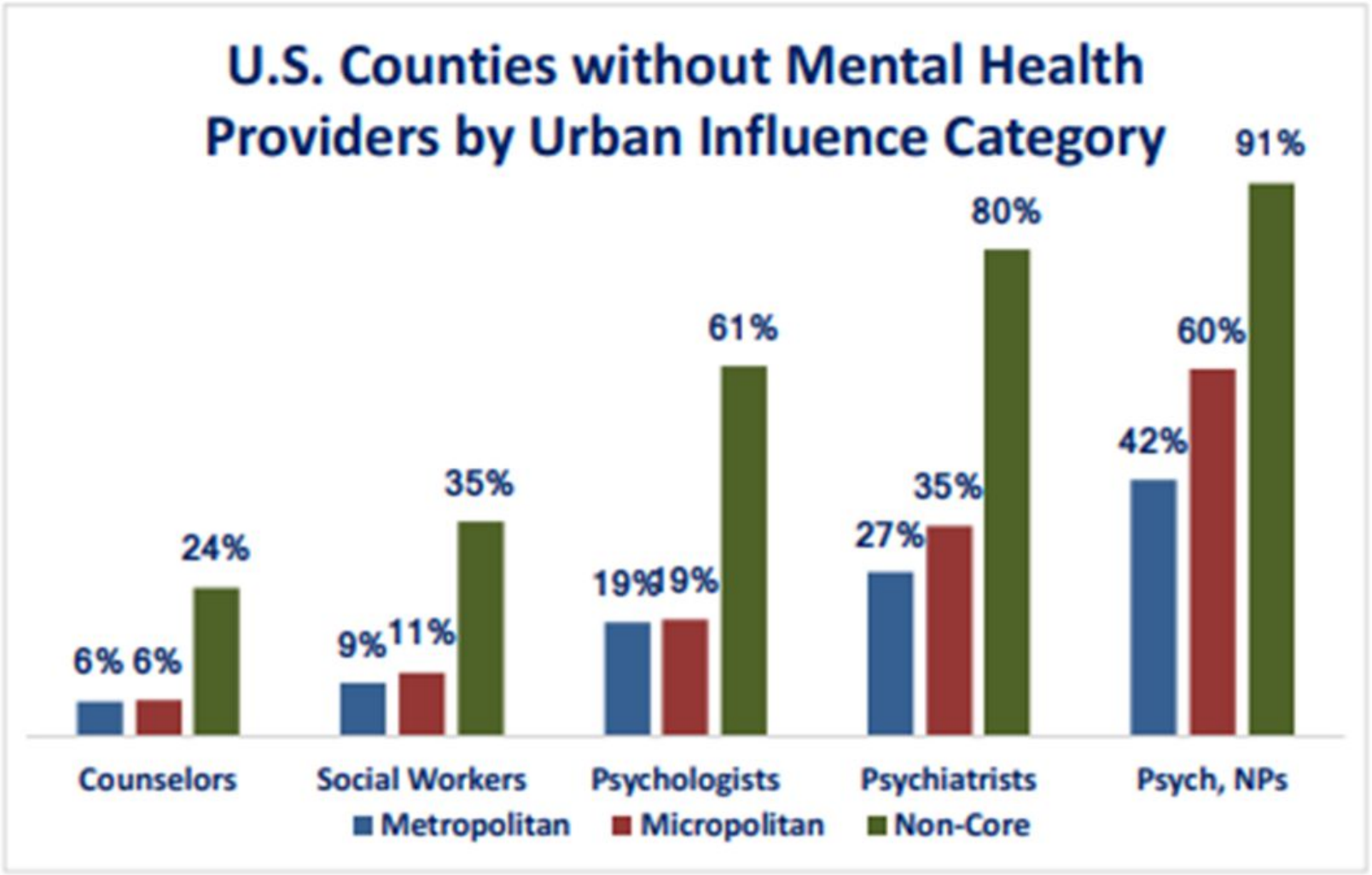
Rural Nursing Home Closures



- 10% of rural counties are nursing home deserts
- From 2008-2018, *400* rural counties experienced at least 1 nursing home closure

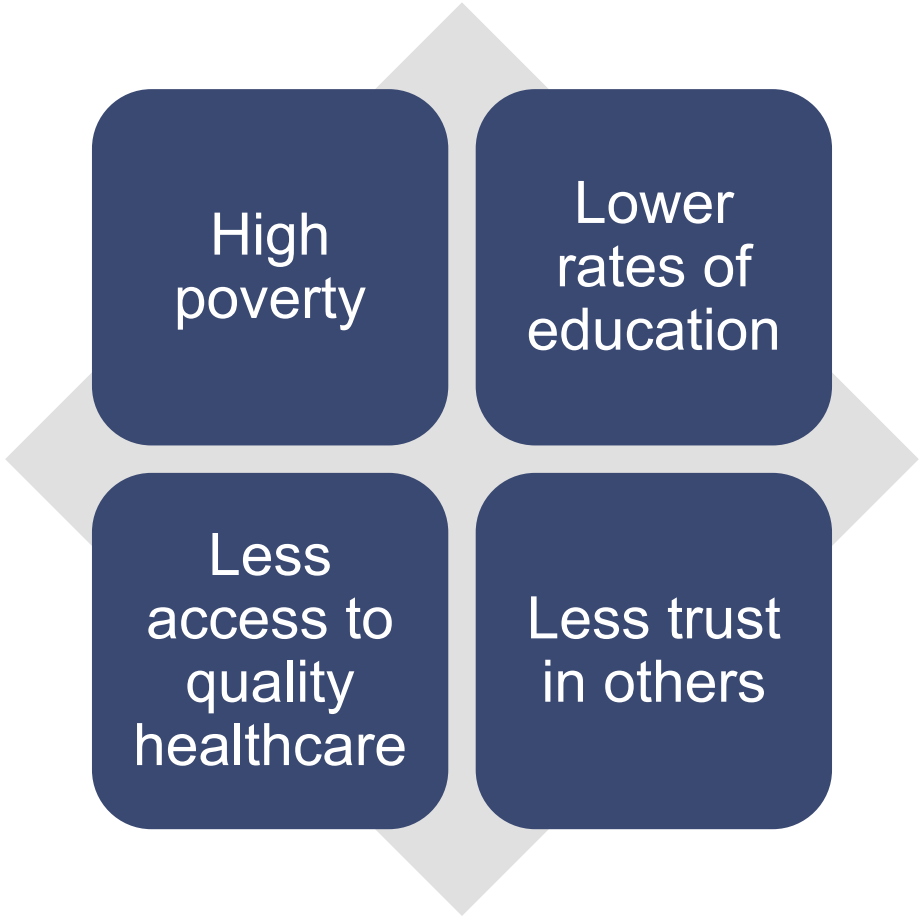
- https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

Behavioral/Mental Health Workforce



https://www.ruralhealthresearch.org/assets/411-1089/071817-behavioral-health-workforce-supply-webinar-ppt.pd

Common Denominators where Covid Deaths Rates were High



What is clear is that COVID-19 exploited and compounded existing local racial inequities, health disparities, and partisan politics to create a syndemic—a combination of local factors that interact, increasing the burden of disease from this pandemic and the likelihood of poor outcomes.

--Thomas Bollyky, Lancet, 2023

Looking Ahead: Innovation

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If you want to build a ship, don't drum up men and women to gather wood, divide the work and give orders.

Instead, teach them to yearn for the vast and endless sea.

--Attributed to Antoine de Saint-Exupery

Payment Transition Plan: CMS & CMMI

Goal: 100% of Medicare payments to providers are through a VBP approach

Million Hearts Campaign Focus on Health Equity

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Pregnant and Postpartum Women With Hypertension	People from Racial/ Ethnic Minority Groups	People with Behavioral Health Issues Who Use Tobacco	People with Lower Incomes	People who Live in Rural Areas and Other 'Access Deserts'
Strategies • Champion widespread SMBP use • Expand / extend Medicaid coverage • Close gaps in transition of care • Promote aspirin use to prevent preeclampsia	**Strategies** • SMBP, HMM in trusted spaces • Expand Medicaid coverage • Tailored protocols to increase med intensification / med adherence • Enhance sodium reduction • Policies prohibiting sale of flavored tobacco products	**Strategies** • Support integration of tobacco cessation treatment into mental health, substance use care • Encourage smoke-free behavioral health facilities • Expand Medicaid coverage	**Strategies** • Expand Medicaid coverage • Support SMBP device loaner programs • Support inclusion of evidence-based strategies in value-based care delivery	**Strategies** • Support availability of robust virtual and remote models of cardiac rehabilitation • Support the use of SMBP and related telehealth • Support expanded scopes of practice for NPs, PAs, PharmDs, and CHWs

SMBP = self-measured blood pressure monitoring; HMM = hypertension medication management; NP = nurse practitioner; PA = physician assistant; CHW = community health worker

CMMI: AHEAD Model

CMMI has announced a new innovation model for up to 8 states starting in 2025 that will include the following:

- Global Budget for hospitals (similar to PaRHM)
- Include a TCOC target/approach
- All-payer participation
- Include a primary care/provider incentive
- Directed toward safety-net providers (including rural)
- Address Mental health, SUD and SDOH
- Address Health Equity

CMMI: AHEAD Model

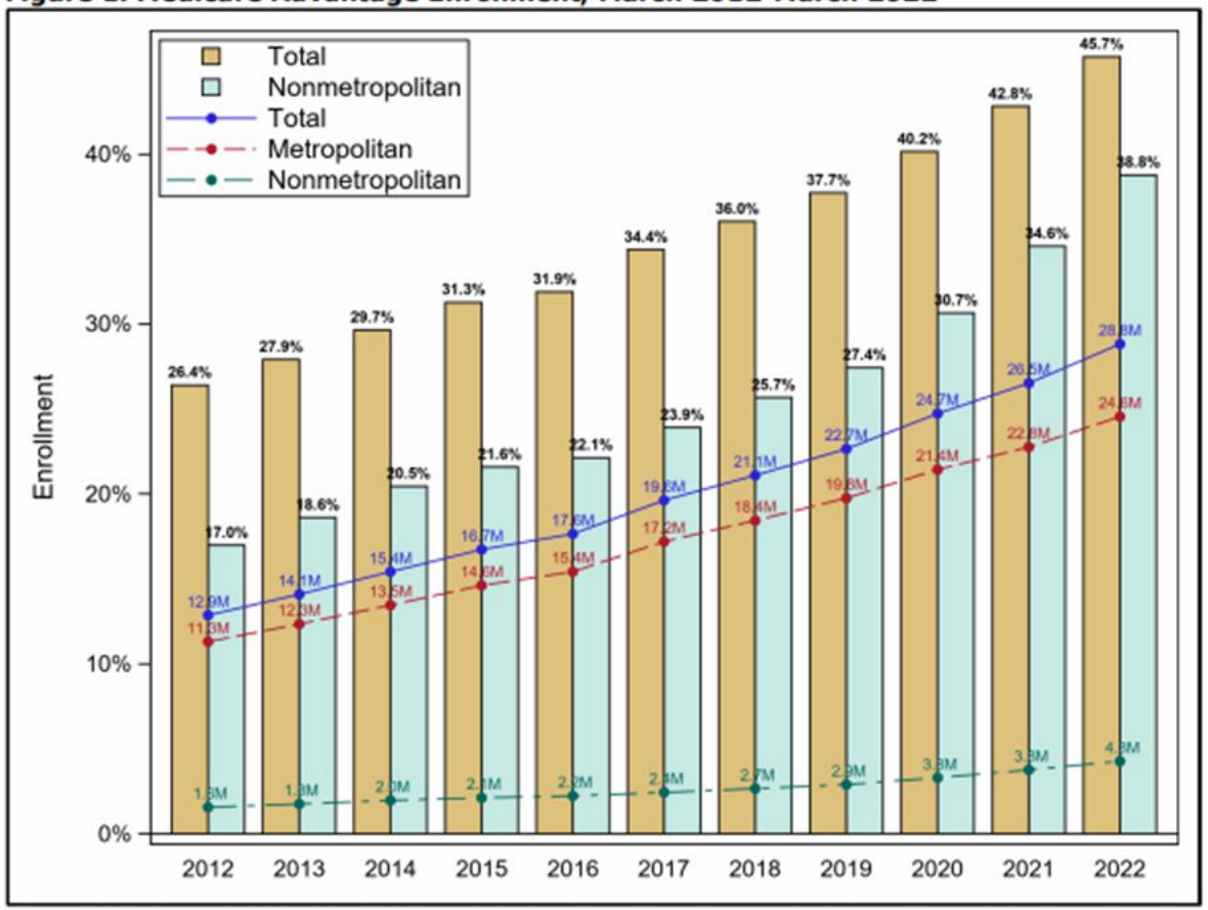
Tentative timeline for model release/implementation:

- December, 2023 release NOFO
- 2024 Select Model Participants
- 2025 Implement Model
- 10-year horizon for demonstration
- $12M grant for lead agency—5 years

Like the Pennsylvania model, AHEAD model requires state to organize and implement the features of this program.

Medicare Advantage Data—2022

Figure 1. Medicare Advantage Enrollment, March 2012-March 2022



Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.

- Overall MA enrollment grew by 8.7 percent (2.3 million) from 2021 to 2022.
  - The rate of growth was higher in *nonmetropolitan counties* (13.4 percent) than in *metropolitan counties* (7.9 percent).
- Overall, more than half of MA enrollees (57.9 percent) were in Health Maintenance Organization (HMO) plans.
  - The largest proportion of *nonmetropolitan enrollees* (51.5 percent) were in Local Preferred Provider Organization (PPO) plans
  - The largest proportion of *metropolitan enrollees* (61.4 percent) were in HMO plans

"Offering a rural payment add-on for MA plans that operate in rural areas may incentivize the delivery of high-quality care in rural areas" *Health Payer Intelligence*

ACO Advanced Investment Payment

CMS finalized new policies for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) to support providers treating rural and underserved populations, including changes to:

- Provide Advance Investment Payments (AIPs) to Certain ACOs
  - A one-time payment of $250,000
  - Eight quarterly payments, based on the number of assigned beneficiaries capped at 10,000
- Smooth the Transition to Performance-Based Risk
- Support Longer Term Participation in ACOs
- Promote Health Equity
- Update the Financial Methodology
  - Reduce the effect of ACO performance on historical benchmarks
  - Address market penetration
  - Strengthen incentives for ACOs serving medically complex and high-cost populations
- Next application period in 2024 for a Jan. 1, 2025 start date. More information.

News from Washington: Preparing for the Future

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CDC Office of Rural Health

- CDC Office of Rural Health is now official!
- Located in the new Public Health Infrastructure Center
- Staffing:
  - Diane Hall, Acting Director
  - Scott Miller, Senior Advisor for Rural Health
  - Kevin Matthews, Coordinator of Rural Public Health Research
- Initial steps: layout of mission, functions and structures
- Next step: develop a rural public health strategic plan
- Example of the political turning into policy

OPPS NPRM

CY 2024 Outpatient Prospective Payment System **proposed rule**.

- NRHA **summary**.
- Comments are due September 11 via regulations.gov.
- Overall, **2.8%** payment update, **4.4% for rural hospitals**.
  - Based on IPPS market basket increase minus productivity adjustment.
- Hospital price transparency –
  - Changes to required data elements
  - Machine Readable File (MRF) format – new CMS template/layout requirement.

OPPS NPRM

CY 2024 OPPS, cont.

- Indian Health Service hospitals can convert to REH and continue to receive all-inclusive rate for outpatient services.
- Last year, finalized policy to allow NPs, PAs, and Clinical Nurse Specialists (CNS) to provide direct supervision for cardiac rehab – clarifying that this may be furnished through telehealth thru Dec. 31, 2024.

MPFS NPRM

CY 2024 Medicare Physician Fee schedule (MPFS) **proposed rule**.

- NRHA **summary**.
- Comments are due September 11 via regulations.gov.
- Physicians facing **-3.3% payment cut** in 2024 due to statutory requirements and budget neutrality.
- Proposing new G codes to cover community health integration (incl. CHW services), SDOH risk assessments, and principal illness navigation.

MPFS NPRM

CY 2024 MPFS cont.

- Marriage & family therapists, mental health counselors can bill Medicare directly for services Jan. 1, 2024.
  - Addiction counselors that meet Mental Health Counselors (MHC) requirements can enroll in Medicare as MHC.
- HCPCS code for psychotherapy services furnished outside of a facility.
- Implementing telehealth flexibility extensions from Consolidated Appropriations Act of 2023.

MPFS NPRM

CY 2024 MPFS cont.

- RHCs/FQHCs:
  - Can bill for community health integration & principal illness navigation.
  - Remote physiologic monitoring and remote therapeutic monitoring in the general care management code.
  - General supervision for behavioral health services furnished incident to physician/NPP's services.
- Minor changes to Medicare Shared Savings Program.

Mental Health Parity NPRM

Requirements Related to the Mental Health Parity and Addiction Equity Act **proposed rule**

- Issued by Departments of Health & Human Services, Labor, and Treasury. Press release **here**.
- Comments due 60 days after publication in Federal Register.
- Amends regulations implementing the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Overall, strengthening “no more restrictive” standard for mental health/SUD benefits.

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CY2024 Medicare Advantage Policy and Technical Changes

- Prior authorization
  - Can only be used to confirm diagnosis, determine medical necessity
  - MA plans must comply with coverage and benefit conditions in traditional Medicare, national & local coverage determinations
  - When Medicare coverage criteria are not established, MA plans:
    - Must make publicly accessible coverage policies based upon widely used treatment guidelines or clinical literature
  - MA plans cannot revise its medical necessity determinations
  - 90-day transition period for ongoing course of treatment

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CY2024 Medicare Advantage Policy and Technical Changes

- Network adequacy
  - MA plans must arrange for out-of-network medically necessary items and services that are not available in-network
- Behavioral health
  - Clinical psychologists and social workers now subject to time, distance, and minimum number requirements – can receive 10% credit
  - Did not finalize MOUD-waivered providers for network adequacy requirements
  - Primary care appointment wait times apply to behavioral health care
    - Emergency services: immediately
    - Not emergency but requires medical attention: within 7 business days
    - Routine/preventive: within 30 business days
  - Emergency medical services include mental health services. MA plans must cover emergency services without regard for prior authorization

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CY2024 Medicare Advantage Policy and Technical Changes

- Targeting misleading marketing and advertising
  - MA ads must include specific plan name
  - Superlatives prohibited without supporting documentation
  - Prohibited from advertising benefits not available in a service area
  - Must provide annual notice that beneficiaries may opt out of business calls
  - Pre-enrollment checklist must include “effect on current coverage” item
  - Scope of appointments, business reply cards, and other contact mechanisms are valid for 12 months
  - Prohibited from using Medicare name, CMS/HHS logo in misleading way

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CY2024 Medicare Advantage Policy and Technical Changes

- Health equity
  - Health Equity Index is added to the Star Ratings program to encourage MA plans to focus on improving care for enrollees with social risk factors.
  - MA plans must develop procedures to identify and offer digital health education to help enrollees access medically necessary telehealth benefits

Updates from Congress

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Bipartisan Rural Health Care Caucus

- **Relaunched** by Reps. Jill Tokuda (D-HI) and Diana Harshbarger (R-TN)
- An opportunity to host briefings and events to educate and inform Members of Congress and the public.
- Will allow Members to interact with patients, providers, and health advocates.
- Another great legislative vehicle to help move NRHA's rural health priorities.

FY 2024 Appropriations Request

- **CDC Office of Rural Health** - $10m
  - The office will enhance implementation of CDC's rural health portfolio, coordinate efforts across CDC programs, and develop a strategic plan for rural health
- **Increase funding for Rural Maternal and Obstetric Management Strategies** – $24.6m
  - To improve maternal health outcomes, NRHA is requesting an increase across all three RMOMS programs: RMOMS grantee program cohorts, Rural Obstetrics Networks Grants programs, and the Rural Maternal and Obstetric Care Training Demonstration
- **Rural Hospital infrastructure and sustainability**
  - USDA Technical Assistance Program - $5m
  - Financial and Community Sustainability for At-Risk Hospital Program - $10m
  - Rural Hospital Stabilization Pilot Program - $20m

FY 2024 Appropriations Request

- **Rural Residency Planning and Development Program-** $14.5m
  - Expand the number of rural residency training programs and increase the number of physicians choosing to practice in rural areas
- **Medicare Rural Hospital Flexibility Grant Program** - $73m
  - Used by states to implement new technologies, strategies, and plans in CAHS, in addition to technical assistance funds for REHs
- **Behavioral Health and SUD treatments**
  - Rural Communities Opioid Response Program - $165 million
  - Rural Health Clinic Behavioral Health Initiative - $10 million

ADVOCATE WITH US!

https://www.ruralhealth.us/advocate/rural-health-advocacy-campaigns

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Thank you.

bslabach@ruralhealth.us
@bslabach
#ruralhealth

New 2023 Policy Papers Posted

- Emergency Preparedness for Rural Communities
- Center for Medicare and Medicaid Innovation Initiatives to Address Rural Health and Health Disparities
- Health Care's Role in Rural Economic Development:
  - Addressing Health Workforce Needs
  - How Broadband Can Improve Health Outcomes
  - How Work Support Programs Improve Health and Stimulate Rural Economies
- Integrating Z Coding for Social Determinants of Health and its Impact on Rural Areas

New 2023 Policy Papers Posted

- Obesity Prevention and Treatment in Rural America
- Obstetric Readiness in Rural Communities Lacking Hospital Labor and Delivery Units
- QI in Rural Health Care
- Retaining Rural Health Care Professionals: Strategies to Reduce Burnout
- Rural Reclassified Hospitals and RTPs
- Urban Bias in Rural Data Sets