

2019 RURAL HEALTH REQUEST

EMPOWER RURAL AMERICA

Access to health care in rural America is as essential to rural life and the rural economy as roads, power, and water. Today, the health of rural Americans and the strength of rural economies are failing because access to health care is disappearing. **It is time to empower rural Americans through the support of vital health care infrastructure.**

THE PROBLEM

RURAL AMERICA IS HANGING ON BY A THREAD.

- **The Great Recession still impacts rural America.** Two-thirds of rural counties have fewer jobs today than in 2007. 19% of rural Americans, including 25% of rural children, are living in poverty.
- **Rural populations are on average 6 years older than their urban counterparts** and make up about 20% of the population, but more than 23% of Medicare beneficiaries across the country.
- **Rural health disparities continue to grow.** According to the CDC rural Americans are substantially more likely to die from the five leading causes of death creating a growing mortality gap between rural and urban populations.
- **Health insurance costs more for rural Americans.** Lack of market competition in rural areas means 41% of rural marketplace enrollees have only a single option of insurer. This lack of competition in the marketplace means higher premiums (\$569.34 for small town rural vs. \$415.85 for metropolitan).

PRESERVING ACCESS IS ESSENTIAL.

- **Rural hospitals are closing resulting in a loss of emergency care.** Since 2010, 95 rural hospitals have closed and nearly 700 are still vulnerable. 46% now operate at a loss (up from 40% just 2 years ago). **When a rural hospital can stay open, it is often the first or second largest employer in a rural area.**
- **Rural Health Clinics providing primary care services are closing.** Since 2012, 388 RHCs have closed, impacting 3.86 million rural Americans access to primary care.
- **The rural health care workforce is dwindling and impacting access to care.** Health care job creation is not happening in rural areas but is a huge part of national job growth. While there are surpluses of medical professionals in other areas, rural areas face devastating shortages.

THE SOLUTION

Support the rural health safety net. Despite these challenges, there are commonsense bipartisan solutions to address the needs of rural communities.

1. KEEP THE DOORS OPEN.

- Stop the rural hospital closure crisis by ending devastating payment cuts;
- Develop a new and sustainable rural hospital model that makes sense for patients and providers in rural America;
- Protect the 340B Program and other safety net programs for rural providers; and
- Ensure Rural Health Clinics receive adequate payments that reflect the cost of care in rural areas.



2. INVEST IN RURAL COMMUNITIES.

- Increase recruitment and retention of the rural health care workforce;
- Expand access to broadband and telehealth to fill gaps in rural health care infrastructure;
- Ensure critical funding for substance use disorders reaches rural communities; and
- Maintain access to capital and technical assistance for rural health providers by building upon provisions in the 2018 Farm Bill.

3. MAKE CARE AFFORDABLE.

- Any reforms to health care must consider the unique market forces in rural America including distance, provider scarcity, and vulnerable patient populations.
- Utilize a rural lens to ensure any reform policies benefit rural America.

4. SUPPORT STABLE FUNDING.

- The federal investment in rural health programs is a small portion of federal health care spending, but it is critical to rural Americans. Rural health safety net programs have major impacts, at little cost to Congress.
- As we begin discussions regarding funding for FY20, we must maintain our commitment to rural Americans.

5. JOIN THE SENATE RURAL HEALTH CAUCUS OR HOUSE RURAL HEALTH COALITION

- Join your colleagues in the Senate and House as part of the Senate Rural Health Caucus or House Rural Health Care Coalition. The Caucus and the Coalition are a collection of rural health champions and have passed significant legislation improving the lives of 60 million rural Americans. **Stand up for rural health care in the 116th Congress by joining these important groups!**
 - **Co-Chairs of the Senate Rural Health Caucus:**
Sen. Pat Roberts (R-KS) and Sen. Tina Smith (D-MN)
 - **Co-Chairs of the House Rural Health Care Coalition:**
Rep. Ron Kind (D-WI) and Rep. Cathy McMorris Rodgers (R-WA)

THE CONCLUSION

It is time for Congress to **empower rural Americans** by ensuring access to care and a strong and healthy economic future.

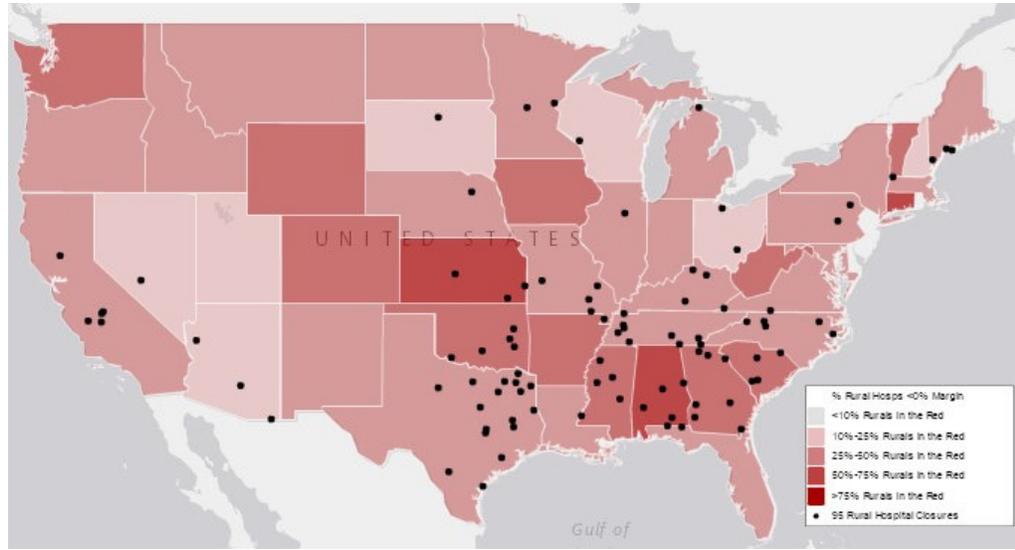


Rural Hospital Closures

95

rural hospitals have closed since 2010.

Nearly 700 rural hospitals are vulnerable to closure.



Impact of Medicare Cuts on Rural Provider Operating Margins



40%
2017



44%
2018



46%
2019

Bad debt cuts, sequestration, and other Medicare changes for rural providers have forced more and more into the red.

Impact of Existing Cuts to Rural Providers Revenue



\$498.3M
provider revenue lost within 1 year



10,911
jobs lost within 1 year

Losing vulnerable providers will jeopardize



11.7M
patient encounters within 1 year



99k
healthcare jobs lost within 1 year



137k
community jobs lost within 1 year



\$277B
loss to GDP within 10 years

SAVE RURAL PROVIDERS

Rural provider closures are escalating. Since 2012, 388 rural health clinics have closed. Since 2010, 95 rural hospitals have closed. To end this crisis Congress must stop the cuts and provide a path forward.

STOP THE CUTS >>>

Immediately stop the current flood of rural hospital closures.

Continued payment cuts have taken their toll, forcing hospitals to close.

Stop devastating cuts to rural providers that create financial instability.

Rural hospitals have lost millions in revenue needed to keep their doors open from cuts.

- Stop “bad debt” reimbursement cuts (\$180.3 million in lost revenue for rural hospital);
- Stop Medicare Sequestration for rural hospitals (Rural hospitals have absorbed \$318 million in cuts under sequestration);
- Stop DSH payment reductions; and
- Make temporary rural Medicare payment programs permanent.

<<< PROVIDE A PATH FORWARD

Innovative future rural models are needed, such as the Community Outpatient Hospital (COH). A new model must ensure access to emergency care and allow hospitals the flexibility to offer outpatient care that meets the needs of their community.

Emergency Services: A COH must provide emergency medical care and observation care (not to exceed an annual average of 24 hours), 24 hours a day, 7 days a week. The COH must also have protocols in place for the timely transfer of patients who require a higher level of care or inpatient admission.

Community Needs: Based upon a community needs assessment, a COH could provide medical services in addition to the Emergency services, but not limited to observation care, skilled nursing facility (SNF) care, infusion services, hemodialysis, home health, hospice, nursing home care, population health and telemedicine services.

Create a new model for rural hospitals that flexibly provides critical services.

Ensure the model provides emergency services and community focused care.



REBUILD RURAL

RURAL DEVELOPMENT AND HEALTH CARE

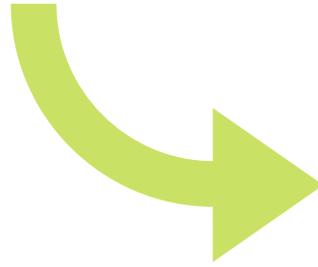
As we move forward in discussing an infrastructure package, we must recognize how critically important health care is in this process.

Health care providers are critical to both the health and economic well being of rural America. They are one of the largest employers in the community.

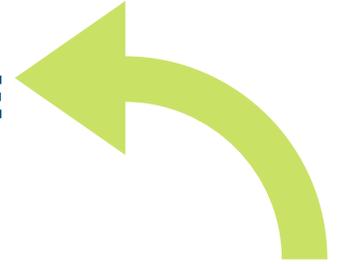
Health care access is vital for growth. No business wants to open in an area where their employees cannot access emergency care in the case of an accident. No family wants to move to a community where there isn't a pediatrician for their child.

The 2018 Farm Bill built on existing programs under USDA which encourage rural development and economic growth. Recognizing health care's role, Congress included an entire section under the Rural Development Title of the bill on rural health. Let's continue this work.

**SMALL
INFRASTRUCTURE
INVESTMENTS**



**BIG RURAL
HEALTH GAINS**



RURAL INFRASTRUCTURE NEEDS

- Provide access to capital through grants and loans for rural facilities to adopt new technology to meet the ever-changing requirements of health care.
- Identify strategies to assist individuals to ensure that they can access local and distant care through studies of transportation challenges in rural areas.
- Research grant programs are needed to fund the study of best practices and innovations from local EMS agencies across the U.S.
- Build upon the newly created technical assistance program at USDA to preserve local access to care.
- Examine changes that can be made to ensure that USDA loan and grant applications are easy to complete, and we must work improve the process in order to have applications considered more efficiently.



Developing the Rural Workforce

One of the most enduring characteristics of the rural health landscape is the uneven distribution and shortage of health care professionals. As a result, many rural residents experience a lack of basic services.



Primary Care

When even a single physician, nurse, or other provider retires or moves it can precipitate a health care coverage crisis in a community. While 20% of Americans live in rural areas only 9% of physicians practice there leaving 77% of rural counties as primary care Health Professional Shortage Areas (HPSAs).



Maternity Care

More than 200 rural obstetrics units closed between 2004-2014, leaving 54% of rural counties without hospital-based obstetrics. The majority of rural woman live further than the recommended 30 minutes to a hospital offering maternity services.



Oral Health

20 million rural residents live in dental HPSAs, leaving many rural Americans with the Emergency Department (ED) as their only source of dental care. ED services are expensive, costing taxpayers \$2 billion in 2015 alone, and result in 50% of patients with dental pain receiving an opioid prescription.



Mental Health

60% of Mental Health Professional Shortage Areas are located in rural communities. 13% of rural counties have no behavioral health providers, 65% of rural counties do not have a practicing psychiatrist, 47% lack a psychologist, and 81% lack a psychiatric nurse practitioner.

Solutions

- Rural residency programs and non-physician training programs must be expanded and be allowed to thrive;
- Workforce shortages must be addressed locally through programs, like Area Health Education Centers (AHECs);
- Extreme shortages must be improved by addressing inadequate reimbursement issues; and
- National Health Service Corps must be expanded and fully funded.



Protect the 340B Drug Program

Keeping the rural health safety net afloat

Many policy decisions have negatively impacted rural hospitals, but programs like 340B that enable rural providers to provide care to patients are invaluable to the sustainability of the rural safety net.

The 340B Drug Pricing Program helps rural hospitals keep their doors open to provide local care. The program has created median monthly savings on outpatient drugs of \$10,000 for rural hospitals, and 90% of participants use savings to offset care for the under and uninsured.

Without these savings, 73% of hospitals will have to reduce staff, 71% will have to reduce pharmacy services, and 40% would have to close clinics. 75% of participating hospitals use 340B savings just to keep their doors open.

The 340B Drug Program saves taxpayers' dollars and is scored by the Congressional Budget Office as savings.

Quality, local rural care created by 340B

- Multiple hospitals, including **Boone County Hospital in Iowa**, are only able to staff their labor and delivery unit because of 340B, preventing women from traveling long distances to deliver a baby.
- Other facilities use 340B funds to staff their Emergency Department, offset uncompensated care, or simply keep their doors open, such as **Cole Memorial Hospital in Pennsylvania**.
- For **Lake Regional Health System in Missouri**, the 340B program allows them to set up off-site primary care visits for the elderly with substantial transportation challenges at a loss to the hospital.
- Multiple hospitals report the 340B program is the reason the hospital can provide oncology infusions to those in their community. **Childress Hospital in Texas** is about 100 miles from another hospital that provides oncology care, and for its patients the opening of the oncology infusion unit meant they do not have to travel 4 hours each way to receive chemotherapy. This sort of travel is particularly difficult in light of common chemotherapy side effects such as fatigue, nausea and vomiting, and diarrhea.
- **Hardin County General Hospital in Tennessee** is currently able to provide medical and radiation oncology care as a result of 340B. The next closest hospital that provides oncology care is 1 hour and 15 minutes away and many patients travel to Vanderbilt 3 hours away. Although they serve a challenging patient population, they do not turn any patients away from their oncology practice because they know for many that it "would be a death sentence."
- **Neshoba County General Hospital in Mississippi** utilizes 340B to offset charity care losses and to staff an infusion center. The majority of patients served receive antibiotics that would otherwise be provided in an inpatient setting at a higher cost to taxpayers through Medicaid and Medicare.
- **Kearney County Hospital in Kansas** utilized 340B to provide care coordination and unfunded care that prevents high cost interventions. They are able to provide solutions outside of the traditional "health care" silo, such as paying an electric bill to ensure a patient's insulin remained refrigerated.
- **Bunkie General Hospital in Louisiana** is a Critical Access Hospital that passes along savings from the 340B program directly to indigent patients and those that are underinsured or need medications not on their plan formulary.



MAKE CARE AFFORDABLE

The laudable goals of previous health care reforms were not realized in rural America. Lack of plan competition; exorbitant premiums, deductibles and co-pays; devastating Medicare cuts, and the lack of Medicaid expansion have exacerbated rural America's care crisis.

IT'S TIME FOR SOLUTIONS.

1. MEDICAID ADEQUACY

Rural providers serve a higher percentage of Medicaid patients (21% rural vs. 16% urban). Many rural providers lose money on providing care to Medicaid patients, a significant cause of providers closing their doors. A targeted increased federal match is needed for states with grave population health needs and high poverty. **Enhancements must be equivalent to the cost of providing care for rural safety net providers.**

2. MARKET REFORM

Insurance companies are cherry picking those who get coverage. 41% percent of rural marketplace enrollees have only a single option of insurer, representing 70% of counties that have only one option. Lack of competition means higher premiums. Reforms must **address the fact that insurance providers are withdrawing from rural markets.** Demographic realities of the rural population make the market less profitable, and thus less desirable, for insurers with no incentive to take on risk. In the same way that financial service institutions are required to provide services to underserved neighborhoods, **profitable insurance companies should be required to do the same.**

3. MEDICARE BAD DEBT CUTS

Rural hospitals serve more Medicare patients (46% rural vs. 40.9% urban), thus across the board Medicare cuts do not have across the board impacts. The Medicare bad debt cuts alone equate to over \$1 billion in lost revenue for rural hospitals within a single decade, a small number in terms of Congressional budgets but for a small rural hospital these losses can push them from financial vulnerability to closure. Reforms must **stop Medicare cuts to rural hospitals, especially bad debt cuts.** Current rural programs for hospitals and providers must be maintained.

**AFFORDABLE
CARE FOR
EVERY RURAL
AMERICAN**



**EQUAL ACCESS
TO CARE,
REGARDLESS OF
WHERE YOU LIVE**



**A RURAL
STRATEGY FOR
SOLUTIONS
AND REFORMS**



Support Stable Funding

FY2020 Appropriations

Rural health discretionary spending is relatively small but vitally important for maintaining access to care for individuals living in rural America. To better meet these needs, while simultaneously understanding the fiscal constraints demanded by Congress, NRHA requests a modest, across-the-board funding increase of 10 percent (unless another amount has specifically been authorized by law).

	FY 2016 Omnibus	FY 2017 House	FY 2017 Senate	FY 2018 Omnibus	FY 2019 L-HHS/Defense Minibus	FY 2020 NRHA Request
HHS Programs for Rural Health						
Rural Outreach & Network Grants ¹	63.5	65.5	65.5	65.5	77.5	85
Rural Health Research/Policy	9.4	9.4	9.4	9.4	9.4	10.4
State Offices of Rural Health	9.5	10.5	9.5	10	10	12.5
Rural Communities Opioid Response				100	120	132
Rural Hospital Flexibility Grants	41.6	45.6	41.6	49.6	53.6	59
Telehealth ²	17	19	18	18.5	24.5	27
National Health Service Corps	0	0	0	0	15	16.5
Title VII and VIII Programs of Particular Interest to Fund						
Rural Residency Development Program				15	10	15
Area Health Education Centers	30.3	30.3	30.3	30.3	39.3	43
Geriatric Programs	38.7	38.7	38.7	38.7	40.7	45
USDA Programs for Rural Health						
Rural Hospital Technical Assistance					0 ³	0.5

Source: National Rural Health Association

1. Rural & Community Access to Emergency Devices is funded through this program.
2. Reflects only telehealth funding for the Office for the Advancement of Telehealth, including the telehealth Network Grant Program.
3. In late 2018, USDA developed a pilot of a technical assistance program for rural hospitals. For 2019 the program was funded with discretionary USDA funds at \$300,000 for a small number (10-12) of hospitals with existing USDA loans. The 2018 Farm Bill included committee report included language encouraging USDA to expand on this program. These funds will allow USDA to expand on this much needed program.



Rural Health Funding

A quick program breakdown

- The **Outreach Grant Program** funds community-based projects for three years to increase access to care. Typical projects address diabetes, obesity, screening, adolescent health, oral health, and mental health. More than 2 million people have benefited and more than 85% of grant programs continue to deliver services five years after federal funding has ended.
- **Network Development Grants** address the business and management challenges of working with underserved rural communities, including help to overcome the fragmentation of health care services in rural areas and to achieve economies of scale. The program provides funding to rural communities that are beginning to examine the benefits of building networks so they can initiate the process.
- **Rural Health Research/Policy** funds the Federal Office of Rural Health Policy (FORHP). FORHP administers rural health programs, coordinates activities related to rural health care, and advises the Secretary on access to care, the viability of rural hospitals, and the availability of physicians and other health professionals.
- **State Offices of Rural Health**, located in all 50 states, help rural communities build health care delivery systems by collecting and disseminating information, providing technical assistance, helping coordinate rural health state-wide, and by supporting efforts to improve recruitment and retention of health professionals.
- **Rural Hospital Flexibility Grants** are used by each state to implement new technologies, strategies and plans in Critical Access Hospitals (CAH). CAHs provide essential services to a community. Their continued viability is critical for access to care and the health of the rural economy. Additional funding for the **Rural Hospital Flexibility Grants in the 2018 Omnibus allowed for the Vulnerable Rural Hospitals Assistance Program**. This program will fund one entity up to \$800,000 to provide targeted, in-depth assistance to vulnerable rural hospitals struggling to maintain health care services. The awardee will work with individual hospitals and their communities on ways to understand community health needs and find ways to ensure hospitals and communities can keep needed care locally.
- **EMS Sustainability Grants** are included under the Flexibility Grants program and build an evidence base for sustainable rural EMS model, and are essential in the changing landscape of rural EMS. These grant programs offer the opportunity to develop and implement projects to ensure continued access to EMS in rural America.
- **Rural Communities Opioids Response Programs** provide funds to support treatment for and prevention of substance use disorder, focusing on rural communities with the highest risk for substance use disorders.
- **Telehealth** funding is for the Office for the Advancement of Telehealth, including the **Telehealth Network Grant Program**, which promotes the effective use of technologies to improve access to health services and to provide distance education for health professionals.
- **National Health Service Corps** supports qualified health care providers by providing scholarship and loan-repayment programs for those serving medically underserved communities and populations with health professional shortages and/or high unmet needs for health services.
- **Title VII and VIII programs, including Rural Physician Training Grants, Area Health Education Centers, and Geriatric programs**, provide policy leadership and grant support for health professions workforce development for shortage areas.
- The **USDA's Rural Hospital Technical Assistance Program** was created in 2018 using discretionary funding in the USDA's Office of Rural Development. The program will provide technical assistance to rural hospitals with USDA loans to ensure their continued viability and financial success. NRHA requests Congressional support, building upon language in the 2018 Farm Bill, to slowly and responsibly grow this program as it demonstrates success to expand technical assistance to struggling rural providers.
- **Community Health Centers** provide essential community care, including primary care, oral health, and mental health, as well as other necessary services to medically underserved areas. Robust funding is necessary for their continued growth and to ensure they can provide quality, affordable care.

