Health Update from The National Advisory Committee on Rural Health and Human Services

February 18, 2015
1:00 p.m. CT

Kristine Sande, Moderator

Presentation

• Q & A to follow – Submit questions using chat tab directly beneath slides
• Slides at www.raonline.org/webinars/nacrhhs-health-update
• Do not close webinar window
• Technical issues: 701.777.6305
Presenters

**NACRHHS Committee Chair**
Ronnie Musgrove

**NACRHHS Executive Secretary**
Steve Hirsch

**Committee Members**
Christy Whitney

The National Advisory Committee on Rural Health and Human Services (NACRHHS)

Rural Assistance Center
Webinar
February 18, 2015
What is the NACRHHS?

• An independent advisory board to the Department of Health and Human Services (DHHS) on issues related to how the Department and its programs serve rural communities.

What Does the NACRHHS Do?

• Serves as an independent, external voice to DHHS Secretary.

• Prepares an Annual Report and/or Policy Briefs to the Secretary on key rural issues.
  – In the past four years the Committee has sent eighteen Policy Briefs to the Secretary.
Committee Background

- **1987** Established by the Secretary of HHS
- **2002** Secretary Thompson expanded the focus to include human services
- **2010** Ronnie Musgrove, former governor of Mississippi appointed as Chair

Meetings

- Meets in the spring and fall, usually in the field
  - Members hear presentations from national and regional experts on the selected white paper topics
  - The field visits include site visits to rural locations and panel discussions around the selected white paper topics
Field Meetings

• Grand Junction, CO
  – April 3-5, 2013

• Bozeman, MT
  – September 4-6, 2013

• Omaha, NE
  – April 28-30, 2014

• Sioux Falls, SD
  – September 24-26, 2014,

Rural Challenges

• Rural America has almost 20% of the Total Population

• Rural America has 10% of the Nation’s Physicians

• The Physician Shortage is Especially Acute for Specialists
Rural Challenges - 2

- Higher rates of chronic illness and poor overall health are found in rural communities when compared to urban populations
- The uninsured rate is higher in Nonmetro counties than in Metropolitan counties

Policy Brief Topics

- Affordable Care Act Plans and Premiums in Rural America
- Rural Implications of the Affordable Care Act Outreach, Education, and Enrollment
- Rural Implications of Changes to the Medicare Hospice Benefit
Rural Implications of the Affordable Care Act
Outreach, Education, and Enrollment

Rural Uninsured

- Rural residents are more likely to be uninsured (18 percent of non-metro residents are uninsured compared to 15 percent metro-residents)
- As population density and proximity to an urban area decrease, the insurance rate increases
- Outreach and Enrollment activities are more difficult in rural areas because the uninsured individuals are spread over a larger geographic area
- The Committee wanted to ensure that Outreach, Education, and Enrollment activities would not omit rural areas.
State Based Marketplaces and the Federal Marketplace

• There are three main types of Marketplaces: a State-Based Marketplace (SBM), in which the state assumes primary responsibility, a Federally-Facilitated Marketplace (FFM), operated by the Department of Health and Human Services, or the State-Partnership Marketplace (SPM), a hybrid of the two

• There are 14 State-based Marketplaces; 10 State-Partnership Marketplaces; 27 Federally-facilitated Marketplaces

• HHS is operating the Marketplaces in states that account for two-thirds of the uninsured population

• SBMs had almost four times more consumer assistance funding available to them than in Federally-facilitated states

Federal Funding for Marketplace Consumer Assistance

• HHS made $67 million in Navigator grants awarded to entities working in the 36 states with FFMs and SPMs

• HHS awarded $150 million in Health Center Outreach and Enrollment Assistance Awards to health centers across the country

• HHS also made $1.3 million in supplemental awards to 52 rural health organizations

• USDA awarded $1.25 million to set up a network of Cooperative Extension Service educators in 12 FFM states to help the uninsured and underinsured
Reaching the Rural Uninsured

Key Recommendations

1. Target Subsequent OE&E Efforts to Build on Rural Lessons Learned and Baseline Data from Initial Enrollment Period
   - Mass campaigns through direct mail, phone calls, and state-wide media blasts aren’t effective
   - Rural stakeholders emphasized the importance of trust and personal relationships in conducting OE&E in rural America
   - The Committee believes that it is critical to develop a strong baseline assessment of Marketplace enrollment in the first year and examine enrollment data and analysis by geographic location
Key Recommendations

2. Inform hospitals on the IRS Form 990 Community Benefit
   - Small rural hospitals tend to be a trusted resource in the community and the hub of local health care
   - Hospitals classified as tax-exempt charitable organizations are required to provide and report benefit to the community
   - At the time of the meeting, the IRS had proposed that hospitals helping uninsured individuals and their families learn about and enroll in sources of insurance, including insurance plans on the Marketplaces, could be reported under the IRS Form 990 Community Benefit
   - The IRS rule has since been made permanent

Key Recommendations

3. CMS Advisory Panel on Outreach and Education
   - The Committee recommended that the Secretary direct the panel to include rural considerations in the future
   - The Committee suggested strategies for reaching rural America included:
     » Radio and Local newspaper
     » Flyers through bill statements (e.g. cable, electricity bills) and bank deposit slips
     » Leveraging family members and respected members of the community
     » Town-hall meetings and community dinners
     » State fairs and Community health enrollment fairs
     » School-based campaigns
     » Working with Chambers of Commerce, Rotary Clubs, and other civic groups
     » Training retirees as OE&E volunteers
     » Working with USDA Cooperative Extension Service
     » Working with the faith based communities
Affordable Care Act Plans and Premiums in Rural America

Network Adequacy and Access to Health Care Plans

- Rural residents have historically faced barriers to accessing both providers and private health insurance options
- The Committee heard preliminary research findings from the Rural Policy Research Institute (RUPRI) on the rural coverage in the 2014 Marketplace
Data on Rural Marketplace Premium Pricing

- Four Important Factors:
  - The rating area design (state-level decision)
  - The “metal level” of plans
  - The effect of age, family status, and tobacco use on actuarial value
  - The cost of living in a rating area

Rating Area Design

- Rating areas are geographic areas within a state where health insurance plans must charge the same premium to consumers
- States must construct rating areas based on one of the following:
  - Counties
  - Three-digit ZIP codes
  - MSAs and non-MSAs
  - A combination methodology
Rating Area Design - 2

- There is considerable variability in rating area design from one state to the next.

<table>
<thead>
<tr>
<th>Rating Area Design</th>
<th>Table 1: State Rating Area Decisions Actively Established at the State Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Statewide Rating Area</td>
<td>Region within a State: Groups of Counties</td>
</tr>
<tr>
<td>DE HI NH NJ RI VT</td>
<td>AZ, AK, CA, CO*, GA, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO*, MT, NV, NY, NC, OH, OR, PA, SD, TN, UT, WA, WV, WI</td>
</tr>
</tbody>
</table>

RUPRI: State decisions on rating area design
* These states were permitted to use more rating areas than the statutory limit.

Rating Area Design - 3

- RUPRI used population density as a proxy for rurality.
- States with a small total population, but with a high percentage of their population living in rural areas, tended to have higher premiums than other states (an average of $265 compared to $243 for the “least rural states”)
- Average monthly premium prices decreased in rating areas as population density increased.
Rating Area Design - 4

- RUPRI also suggested that premiums seem to be impacted by rating area design
- In States where rating areas were individual counties, premiums were higher.
- Smaller rating areas and the resulting lack of competition could be linked to higher insurance rates

Key Recommendations

1. The Committee recommends that the Secretary educate states on the implications of using small rating area designs on premium pricing for low population density areas
2. The Committee recommends that the Secretary include Rural Health Clinics under the definition of Essential Community Providers
3. The Committee recommends that the Secretary evaluate all Marketplace data—including premium pricing, enrollment, and network adequacy—by rurality
4. The Committee recommends that the Secretary provide hospitals and other health care providers with maximum flexibility to conduct outreach and enrollment
Rural Implications of Changes to the Medicare Hospice Benefit

Medicare Hospice Benefit

- The Medicare hospice benefit was created in 1983 to offer Medicare beneficiaries a choice in their end-of-life care
- Medicare defines hospice care as “a comprehensive set of services…identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family member.”
Increasing Use of the Hospice Benefit

- The number of beneficiaries choosing hospice and total Medicare hospice spending have more than doubled since 2000.
- In FY 2012, enrollment grew to 1.25 million beneficiaries, or 45.2 percent of all Medicare decedents, and spending increased to $14.7 billion.
- The increase in hospice spending reflects both the higher number of beneficiaries electing the benefit as well as increased costs per enrollee.

Hospice Benefits

- Include physician and nursing services, hospice aide/homemaker services, social work, counseling, drugs, supplies, therapies, durable medical equipment for palliative care, and other measures normally covered by Medicare.
- Four levels of care
  - Routine Home Care
  - Inpatient Respite Care
  - General Inpatient Care
  - Continuous Home Care
The ACA and Hospice

- Quality reporting – failure to report will result in a two percent reduction in reimbursement
- Requires beneficiaries to have a face-to-face visit with a hospice physician or NP prior to recertification for the third and any subsequent benefit period
- Authorized CMS to design a Medicare Hospice Concurrent Care Demonstration Program

Rural Hospice

- In 2011 45.2 percent of all Medicare decedents elected hospice
- The proportion steadily declined from urban to rural decedents
  - Metro - 46.6 percent
  - Micro - 41.4 percent
  - Rural, Adjacent - 40.2 percent
  - Rural, not Adjacent - 35.9 percent
  - Frontier - 30.7 percent
Rural Hospice - 2

• The number of Hospices in Urban Areas is Growing as the number of Hospices in Rural Areas is in decline

• The lower growth rate among rural providers is consistent with the lower number of rural for-profit and freestanding hospices

### COMPARISON OF URBAN AND RURAL HOSPICE OWNERSHIP AND MARGINS

<table>
<thead>
<tr>
<th>Ownership Status</th>
<th>Urban</th>
<th>Rural</th>
<th>Average Financial Margins in 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-Profit</td>
<td>40.0%</td>
<td>36.9%</td>
<td>+12.4%</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>51.2%</td>
<td>47.5%</td>
<td>+3.2%</td>
</tr>
<tr>
<td>Government-Owned</td>
<td>8.9%</td>
<td>14.3%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Urban</th>
<th>Rural</th>
<th>Average Financial Margins in 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding</td>
<td>74.2%</td>
<td>60.5%</td>
<td>+10.7%</td>
</tr>
<tr>
<td>Hospital-Based</td>
<td>9.5%</td>
<td>22.7%</td>
<td>+3.2%</td>
</tr>
<tr>
<td>Home-Health-Based</td>
<td>16.1%</td>
<td>15.3%</td>
<td>-16.0%</td>
</tr>
<tr>
<td>Skilled-Nursing-Facility-Based</td>
<td>0.3%</td>
<td>0.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>72.6%</td>
<td>27.3%</td>
<td>7.5%</td>
</tr>
</tbody>
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Rural-Urban Differences

- Financial margins for rural hospice facilities (5.3 percent) are lower than urban hospice facilities (7.8 percent)
- The rural-urban difference is driven in part by the greater rural prevalence of hospital-based hospices
- Rural hospices also receive $17 less per day per beneficiary ($158 versus $141) after adjusting for the wage index

Rural-Urban Differences - 2

- Rural hospice patients are more likely to receive care in their home than urban patients
- Care provided in patients’ homes may mean a greater number of visits by rural hospice care providers to patients’ homes, longer travel time, and increased expense for hospice employees
- Rural patients are also more likely to receive exclusively routine home care than urban patients
Key Recommendations

1. The Committee recommends that the Secretary work with the Congress to allow physician assistants and nurse practitioners at rural health clinics to furnish and bill for hospice services

2. The Committee recommends that the Secretary examine allowing telehealth consultations to count as face-to-face encounters and allowing nurse practitioners and physician assistants to certify the need for hospice care through face-to-face visits in rural areas

3. The Committee recommends that the Secretary provide greater flexibility in cost reporting for CAHs to encourage more collaboration between hospice providers and CAHs

4. The Committee recommends that the Secretary task CMS to do a careful analysis of the cost of “windshield time” among providers.
2015 Committee Meeting

- Slade, Kentucky
  - April 29 – May 1, 2015

Uses for the Committee Reports

- Inform the policy decisions of the Secretary for HHS
- Resource for rural providers who can then share findings and recommendations with others in the field
- Resources for policy makers
For More Information…

To find out more about the NACRHHS, please visit our website at [http://www.hrsa.gov/advisorycommittees/rural/](http://www.hrsa.gov/advisorycommittees/rural/) or contact:

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Q & A

- Submit questions using Q & A tab directly beneath slides.
Thank you!

• Contact us at www.raconline.org with any questions
• Please complete webinar survey
• Recording and transcript will be available on RAC website