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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.raconline.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

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National Advisory Committee
On Rural Health and Human Services

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

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National Advisory Committee
On Rural Health and Human Services

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

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National Advisory Committee
On Rural Health and Human Services

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

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National Advisory Committee
On Rural Health and Human Services

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

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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,

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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

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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

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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

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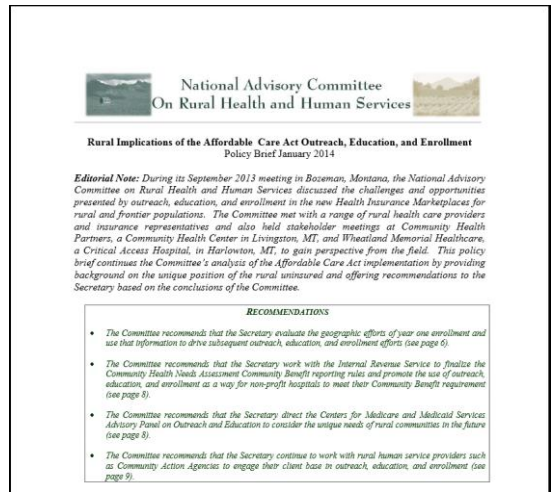
Rural Implications of the Affordable Care Act Outreach, Education, and Enrollment



National Advisory Committee
On Rural Health and Human Services

Rural Implications of the Affordable Care Act Outreach, Education, and Enrollment
Policy Brief January 2014

Editorial Note: *During its September 2013 meeting in Bozeman, Montana, the National Advisory Committee on Rural Health and Human Services discussed the challenges and opportunities presented by outreach, education, and enrollment in the new Health Insurance Marketplaces for rural and frontier populations. The Committee met with a range of rural health care providers and insurance representatives and also held stakeholder meetings at Community Health Partners, a Community Health Center in Livingston, MT, and Wheatland Memorial Healthcare, a Critical Access Hospital, in Harlowton, MT, to gain perspective from the field. This policy brief continues the Committee's analysis of the Affordable Care Act implementation by providing background on the unique position of the rural uninsured and offering recommendations to the Secretary based on the conclusions of the Committee.*

RECOMMENDATIONS

- *The Committee recommends that the Secretary evaluate the geographic efforts of year one enrollment and use that information to drive subsequent outreach, education, and enrollment efforts (see page 6).*
- *The Committee recommends that the Secretary work with the Internal Revenue Service to finalize the Community Health Needs Assessment Community Benefit reporting rules and promote the use of outreach, education, and enrollment as a way for non-profit hospitals to meet their Community Benefit requirement (see page 8).*
- *The Committee recommends that the Secretary direct the Centers for Medicare and Medicaid Services Advisory Panel on Outreach and Education to consider the unique needs of rural communities in the future (see page 8).*
- *The Committee recommends that the Secretary continue to work with rural human service providers such as Community Action Agencies to engage their client base in outreach, education, and enrollment (see page 9).*

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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 uninsurance 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.

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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

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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

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Reaching the Rural Uninsured

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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

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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

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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

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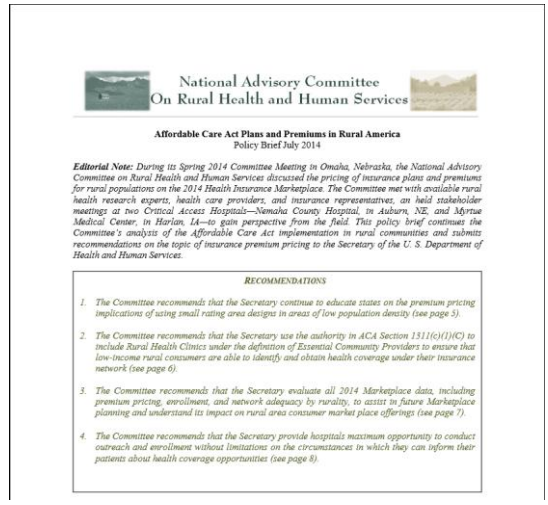
Affordable Care Act Plans and Premiums in Rural America



National Advisory Committee
On Rural Health and Human Services

Affordable Care Act Plans and Premiums in Rural America
Policy Brief July 2014

Editorial Note: *During its Spring 2014 Committee Meeting in Omaha, Nebraska, the National Advisory Committee on Rural Health and Human Services discussed the pricing of insurance plans and premiums for rural populations on the 2014 Health Insurance Marketplace. The Committee met with available rural health research experts, health care providers, and insurance representatives, an held stakeholder meetings at two Critical Access Hospitals—Namaha County Hospital, in Auburn, NE, and Myrtue Medical Center, in Harlan, IA—to gain perspective from the field. This policy brief continues the Committee's analysis of the Affordable Care Act implementation in rural communities and submits recommendations on the topic of insurance premium pricing to the Secretary of the U. S. Department of Health and Human Services.*

RECOMMENDATIONS

1. *The Committee recommends that the Secretary continue to educate states on the premium pricing implications of using small rating area designs in areas of low population density (see page 5).*
2. *The Committee recommends that the Secretary use the authority in ACA Section 1311(c)(1)(C) to include Rural Health Clinics under the definition of Essential Community Providers to ensure that low-income rural consumers are able to identify and obtain health coverage under their insurance network (see page 6).*
3. *The Committee recommends that the Secretary evaluate all 2014 Marketplace data, including premium pricing, enrollment, and network adequacy by rurality, to assist in future Marketplace planning and understand its impact on rural area consumer market place offerings (see page 7).*
4. *The Committee recommends that the Secretary provide hospitals maximum opportunity to conduct outreach and enrollment without limitations on the circumstances in which they can inform their patients about health coverage opportunities (see page 8).*

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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

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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

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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

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Rating Area Design - 2

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

Table 1: State Rating Area Decisions Actively Established at the State Level				
One Statewide Rating Area	Region within a State: Groups of Counties	Region within a State: Groups of 3-Digit ZIP Codes	Each County Its Own Rating Area	(ACA Default) MSAs + 1
DE HI NH NJ RI VT	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	AK ID MA NE	CT* FL* SC*	AL NM ND OK TX VA WY

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

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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

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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

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On Rural Health and Human Services

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

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Rural Implications of Changes to the Medicare Hospice Benefit

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Rural Implications of Changes to the Medicare Hospice Benefit
Policy Brief August 2013

Editorial Note: *During its April 2013 meeting in Grand Junction, Colorado, the National Advisory Committee on Rural Health and Human Services discussed challenges and innovations in hospice and palliative care in rural and frontier areas. The Committee met at Hospice and Palliative Care of Western Colorado and visited two of its satellite hospice facilities in northwestern Colorado. In particular, the Committee examined the modifications of the Medicare hospice benefit mandated by Section 3132 of the Affordable Care Act[1] (ACA) in the context of recent changes in utilization patterns of hospice and palliative care in rural and urban areas. This policy brief continues the Committee's series of analyses of ACA provisions which may have rural implications by providing background on the Medicare hospice benefit, describing unique features of hospice care in rural areas, and submitting recommendations to the Secretary based on the outcome of the Committee's deliberations.*

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 (see page 9).*
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 (see page 9).*
3. *The Committee recommends that the Secretary examine allowing hospices serving rural areas greater flexibility in fulfilling covered service requirements that takes into account potentially higher costs in rural areas such as for durable medical equipment and pharmaceuticals (see page 10).*
4. *The Committee recommends that the Secretary provide greater flexibility to Critical Access Hospitals (CAHs) in cost-reporting carve outs related to the provision of hospice services so as not to lower the CAHs' cost-based reimbursement (see page 10).*
5. *The Committee recommends that the Secretary consider allowing cost-based reimbursement for hospice services in the upcoming Frontier Community Health Integration Program Demonstration (see page 10).*
6. *The Committee recommends that the Secretary request that the Institute of Medicine evaluate the current status of terminal prognoses and make recommendations concerning both documentation and medical review of such (see page 11).*
7. *The Committee recommends that the Secretary solicit feedback from rural hospices about specific instances of inconsistency among Medicare Administrative Contractors in evaluating patient eligibility for the Medicare Hospice Benefit and work with these parties to improve consistency (see page 11).*
8. *The Committee recommends that the Secretary reexamine disparities in costs incurred in travel (i.e., windshield time) between urban and rural hospice providers given changes in utilization patterns over the past decade (see page 11).*

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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."

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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.

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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

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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

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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

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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

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COMPARISON OF URBAN AND RURAL HOSPICE OWNERSHIP AND MARGINS

	Urban	Rural	Average Financial Margins in 2010
Ownership Status			
For-Profit	40.0%	36.9%	+12.4%
Non-Profit	51.2%	47.5%	+3.2%
Government-Owned	8.9%	14.3%	N/A
Facility Type			
Freestanding	74.2%	60.5%	+10.7%
Hospital-Based	9.5%	22.7%	+3.2%
Home-Health-Based	16.1%	15.3%	-16.0%
Skilled-Nursing-Facility-Based	0.3%	0.2%	N/A
Total	72.6%	27.3%	7.5%

Source: 2010 Hospice Data Claims and Chapter 12, MedPAC March 2013 report.

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

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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

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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

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Key Recommendations

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.

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2015 Committee Meeting

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

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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

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On Rural Health and Human Services

For More Information…

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

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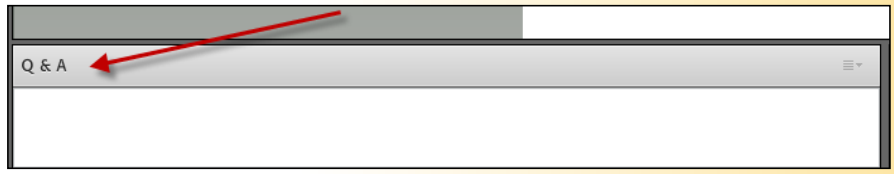
Q & A

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



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- Please complete webinar survey
- Recording and transcript will be available on RAC website

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