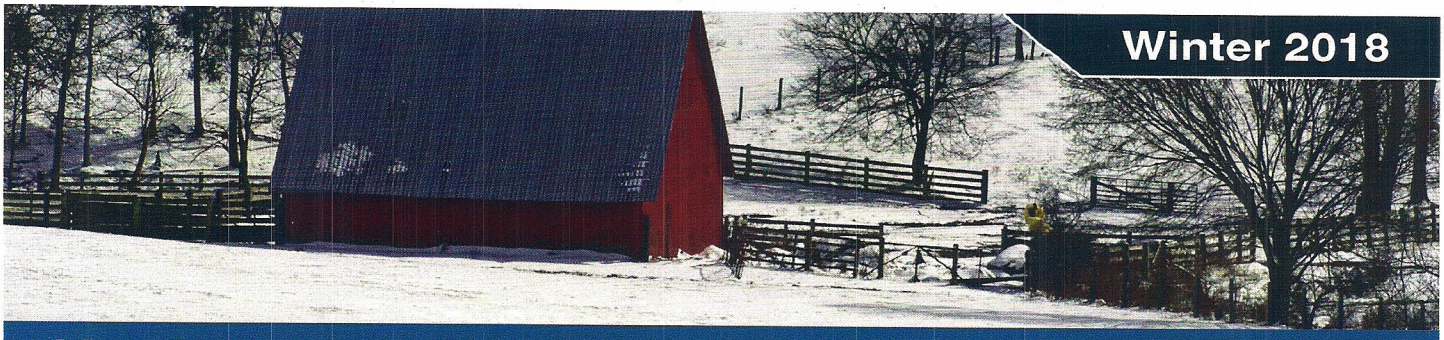


Winter 2018

Key Issues Affecting Kentucky's Rural Hospitals

Kentucky's small rural and critical access hospitals (CAH) are facing increasing challenges in serving the nearly 45 percent of Kentuckians residing in rural areas.

In recent years, rural providers have endured major challenges through expansion of Medicaid, sequestration, Medicaid cuts and the threat of cuts by other government payers. Rural hospitals in Kentucky are a critical infrastructure and a health care safety net for rural Kentuckians. Since 2014, two Kentucky rural hospitals have closed and two more have discontinued inpatient services.

- **Nearly 45 percent of the population reside in rural areas.**
- **Sixty-four of the 97 acute hospitals in the Commonwealth are located in rural areas.**
- **Kentucky now has 27 certified critical access hospitals (CAHs) representing nearly one-third of the acute care hospitals in the state.**
- **There are rural hospitals and CAHs in every congressional district in Kentucky, save one. In that district (Third Congressional District), all the hospitals have direct ties to other rural hospitals throughout the state due to transfers and referrals for specialty services.**
- **Over one third of Kentucky acute care hospitals have a special Medicare designation, such as "Rural Referral Center," "Medicare Dependent Hospital" or "Sole Community Hospital," indicating the extent to which they serve the rural population.**

LEGISLATIVE ISSUES: The issues outlined below are critical to Kentucky's hospitals, including small hospitals, ability to sustain health care services. The Kentucky Hospital Association urges our congressional delegation to support each of these efforts.

Reinstate Critical Rural Health Programs

- Several critically important rural Medicare "extenders" – including Medicare Dependent Hospital and Low Volume Hospital programs – expired on October 1, 2017. Congress created these unique payment structures for certain rural providers to meet the extreme challenges of rural health care delivery and enable them to keep their doors open. If Congress does not act, rural health providers will be hit with hundreds of millions of dollars in reimbursement cuts, and Kentucky hospitals will close. These extenders include important payments to small rural hospitals, rural ambulances and other critical providers.

  Kentucky's hospitals urge Congressional action to extend these critical programs without enacting cuts to other critical rural hospital programs.

  - Medicare Dependent Hospital (MDH) Program: To qualify as a MDH, a hospital must be located in a rural area, have 100 or fewer beds, not be classified as a sole community hospital (SCH), and have had at least 60 percent of its inpatient days or discharges attributable to Medicare beneficiaries. **There are 20 Kentucky hospitals which receive approximately $9 million in additional Medicare payments under the MDH program.**
  - Low Volume Hospital (LVH)Adjustment: Medicare identifies rural hospitals with a low volume of Medicare patients and be at least 15 miles from another hospital as qualifying for the LVH program. **The 25 Kentucky hospitals qualifying for the LVH program receive a total of approximately $12 million in additional Medicare payments.**

- continued over -

Key Issues Affecting Kentucky's Rural Hospitals - continued

Physician Supervision

- In the Calendar Year (CY) 2009-2013 outpatient PPS rules, CMS mandated new requirements for "direct supervision" of outpatient therapeutic services, requiring that a physician or a non-physician practitioner be immediately available to furnish assistance and direction throughout certain outpatient procedures. Small, rural PPS hospitals and critical access hospitals have expressed concern that shortages of physicians and nurse practitioners in their communities make it difficult to comply with this requirement in cases where patient safety is not a factor requiring direct supervision. This policy reduces access to outpatient therapeutic services for Medicare patients at local rural hospitals, since hospitals unable to comply may limit their hours of operation or close certain programs.

Critical Access Hospital Relief of 96-Hour Physician Certification Rule

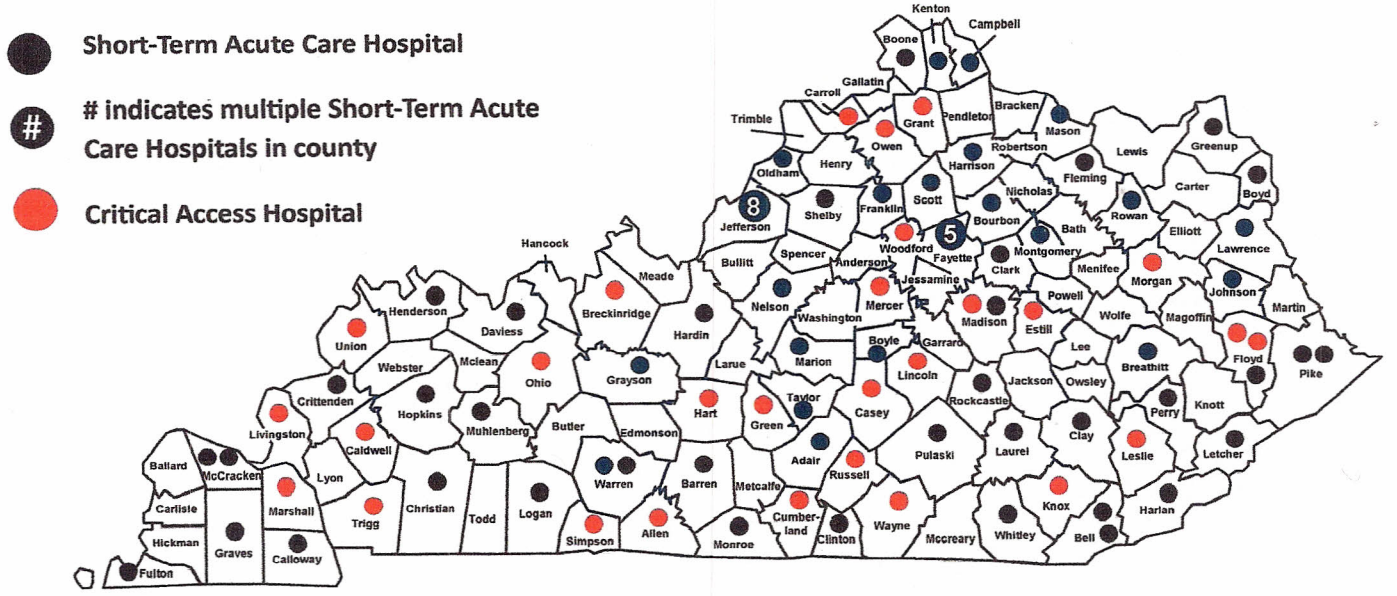
- CMS interprets current law to require physicians admitting patients to a CAH to certify the patient will stay 96 hours or less in the hospital as a *condition of payment.* There are many contributing factors that may result in a patient staying longer than anticipated in a hospital including approval for post-acute services and ability to appropriately place a patient following discharge. Please support legisation to eliminate the 96-hour physician certification requirement for inpatient services at CAHs but keep intact other important certification requirements.

Action Needed to Stabilize the Health Insurance Market

- Policy changes are needed to increase the competition among insurance providers in the private market. Currently in Kentucky, there are 76 counties with only one insurance carrier choice under the federal exchange – virtually creating provider networks leaving few health care choices for patients and leaving health insurance prices unchecked. Action is needed to promote growth in the insurance market to insure better access to health care coverage for all.

340B Drug Discount Program

- In the Outpatient Prospective Payment Rule, the Centers for Medicare and Medicaid Services cut outpatient pharmacy reimbursement to qualifying 340B hospitals by 28%. Action is needed by Congress to reverse this policy change and to reinstate these payments to hospitals. These 340B payments help hospitals to provide care for indigent and low income patients.



For questions about issues affecting Kentucky rural hospitals, contact:
Sarah Nicholson (**snicholson@kyha.com**) or Elizabeth Cobb (**ecobb@kyha.com**).

Kentucky Hospital Association

Proven Experts on the Ground

State Offices of Rural Health

25+ Years of Making Health Care Better for Nearly 60 Million People in America

What does a SORH do?

No Other Resource Does the Work of a SORH

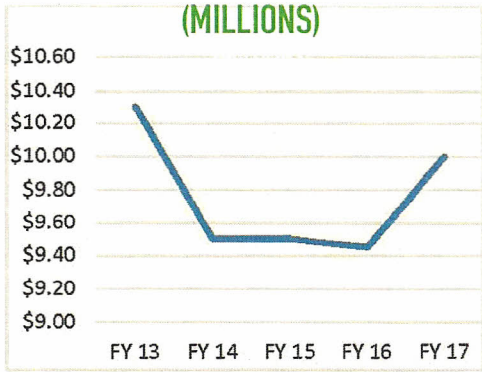
SORHs build partnerships to grow innovation and improve health in our nation's rural communities, collect and disseminate data which informs public policy decisions that impact rural providers, provide technical assistance that improves quality of care, aid in health care provider recruitment and workforce development, and build and expand access to life-saving health care services for 60% of the nation's counties.

SORHs are a one-stop shop for community leaders and health care providers in the nation's rural communities. They connect State and Federal resources for hospitals, rural health clinics, EMS, thousands of rural health partners, and millions of people living and working in rural communities across the United States.

Provide Vital Assistance to:
2,168 Communities
1,992 Hospitals
3,632 Clinics
1,215 Emergency Medical Services
5,142 Health Care Providers

63,160 Total Technical Assistance Transactions to 22,618 Clients

SORH FUNDING 5 YEAR HISTORY (MILLIONS)



What we need Congress to do:

Pass S. 2278, the State Offices of Rural Health Reauthorization Act, introduced by Senators Roberts and Heitkamp and adopt a House companion bill to reauthorize and update the SORH grant program. SORH equip rural communities with the resources they need to keep up with information and provide assistance to strengthen rural health care delivery.

Fast Fact Wise Investment of Taxpayer Dollars
Every SORH Grant Dollar is Matched with $3 in Non-Federal Funds!

Snapshot of the SORH Impact

- Assure access to life-saving and cost-saving care.
- Protect rural communities from devastating hospital closures.
- Improve health quality and safety for rural health clinics and emergency medical service patients.
- Help recruit and retain physicians and other health care providers in rural America.
- Coordinate solutions to address population health issues, solve the rural opioid epidemic, increase use of telehealth solutions, and lead other health innovations.

NOSORH
National Organization of State Offices of Rural Health
www.nosorh.org

Ask an Expert:

Teryl Eisinger, Executive Director PHONE: (888) 391-7258, ext. 107 | FAX: (586) 336-4629 | EMAIL: teryle@nosorh.org

Rural Americans — the facts:

Rural residents make up about 20% of the U.S. population but 23% of Medicare beneficiaries. Those 60 million rural Americans are scattered over 95% of the landmass in the U.S.

Rural Americans are older and sicker than their urban counterparts, suffering higher rates of chronic disease such as heart disease and diabetes.

According to a January 2017 Center for Disease Control study, a higher percentage of rural Americans die prematurely.

The opioid crisis is catastrophic in rural America. In fact, the rate of overdose deaths in non-metro counties is 45% higher than in metro counties.

Extreme distances, weather, geography, systemic health care workforce shortages and the hospital closure crisis make access to care the prevailing concern for rural patients.

In an emergency, rural patients must travel twice as far as urban residents to the closest hospital. As a result, 60% of trauma deaths occur in rural America, even though only 20% of Americans live in rural areas.

#RuralHealthDisparities

Health care in rural America is critical to the communities overall wellbeing. It can comprise as much as 20% of the rural economy.

200,000 jobs were lost annually in rural America during the Great Recession, and 19% of rural Americans, including 25% of rural children, are still living in poverty.

In most rural communities, the hospital is the first or second largest employer, but only if the community still has a hospital. 83 rural hospitals have closed since 2010, and 674 (1/3 of all rural hospitals) are vulnerable to closure.

44% of rural hospitals operate at a loss and 30% operate below a -3% margin. Rural hospitals have absorbed a combined $318 million in cuts under sequestration, resulting in a loss of 7, 129 community health care jobs and a $769 million loss to GDP.

If all 674 vulnerable hospitals close, we will lose 99,000 direct health care jobs and 137,000 community jobs, and $277 billion in GDP. Per-capita annual rural incomes will decrease by $703.

#RebuildRural #SaveRural

@NRHA_Advocacy

Your voice. Louder.

NATIONAL RURAL HEALTH ASSOCIATION

Who we are

The National Rural Health Association is a national nonprofit and nonpartisan membership organization with more than 21,000 members. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health. The delivery of health care in rural America is drastically changing. NRHA strives to improve the health of the 60 million who call rural America home.

2018 NRHA Rural Health Champions

Legislative Award

Senator Joe Manchin (D-WV)
Senator John McCain (R-AZ)
Senator Susan Collins (R-AK)
Representative Lynn Jenkins (R-KS-2)
Representative Cheri Bustos (D-IL-17)
Representative Terri Sewell (D-AL-7)

Legislative Staff Award

Steffanie Bezruki
- office of Rep. Cheri Bustos (D-IL)

Beth Wikler
- office of Sen. Tina Smith (D-MN)

Taylor Hittle
- office of Rep. Markwayne Mullin (R-OK)

Our mission:

To provide leadership on rural health issues through advocacy, communications, education and research.

What we fight for

NRHA fights for access to care.

Rural populations are per capita older, poorer and sicker than their urban counterparts. Yet, medical deserts are appearing across rural America leaving many of the most vulnerable populations without timely access to care. Continued cuts have severely hurt rural providers, creating job loss and negative changes in service availability.

NRHA fights for a robust rural workforce.

Rural areas have far fewer health care providers and face dramatic challenges in recruiting and retaining a health care workforce. 77% of rural counties in the United States are Primary Care Health Professional Shortage Areas while 9% have no physicians at all. The uneven distribution of health care providers between rural and urban areas represents an inequality regarding access of care and has an impact on the health of the populations.

NRHA fights to support strong funding for the rural health safety net.

The federal investment in rural health programs is a small portion of federal health care spending, but it is critical to rural Americans. These safety net programs increase access to health care providers, improve health outcomes for rural Americans and increase the quality and efficiency of health care delivery in rural America.

NRHA Supported Legislation 2018

NATIONAL RURAL HEALTH ASSOCIATION

Bill	Effect
Save Rural Hospitals Act H.R. 2957 – Graves (R-MO-6), Loebsack (D-IA-2)	Reverses cuts to rural hospitals; provides regulatory relief; develop a new provider type – the Community Outpatient Hospital – a 24/7 Emergency Room, outpatient services, and primary care services
Community Health Investment, Modernization and Excellence (CHIME) Act of 2017 H.R. 3770 – Stefanik (R-NY-21), Young (R-IA-3), Courtney (D-CT-2), O'Halleran (D-AZ-1) S. 1899 – Blunt (R-MO), Stabenow (D-MI)	Provides a five-year extension of funding for Community Health Center and the National Health Service Corps.
State Offices of Rural Health Act S. 2278 – Roberts (R-KS), Heitkamp (D-ND), Barrasso (R-WY), Casey (D-PA), Grassley (R-IA), Baldwin (D-WI), Smith (D-MN), Shaheen (D-NH)	Authorizes funding for the State Offices of Rural Health (SORH)
Targeted Opioid Formula Act S. 2125 – Shaheen (D-NH), Hassan (D-NH), Capito (R-WV), Manchin (D-WV)	Changes the formula used for allocating opioid funding so that states most in need receive funding by reducing emphasis on population in the formula
The Addiction Recovery for Rural Communities Act H.R. 3566 – Bustos (D-IL-2), Crawford (R-AR-1), Marshall (R-KS-1), Evans (D-PA-2), Kuster (D-NH-2) Companion bill in Senate Opioid Package (S.2137) – Donnelly (D-IN), Roberts (R-KS)	Sets aside 20% of the USDA's Distance Learning and Telemedicine Program grant funding for substance abuse treatment; prioritizes USDA Rural Health and Safety Education grant funding for applicants seeking to improve education and outreach on substance abuse issues
USDA Rural Health Liaison H.R. pending – Bustos (D-IL-2)	Creates a liaison in department of agriculture to work with HRSA on rural health
CONNECT for Health Act S. 1016 – Schatz (D-HI), Wicker (R-MS), Cochran (R-MS), Cardin (D-MD), Thune (R-SD), Warner (D-VA)	Improve affordability and accessibility to telehealth services in rural America by expanding Medicare coverage of critical programs
CRIB Act H.R. 2501 – Jenkins (R-WV-3), Turner (R-OH-10), Ryan (D-OH-13), Clark (D-MA-5) S.1148 – Brown (D-OH), Capito (R-WV), King (I-ME), Portman (R-OH)	Allow a state Medicaid program to cover inpatient or outpatient services at a residential pediatric recovery center for infants with neonatal abstinence syndrome (a postnatal drug withdrawal syndrome) and their families.
Combatting the Opioid Epidemic Act H.R. 4501 – Loebsack (D-IA-2), Kuster (D-NH-2), Shea-Porter (D-NH-1), Napolitano (D-CA-32)	Ensure that states receive adequate funding to fight the opioid crisis

Improving Access to Maternity Care Act H.R. 315 – Burgess (R-TX-26), Eshoo (D-CA-18), Roybal-Allard (D-CA-40)	Designates maternity care health professional shortage areas and collects data regarding the full scope of maternity care including labor, birthing, prenatal, and postnatal care
Rural Hospital Regulatory Relief Act H.R. 741 – Jenkins (R-KS-2), Loebsack (D-IA-2) S. 243 – Thune (R-SD), Heidi Heitkamp (D-ND)	Permanently extends the non-enforcement of the direct supervision of therapy services requirement
Restoring Rural Residencies Act S.455 – Tester (D-MT)	Reimburses medical residency training programs under Medicare for certain GME costs associated with resident time spent CAHs
Rural Hospital Access Act S. 872 – Grassley (R-IA) H.R. 1955 – Reed (R-NY-23)	Makes permanent the extension of the Medicare-dependent hospital (MDH) program and the increased payments under the Medicare low-volume hospital (LVH) program
Veterans Community Care and Access Act S. 2184 – McCain (R-AZ), Moran (R-KS)	Requires the VA to pay CAHs providing care through the community care program at the CAH Medicare-established rate instead of the service-based Medicare rate used at larger facilities; expands use of telehealth programs at the VA
Repeal of the Obamacare Bay State Boondoggle Act H.R. 2224 – Smith (R-NE-3)	Eliminates an ACA provision that manipulates the Medicare wage index to benefit a few states while reducing the wage index for the rest of the nation
Pharmacy and Medically Underserved Areas Enhancement Act H.R. 592 – Guthrie (R-KY-2), Kind (D-WI-3)	Provide for coverage under the Medicare program of pharmacist services
Top OD Act H.R. 664 – Joyce (R-OH-14), Ryan (D-OH-13)	Expands grants for education and naloxone training and administration
Preserve Access to Medicare Rural Home Health Services Act S. 353 – Collins (R-ME)	Extends through 2022 the rural add-on payment for Medicare home health services furnished to patients in rural areas
Rural Access to Hospice Act S. 980 – Capito (R-WV) H.R.1828 – Jenkins (R-KS-2)	Allows RHC and FQHCs to receive payment for certain care provided to Medicare hospice patients
Medicare Ambulance Access, Fraud Prevention, and Reform Act S. 967 – Stabenow (D-MI)	Makes permanent the add-on Medicare payment rates for ambulance services in rural areas, among other important reforms
Helping Expand Access to Rural Telehealth (HEART) Act H.R. 2291 – Duffy (R-WI-7)	Expands Medicare telehealth coverage to include home-based monitoring for congestive heart failure and chronic obstructive pulmonary disease
H.R. 4520 Jenkins (R-KS-2)	Extends the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals
Advancing Rural Health for Tomorrow (AHRT) Act Pending	Creates a voluntary national value-based quality payment system for critical access hospital services
H.Res.627 Jenkins (R-KS-2), Kind (D-WI-3), McMorris Rodgers (R-WA-5), Welch (D-VT-At Large)	Recognizing that access to hospitals and other health care providers for patients in rural areas of the United States is essential to the survival and success of communities in the United States.

REBUILD RURAL

#RebuildRural

OVERVIEW

The Rebuild Rural Infrastructure Coalition is comprised of more than 200 organizations from across the country focused on rural communities, U.S. agricultural producers, rural businesses, and rural families. The Rebuild Rural Coalition is dedicated to advocating for investment in rural America's infrastructure and understands that rural America's infrastructure needs are fundamentally different.

Past infrastructure initiatives often focused on urban and suburban areas while not adequately addressing the unique needs of rural communities. Rural communities have seen their infrastructure deteriorate, jeopardizing their jobs, their families' health and wellbeing and their competitiveness in both agricultural and other industries important to rural America.

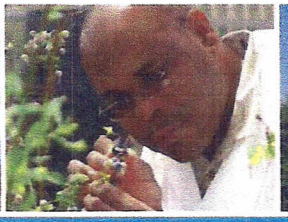
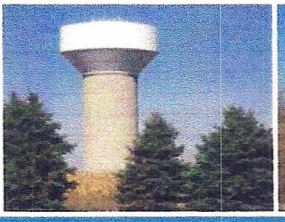
American agriculture truly feeds the world and creates millions of jobs for U.S. workers. Our nation's ability to produce food and fiber and transport it efficiently across the globe is a critical factor in U.S. competitiveness internationally. Our deteriorating infrastructure threatens this leadership position and negatively impacts the ability of rural Americans to do their jobs.

Transportation infrastructure improvement to highways, bridges, railways, locks and dams, harbors and port facilities is the most obvious need in rural communities, but not the only need that must be addressed. In addition, critical needs exist in providing clean water for rural families, affordable housing options for rural residents, expanding broadband to connect rural communities to the outside world, updating Ag research facilities so the rural economy can stay competitive and enhancing the ability to supply affordable, reliable and secure power for the rural economy.

Federal investment in infrastructure plays a vital role in repairing and expanding our nation's infrastructure, however federal funds cannot fully meet the vast diversity of needs. This is why public-private partnerships and other creative solutions are necessary to meet the challenges of rural America. In order for infrastructure funding to be utilized to the highest degree, we must ease burdensome regulations and outdated statutory requirements, as well as fund projects in a way that ensures completion in a timely manner.

The Rebuild Rural Infrastructure Coalition looks forward to begin addressing the nation's infrastructure needs, and will stand as a resource for addressing the infrastructure needs of rural America.




REBUILD RURAL COALITION

50 F Street, NW, Suite 900 · Washington, DC 20001 · 202.626.8710

REBUILD RURAL

#RebuildRural

AG RESEARCH

- Federal government should continue its history of supporting agricultural research.
- Cutting-edge research is being conducted in outdated agriculture research infrastructure.
- $8.4 billion in total deferred maintenance outstanding in Ag Research building and infrastructure.

HEALTHCARE

- 80 rural hospitals closed since 2010, 673 facilities are vulnerable, making up 1/3+ of facilities.
- Funding needed for 77% of rural counties in Primary Care Health Professional Shortage Areas.
- Telehealth, combined with broadband, facilitates early diagnosis & treatment in rural areas that can lead to lower health care costs.

BROADBAND

- Broadband is vital to economic development, education, agriculture, health care & public safety activities.
- The High-Cost Universal Service Fund lacks sufficient resources to reach rate/service parity for rural & urban areas.
- Less federal regulatory burden for permits & access to government lands would boost investment in rural broadband.

HOUSING

- Low income rural Americans depend on multifamily housing loans through USDA Rural Development.
- Need to modernize housing programs such as MPR and Section 538 and Section 521.
- Rural communities need senior care facilities, higher proportion of population over 50 years old.

ENERGY

- RUS loan program helps modernize the grid, combat cyber threats & integrate renewable energy.
- RUS loans produce net income for the Treasury – approximately $300 million in 2016.
- Reducing the regulatory burden on RUS loans & infrastructure siting would increase development.

TRANSPORTATION

- Most of our locks and dams are dilapidated and have outlived their 50-year design lifespan.
- Waterways are critical corridors of commerce & supported $128 billion in ag exports in 2015.
- Most of the US transportation system is rural: 74% of bridges and 73% of roads.

FINANCING

- Access to affordable and long-term financing options is critical for rural infrastructure projects.
- Rural infrastructure facilities often are smaller, don't attract major financial institutions.
- Federal funding often is limited for rural projects, private sector financing partners are needed.

WATER

- 94%+ of U.S. drinking water utilities supply communities with fewer than 10,000 persons.
- USDA Water and Waste Water program backlog is $2.5 billion, with 995 pending applications.
- Aging & deteriorating systems beyond their useful life & have the greatest public health needs, need priority.

REBUILD RURAL COALITION

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NATIONAL RURAL HEALTH ASSOCIATION

Rural Hospital Closures

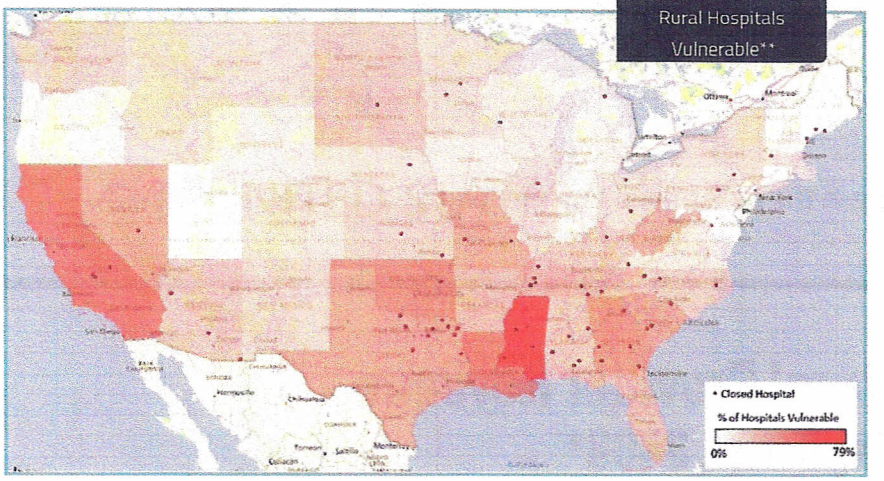
NATIONAL RURAL HEALTH ASSOCIATION

Rural Hospital Closures since 2010*

83

Rural Hospital Vulnerability Heat Map**

673
Rural Hospitals Vulnerable**



Losing vulnerable rural hospitals would jeapordize...

11.7M
Patient Encounters within 1 year**

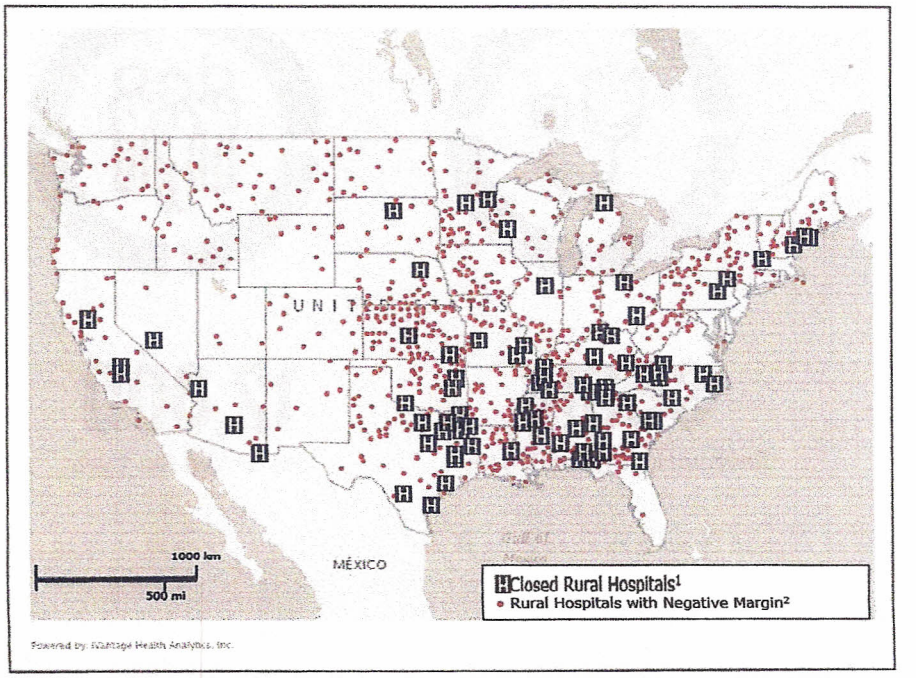
99,000
Healthcare Jobs Lost within 1 year**

137,000
Community Job Lost within 1 year**

$277B
Loss to GDP within 10 years**

2018

Multiple pressure points are pushing a greater number of rural provider operating margins into the red (2018)***



THE CHARTIS GROUP
CHARTIS CENTER FOR RURAL HEALTH

iVantage HEALTH ANALYTICS

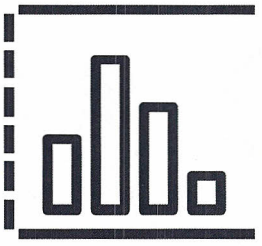
*January 2018, Sheps Center, University of North Carolina, **2016 Rural Relevance Study, iVantage Health Analytics, ***2018. The Chartis Center for Rural Health

NATIONAL RURAL HEALTH ASSOCIATION

Rural Hospital Closures

NATIONAL RURAL HEALTH ASSOCIATION

Impact of Medicare Cuts on Rural Communities
Negative Operating Margins



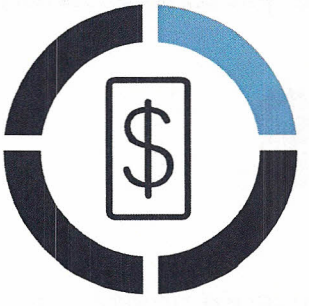
40% 2017 >>> **44%** 2018

The percentage of rural providers operating in the red jumped four percentage points in 12 months.*

Impact of Existing Cuts to Rural Provider Revenue
Sequestration, Bad Debt, PPS Coding Offset, 340B*

$55M
Revenue lost within 1 year

12,000
Jobs lost within 1 year



$1.4B
GDP lost within 1 year

*2018, The Chartis Center for Rural Health.

AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION

AccessDerm

Background

The American Academy of Dermatology is a medical specialty society founded in 1938 that is focused on promoting leadership in dermatology and excellence in patient care through education, research and advocacy. With a membership of 20,000, the AAD is the largest, most influential and representative dermatology group in the United States. .

The AAD's Access Derm program provides physicians treating underserved communities access to the dermatological expertise of AAD member dermatologists and residents in training at no charge to eligible sites. The program facilitates safe and secure provider-to-provider consults with an easy to use teledermatology platform.

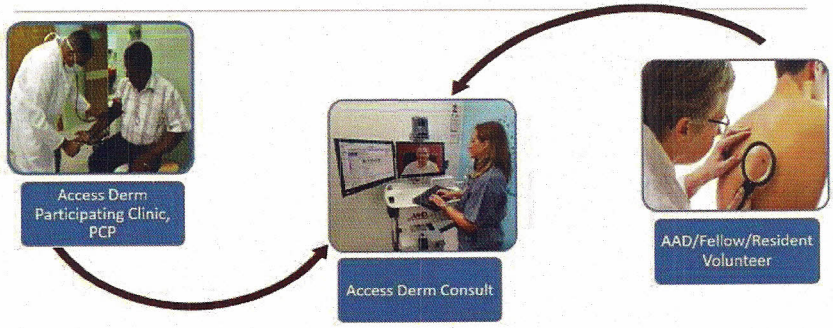
Access Derm/AAD provides:

- Free Board certified dermatologist (or resident working under supervision of a board certified dermatologist) consults
  - Access to free telemedicine platform
- Training for all participating PCP/staff
- Program/registration information and promotion

Benefits for Provider Sites

- Increases the quality of care with immediate access to specialists.
- Speeds up diagnosis and treatment with instant access to data and images.
- Provides physician workload balancing and reporting tools.
- Consultations are sent via a secure Internet connection to consulting specialists for online diagnosis

How it works



Teledermatology services will be coordinated through the patients' primary care provider. The primary care provider will initiate a derm consult via Access Derm by uploading a patient consult request. This request will be transmitted to a dermatologist who will then review the case and provide feedback to the patient's primary care provider. Access Derm offers store-and-forward (Photos, teledermoscopy images, teledermatopathology images) consultations between referring clinicians and dermatologists.

The Academy and its Access Derm program supports the appropriate use of teledermatology as a means of improving access to the expertise of Board certified dermatologists to provide high-quality, high-value care. Teledermatology can also serve to improve patient care coordination and communication between other specialties and dermatology.

For **more information or to participate your clinic in this FREE program contact** Accessderm@aad.org .

NATIONAL RURAL HEALTH ASSOCIATION

Fixing the Funding Cliff for Community Health Centers

Like so many other programs essential to the health of rural America, the funding for Community Health Centers (CHCs) ran out on September 30th, and has not yet been renewed. CHCs are community-based and patient-directed organizations that serve populations with limited access to health care. Most CHCs are based in rural America, where care options are limited. CHCs are a crucial part of core safety net providers in meeting the need for care in underserved populations. There are currently more than 1,400 community health centers across the country that provide care to more than 25 million Americans.

Community Health Centers ensure care for underserved populations that are on average older, sicker, and poorer than urban and suburban areas, but CHCs nationally will lose approximately $3.6 billion a year in federal grant dollars if Congress doesn't work to reauthorize funding.

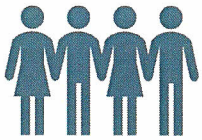
- 90% of rural CHC users are low income patients (less than 200% of the Federal Poverty Level) and two-thirds are uninsured or insured through Medicaid.
- Patients of rural health centers are more likely to be over the age of 65.
- Rural counties with health centers had 25% fewer uninsured Emergency Department visits than rural counties without a CHC.

Community Health Centers are already struggling to face the realities that Congressional inaction have brought to their facilities.

- Jonathan Watson of the Minnesota Association of Community Health Centers explains, "One health center is looking at laying off 45 staff, shutting down their mobile unit and ending the on-site ultrasound for pregnant mothers. Another ... would lay off one-third of their staff. And another health center would be closing six sites. Another would shut down their enrollment."
- In Mississippi, the Mantachie Clinic has had to lay off 4 staff members and decreased hours on Jan. 1. Their executive director Marjorie McKinney the center will run out of federal funds in mid-March without Congressional action.
- Gary Schalla, of Mountain Family Health Centers in rural Colorado says the lack of reauthorization has already resulted in cuts that have caused a nearly 10 percent reduction in the center's staff. When the funding wasn't renewed, Schalla said the center made the decision to eliminate 15 positions, most through attrition but the last few through layoffs, "because of not knowing what was going to happen."

The National Association of Community Health Centers estimates that 9 million patients, more than 2,500 care delivery sites, and 50,000 jobs will be impacted if the funding issue is not resolved soon. We need Congress to act now to ensure that these facilities can continue to provide care.

The Opioid Crisis Tears Through Rural America



As many as 2.5 million people in the US are suffering from opioid addiction. In the last decade this crisis has escalated in rural America: opioid death rates in rural areas have quadrupled among those 18-25 years old.

While only 20% of Americans live in rural areas, rural communities are struggling with greater rates of opioid-abuse: ***the rate of opioid-related overdose deaths in nonmetro counties is 45% higher than in metro counties.***

Rural communities are also seeing increased criminal behavior to support drug habits; higher rates of domestic violence, child neglect, sexual trafficking, and prostitution.

Access to care is a major issue in rural America. 83 rural hospitals have closed since 2010, leaving millions of rural Americans without timely local access to care. ***Access to care is particularly lacking for mental health and substance abuse.*** *In 55% of all American counties, most of which are rural, there are no psychologists, psychiatrists or social workers.*

A recent University of Michigan study found rates of babies born with opioid withdrawal symptoms rising much faster in rural areas, and according to the CDC, teen use of opioids is higher in rural communities.

SOLUTIONS

Protect Medicaid as a funding source to provide treatment.

Expand access to substance abuse treatment services including medication assisted treatment and traditional substance abuse treatment.

Develop evidence-based prevention programs tailored to the needs of rural communities.

Increase the implementation of harm reduction strategies.

Promote use of evidence-based prescribing guidelines and strengthen prescription drug-monitoring programs.

Expand use of substance abuse treatment as an alternative to incarceration.

Legislation:

S. 2125, the Targeted Opioid Formula Act

H.R. 3566, the Addiction Recovery for Rural Communities Act

H.R. 4501, the Combatting the Opioid Epidemic Act

NRHA POLICY INSTITUTE

NATIONAL RURAL HEALTH ASSOCIATION

We need to **make rural America work again,** and that starts **with making rural Americans healthy.**

200,000 annual job loss in rural communities

19% of rural Americans are living in poverty

749 rural counties experience increasing unemployment

In most rural communities, **the hospital is the first or second largest employer, but only if the community still has a hospital.**

83 rural hospitals have closed since 2010 and **674** are vulnerable to closure

44% of rural hospitals operate at a loss and **30%** operate below a **-3%** margin

$318 million in cuts have been absorbed by rural hospitals under sequestration resulting in a loss of **7,129** health care and community jobs and **$769 million** in GDP

And if all **674** vulnerable hospitals close, we will lose **99,000** direct health care jobs, **137,000** community jobs, and **$277** billion in GDP. Per-Capita annual income in rural communities will decrease by **$703**, while rural employment would increase by **1.6** percentage points.

Small infrastructure investments. Big rural health gains.

We need 3 things to rebuild our health care infrastructure:

1. Save Rural Providers

- Pass legislation to keep rural hospitals open, maintain jobs, and ensure access to care.

2. Cut Red Tape

- Reform existing programs that don't bring funding to the communities that need it most.

3. Build Infrastructure

- Improve telehealth and transportation services to increase availability and delivery of care.

NRHA
NATIONAL RURAL HEALTH ASSOCIATION

Rebuild Rural: Infrastructure Development and Health Care

1. Save Rural Providers

- Hospitals are often one of the largest employers in rural areas, thus these institutions are essential to the economic vitality of a rural community.
- If residents are traveling out of the community for healthcare services, we need to provide those services locally to prevent money from leaving the community.
- Access to healthcare is necessary to attract and retain businesses in a rural community. Employers do not want to locate in a community without an emergency room to care for an employee injured on the job, a place to deliver a baby, or a doctor for basic preventive care.

2. Cut Red Tape

- Many of the programs offered by USDA Rural Development and other agencies are underutilized or grants are not awarded to those in the greatest need or for whom the grant would provide the greatest benefit. Changes are necessary to help these agencies more aggressively promote and market assistance programs offered to rural communities to ensure these resources are going where they are needed.
- Applicants for grant and loan applications often complain that the process is inefficient and not business friendly. Hiring expensive consultants should not be necessary to obtain these needed resources. We need to examine changes that can be made to ensure that applications are easy to complete and easy to access, and we must work improve the process in order to have applications considered more efficiently.

3. Build Infrastructure

- Telehealth
  - Telehealth is an important tool in providing access to care in rural America. In 2013, over 40,000 rural beneficiaries received at least one telemedicine visit. Patients report high levels of satisfaction in receiving care via telemedicine. In one CMMI demo 96 percent of patients would recommend telemedicine care to family and friends. Still, telemedicine is only used in 0.2 percent of Medicare Part B visits. We need policies that foster growth.
  - In almost every state, over 90% of the rural population has access to high-speed internet access. However, urban areas are twice as likely as rural areas to have access to copper and cable modem wireline technologies.
  - Provide access to capital through grants and loans for rural facilities to adopt new technology to meet the ever-changing requirements of health care, including all stages of meaningful use. In addition, provide educational programs to train rural IT professionals in health care, as well as doctors, nurses, and medical staff how to use technology, including utilization of data and analytic tools to demonstrate and improve quality.
- Transportation
  - Rural public transit is either non-existent or very limited and more than 90 percent requires a reservation, limiting options for people who need to make unscheduled visits to health care providers, grocery stores or other activities of daily living.
  - Identify strategies to assist individuals to ensure that they can access local and distant care.
- EMS Services
  - In the wake of the rural hospital closure crisis, Emergency Medical Services (EMS) often become the only guaranteed access to health services. Dwindling population, losses in the volunteer workforce, and decreased reimbursement threaten access to EMS. Nearly one-third of rural EMS are in immediate operational jeopardy.
  - Research grant programs are needed to fund the study of best practices and innovations from local EMS agencies across the U.S. In turn, grants can be offered to states authorities, as well as local EMS officials that adopt innovations and best practices found through this research to encourage broader application of best practices.

NATIONAL RURAL HEALTH ASSOCIATION

2018 Rural Health Policy Institute Requests

Rebuild Rural Infrastructure

Health care infrastructure is more than just buildings and roads: it is the nurses, doctors, and other providers that care for patients; it's telehealth services that localize specialty care; and it is community resources that provide jobs and opportunities. Our rural communities are still grappling with the economic consequences of the Great Recession. Rural America has only see 5% of jobs that were lost returned since the end of the Recession. As a result, **749 non-metro counties are still experiencing increasing unemployment.** As Congress begins to construct their infrastructure package, it is critical that we build small rural health investments into this legislation.

Hospitals are often the first or second largest employer in the community… if the hospital can keep its doors open. Since 2010, 83 rural hospitals have closed. 674 additional facilities are vulnerable and could close—this represents over 1/3 of rural hospitals in the U.S. The rate of closures is steadily increasing, and on this trajectory, 25% of all rural hospitals will close in less than 10 years if Congress fails to act. If Congress allows 674 rural hospitals to shut their doors, 11.7 million patients nationwide will lose access to their nearest hospital and its emergency room, **236,000 rural jobs will vanish,** and $277 billion in GDP will be lost over 10 years. Rural communities across the nation will erode – because when a rural hospital closes, the economy of a rural community collapses. The **Save Rural Hospitals Act will stop the flood of rural hospital closures** and provide an innovative, sustainable delivery model for the future of rural health care.

NRHA has developed a three-pronged approach to make rural Americans healthy and bring back jobs: **include provisions to keep rural hospitals open and co-sponsor the Save Rural Hospitals Act, maintain jobs, and ensure access to care; cut red tape by reforming existing programs to bring grants and funding to the communities that need them most; and improve telehealth and transportation services to increase availability and delivery of care.**

Keep Critical Rural Payment Commitments

Several important rural Medicare Extenders expired on October 1, 2017 without any Congressional intervention. Medicare Extenders include Medicare Dependent Hospitals, Low-Volume Hospital adjustments, rural ambulance payments, Medicare Therapy Caps, and the geographic index floor under the Medicare physician fee schedule. While we have encouraged Congress to reauthorize these programs, the House Ways and Means Committee's proposed legislation includes a pay-for that would adjust Critical Access Hospital (CAH) swing-bed reimbursement rates. The swing bed program is essential to hospitals located in underserved areas with high Medicare utilization and are crucial for the continuity of care for seniors and high medical need residents. The Senate Finance Committee's released legislation included a change to Low Volume Hospital (LVH) adjustments, one that would devastate LVH hospitals and force them to close their doors. **These extenders need to be renewed, but we cannot fund some rural hospitals at the expense of other rural hospitals.**

Congress also let funding for Community Health Centers (CHCs) expire on October 1, 2017. CHCs are community-based and patient-directed organizations that serve populations with limited access to health care. **Most CHCs are based in rural America, and they are a crucial part of core safety net providers meeting the need for care in underserved populations.** We need Rural Medicare Extenders and CHCs reauthorized in a long-term package that ensures their future.

Support Appropriations for Rural America

The federal investment in rural health programs is a small portion of federal health care spending, but it is critical to rural Americans. These safety net programs increase access to health care providers, improve health outcomes for rural Americans, and increase the quality and efficiency of health care delivery in rural America. NRHA supports strong funding for the rural health care safety net and encourages Congress to continue funding these important programs in FY 2018 and beyond.

Join Senate Rural Health Caucus or House Rural Health Coalition

Join your colleagues in the Senate and House of Representatives 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 115th Congress by joining these important groups!

Chair of the Senate Rural Health Caucus:
Sen. Pat Roberts (R-KS), Emily Mueller, emily_mueller@roberts.senate.gov
Sen. Heidi Heitkamp (D-ND), Megan DesCamps, megan_descamps@heitkamp.senate.gov

Co-Chairs of the House Rural Health Care Coalition:
Rep. Cathy McMorris Rogers (R-WA), Megan Perez, megan.perez@mail.house.gov
Rep. Ron Kind (D-WI), Alex Eveland, alex.eveland@mail.house.gov

Rural Health Research RECAP

Rural Health Research Gateway

November 2017

Rural Behavioral Health

Funded by the Federal Office of Rural Health Policy (FORHP), the Rural Health Research Gateway strives to disseminate the work of the FORHP-funded Rural Health Research Centers (RHRCs) with diverse audiences. The RHRCs are committed to providing timely, quality national research on the most pressing rural health issues. This resource provides a summary of their most recent research on behavioral health, all of which may be found on Gateway's website at ruralhealthresearch.org.

Prevalence

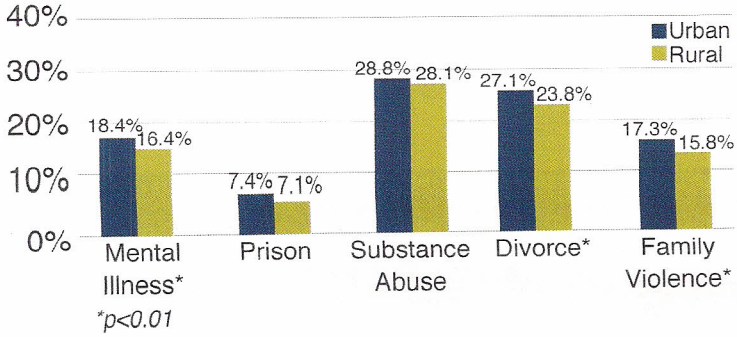
Any mental illness (AMI) is any diagnosable mental, behavioral, or emotional illness other than substance use.[1] During 2015, roughly 43.4 million adults in the U.S. had some kind of mental illness.[2] During 2010-2011, nonmetropolitan counties reported a higher percentage of residents with AMI (19.5%) than metropolitan counties (17.8%).[3] The highest rate of AMI (22.5%) occurred among rural residents in the western U.S. region.[3]

Nationally, 4% reported a serious mental illness, though rates rose with increasing rurality. Rural micropolitan residents in the western U.S. region reported the highest percentage of serious mental illness (6.8%). The lowest rate occurred in large central counties in the southern region of the U.S. (2.7%).[3]

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are occurrences in family relationships that prevent children from finding the support and safety they need for healthy growth. The more ACEs, the higher the risk for behavioral and physical health problems in adulthood.[4] More than half (56.5%) of rural residents had been exposed to some form of ACE during 2011-2013.[4] See Figure 1.

Figure 1. Prevalence of ACE Types in Rural and Urban Adults: Household Dysfunction[4]



Access to Behavioral Healthcare

As of October 2015, rural communities reported a smaller proportion of behavioral healthcare providers than urban areas, including fewer psychiatrists, clinical psychologists, psychiatric nurse practitioners, social workers, and counselors.[5] See Table 1 and Figure 2.

Table 1. Behavioral Health Providers per 100,000 Population in U.S. Counties[5]

	Metropolitan	Micropolitan	Non-Core
Counselors	118.10	100.20	67.10
Social Workers	66.40	45.00	29.90
Psychologists	33.20	16.80	9.10
Psychiatrists	17.50	7.50	3.40
Psychiatric Nurse Practitioners	2.20	2.10	0.90

Figure 2. Percent of U.S. Counties Without Behavioral Health Providers[5]