Nevada Rural Hospital Partners (NRHP) represents 13 of Nevada's 14 rural hospitals. Elko is not in our membership and Nye Regional Hospital in Tonopah closed late this summer. Our members provide the only care in their respective communities. In half our membership, the only physicians serving the community are those employed by the local hospital. In urban areas, Nevada has 182 physicians per 100,000 population and in rural areas there are only 65 physicians per 100,000 population. Rural hospitals provide care for 10% of the state's population covering 90% of the land mass.

In general, rural counties possess older populations versus urban counties. Five rural counties in Nevada have more people aged 65 and over than people aged 17 and under. Currently there are on average: 25.8 people per square mile in Nevada; 383 people per square mile in Carson City; 0.3 people per square mile in Esmerelda; and 5 people per square mile in Lander, Pershing, Mineral, and Lincoln counties. This makes these community hospitals eligible for a federal demonstration project to prove the hypothesis that keeping patients in local communities utilizing cost based reimbursed programs (CAH and RHC) utilizing telemedicine is less expensive than transferring these patients to urban centers.

The total number of hospital employees in rural Nevada of approximately 1900 Full Time Employees (FTEs) equates to a total payroll of $120 million, ranking them in the top three employers in their respective communities. 11 of our 13 hospitals are Critical Access Hospitals (CAH). The other two are currently in the process of converting to CAH status. Our members range in size from four acute beds (two hospitals) to the CAH max of 25 with an average daily census(ADC) ranging from less than one per day to 16 per day. Seven are tax supported District hospitals; these are among the smallest, oldest, and most remote facilities. Two hospitals are for-profit and four are private non-profit. Seven hospitals have distinct part Long Term Care (LTC) units already and one is looking to add the unit. Eight hospitals operate Rural Health Clinics (RHC) and eleven have swing beds.

Emergency Room visits total 73,000 ranging from 312 per year at Incline Village Community Hospital to 15,000 at Banner Churchill Community Hospital. Five hospitals are served by volunteer Emergency Medical Services (EMS) without paramedics.

Even with the beneficial cost based reimbursement recognized by CAHs and RHCs in 2013, seven facilities had net operating losses. Adding in the non-operating revenues of taxes, and net proceeds of mining, there were still two facilities with negative bottom lines. Nationally 41% of CAHs operate at a financial loss.

Nevada's rural hospitals provide access to health care including emergency care and long term care not otherwise available in their local frontier communities. When a hospital closes in a town like Tonopah, families, friends, and neighbors are forced to seek care outside their community; in this instance, traveling over 100 miles in emergencies. Patients, the community and local economy all suffer.

Who better to meet the population health needs of rural Nevada than these local providers? All Nevada CAHs and their RHCs are listed on the Center for Medicare Services (CMS) website as Essential Community Providers (ECP). 45 CFR 156.235 gives a definition of Essential Community Providers as 'safety net' clinics that "serve predominately low-income, medically underserved" populations. Recognizing the important role that the rural providers play in promoting continuity of care as people transition from uninsured to insured is vital. The Federal Government left discretion to the State regarding the roles of ECPs and reimbursement. We urge Nevada to recognize these important

providers as well and will work with legislators, Division of Insurance, payers, and Medicaid to assure the viability of rural providers. With that said, the issues and priorities we hope the Interim Health Committee will consider addressing are as follows:

- A review of swing bed Medicaid reimbursement which would allow more in- community care for rural residents when the distinct part Long Term Care is at capacity but swing beds are available.
- Review Medicaid outpatient reimbursement for Critical Access Hospitals.
- Review Nevada Health Insurance Portability and Accountability Act (HIPPA) regulations which have been interpreted more stringently than federal regulations with regard to behavioral health patients often disallowing sharing of information between behavioral health providers and our rural emergency room staff.
- Review funding for Northern Nevada Adult Mental Health Services and Southern Nevada Adult Mental Health Services to increase access for all patients requiring transfer to these facilities.
- Rural communities rely heavily on mid-level providers. We are happy to hear of the University of Nevada School of Medicine (UNSOM) Physician Assistant (PA) program. Although APRNs are allowed independent practice in Nevada, insurance companies using out of state agencies to adjudicate claims and require collaborating physicians or insureds to pay higher copays. Can the state help?
- We are anxious to have reimbursement for Community Health Workers and Community Paramedicine services resolved and we appreciate being allowed to work with Medicaid and DHHS on this.
- Our members continue to experience long waits for professional licensure with the exception of nursing. As a member of the Governor's Workforce Investment Board- Health Care Sector Council, I've heard this delay cited as a statewide concern since last session. I have asked our members for specific examples and will provide them to you, as there are still long delays for licensure being cited.

On a positive note worth mentioning, the Welfare Division has been very assistive to rural members dealing with eligibility issues for LTC residents. The Department of Health and Human Services and the Department of Health Care Financing and Policy are listening to our concerns regarding Medicaid Managed Care as it can be very complicated in the rural arena due to our cost-based reimbursement.

Thank you for your time and I would be happy to answer any questions the committee may have.