National Rural Health Association Position Paper

Rural PPS Hospital Relief

Despite their critical importance, rural hospitals shuttered at an alarming rate over the last decade.[i] There are 138 rural hospitals that ceased operations since 2010,[ii] with an additional 453 rural hospitals vulnerable to closure[iii]. These conditions that presage closure are more than financial, directly impact hospitals' communities.

Policy Solutions

Address inequities in rural Medicare reimbursement for services provided by rural PPS hospitals.

- Create policies to overcome structural urbanism by setting reimbursement rates based on the cost to rural healthcare organizations of providing care in rural settings.
- Improve reimbursement models in the fee-for-service environment to accommodate rural, low-volume facilities that promote high value for patients.
- Encourage and promote investments in infrastructure, the expansion of existing services, and the adoption of new programs in rural areas.
- Provide funding to support education of rural hospital leaders and governing boards.

Specific rural hospital payment changes include:

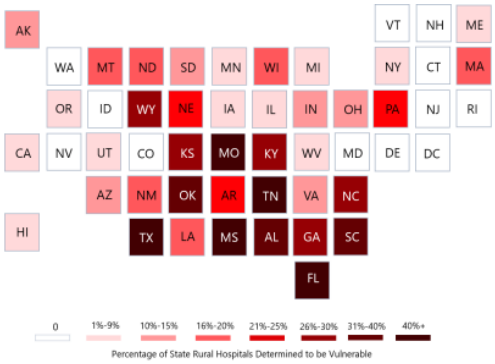
- Enhance the Medicare reimbursement safety net by ending sequestration and increasing reimbursements to offset uncollectable patient debt.
- Make permanent legislation that will support rural hospitals, such as Medicare Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs), and Low-Volume Hospitals (LVHs) programs. Allow MDHs and SCHs to rebase their payments. Reinstate OPPS hold-harmless payments.
- Support rural hospitals as they transition to value-based care by promoting alternative payment models for population health initiatives such as addressing social determinants of health, behavioral health, and chronic care management.
- Continue to evaluate and address wage index disparities among rural hospitals.

Recommended Action

- Support H.R. 6400 Save America's Rural Hospitals Act to provide enhanced payments to rural health care providers under the Medicare and Medicaid programs.
- Support S. 999/H.R. 4066 the Save Rural Hospitals Act to establish an area wage adjustment floor for Medicare hospital payments.
- Support H.R. 1887 Rural Hospital Support Act to modify and extend certain payment adjustments for rural hospitals under Medicare's inpatient prospective payment system.
- Support S. 3105 Hospital Revitalization Act to establish a hospital revitalization program to assist rural facilities.
- Support section 40003 of H.R. 1848 LIFT America Act, which appropriates $10 billion to improve hospital infrastructure. NRHA requests that such funding be accompanied by a 20 percent rural carve-out.
- Support H.R. 1639/S. 644 Rural Hospital Closure Relief Act of 2021 to allow additional hospitals to qualify as critical access hospitals (CAHs) that receive special payment under Medicare.
- Support full funding of programs such as National Health Service Corps Loan Repayment Program to ensure stability in the health care workforce.

Overview

There are more than 2,100 rural hospitals nationwide that provide the majority, or all, of health care to the nearly 20 percent of Americans living in rural or frontier areas. These facilities are the sole access point for primary care, maternity care, rehabilitation, long term care and more. Hospitals may eliminate entire service lines in attempts to remain solvent, depriving their residents of needed care.[i] Between 2013 and 2018, approximately 24 rural hospitals per year closed obstetrics services and 70 to 100 per year ended chemotherapy services. Rural residents who require these lost



services face an additional 30 to 60 minutes of driving to access the care, which can be onerous for those without access transportation or living with a disability, and can lead to delayed or missed care.[iii]

Causes of Rural Hospital Closures

The reasons rural hospitals close are multi-faceted and complex; the downward trajectory is often a result of a convergence of multiple pressure points, including challenging payor and patient mixes, demographic trends, healthcare policies, workforce issues, and emerging healthcare issues.[iii]

Challenging Payor and Patient Mixes- Rural hospitals serve a higher percentage of uninsured patients and patients covered by Medicare or Medicaid programs. In 2017, 56% percent of rural hospitals' revenue were comprised of payments from public insurance, yet these hospitals received 87 cents per dollar spent on treating these patients.[i] These challenges are more pronounced in states that have not expanded Medicaid; Tennessee (52%), Texas (51%), Florida (43%), Missouri (43%), and Mississippi (42%) have the highest rates of risk of closure. [iii] In addition to lower coverage rates, residents in areas of high-risk closure areas tend to be older and sicker. They also have worse behavioral and socioeconomic predictors of health outcomes than their counterparts in non-risk areas. These counties have lower rates of high school graduation, and higher rates of obesity, tobacco use, and those in fair or poor health.[iv] The subsequent need for more intensive treatments and decreased likelihood of sufficient reimbursement contribute to insolvency of rural hospitals.

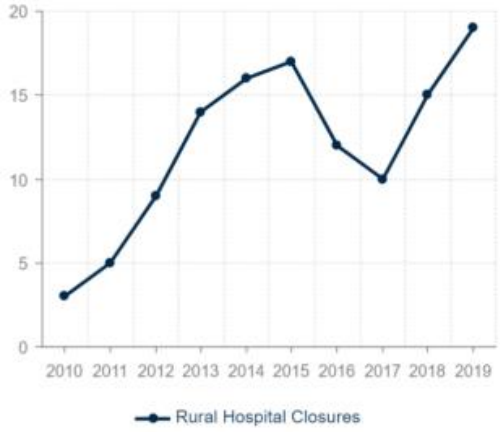


***Figure 1:** With 19 closures, 2019 was the single worst year of the rural hospital closure crisis.*

Demographic Factors- Rural areas have low population density. As a result, hospitals serving these communities may not have a high enough volume of services to generate a positive operating margin. The low volume of services, combined with insufficient reimbursements creates barriers to financing overhead costs and facility maintenance and improvement.[vi] Furthermore, low volumes can prevent these hospitals from participating in performance measures and quality improvement programs due to lack of statistical power.[i]

Healthcare Policies- Rural-specific designations for hospitals have been created to provide supplemental payments to rural hospitals, including Critical Access Hospitals (CAHs), SCHs, MDHs, and LVHs. While they all provide reimbursement for services in excess of the standard Prospective Payment System rates, they can and have been modified upon implementation to reduce the impact of the designations by those who rely on them.[vii] For example, Medicare payments were reduced by 2% in 2013 as a component of Medicare sequestration. Further MDH and LVH designations are temporary, needing to be reapproved periodically, leading to difficulties for these small rural hospitals future planning.[vii,viii]

Workforce Issues-Recruitment and retention of healthcare staff has been a persistent issue for rural hospitals. Nationwide, 20% of Americans live in rural areas, yet only 10% of physicians practice within these communities.[v] Of the 6,941 Health Professional Shortage Areas (HPSAs) across the country 67% were in rural areas, as of 2018.[i] Reductions in available physicians were found to directly correlate to the likelihood of hospital closures.[v] Advanced practice clinicians such as Physician's Assistants and Nurse Practitioners can address these shortages, but licensure laws and supervision requirements can limit the services they can provide.[v,i] Non-clinical and support staffing has also been an issue. More than 60% of hospitals indicated they had trouble identifying qualified individuals for such roles, reflecting a broader difficulty in rural workforce recruitment.[i]

Emerging Healthcare Issues- Rural hospitals are particularly susceptible to extended pandemics. Beyond the extended and expensive care required for COVID-19 patients, nonemergency services were halted to prevent transmission. The reduction in outpatient services caused significant losses in revenue. Chartis estimates that 77% of revenue from these facilities stem from outpatient services, and stoppage caused losses of up to $5 million in revenue per month for most hospitals. Chartis found that nationally, rural hospitals have a median of 33 days cash on hand, and in 13 states have between zero and nineteen days cash on hand.[iii]

[i]American Hospital Association, *Rural Report; Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care*, February 2019

[ii]The Scheps Center for Health Services Research, "Rural Hospital Closures," https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/, Accessed 1/10/22

[iii]The Chartis Group, *Crises Collide | The COVID-19 Pandemic and the Stability of the Rural Health Safety Net, https://www.chartis.com/resources/files/Crises-Collide-Rural-Health-Safety-Net-Report-Feb-2021.pdf*, February 2021

[iv]The Scheps Center for Health Services Research, "Findings Brief; Characteristics of Communities Served by Rural Hospitals Predicted to be at High Risk of Financial Distress in 2019" https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2019/04/FDI-Community.pdf, April 2019

[v] United States Government Accountability Office, *RURAL HOSPITAL CLOSURES Affected Residents Had Reduced Access to Health Care Services*, https://www.gao.gov/assets/gao-21-93.pdf, December 2020

[vi]National Rural Health Association, "Rural hospitals: The beating heart of a local economy," https://www.ruralhealth.us/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ, June 2018

[vii]National Rural Health Association, "NRHA Policy Paper: "Tweener" Hospital Crisis," https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/2020-NRHA-Policy-Document-Tweener-Hosptials-Crisis-FINAL.pdf, 2020

[viii]Rural Health Information Hub, "Critical Access Hospitals," https://www.ruralhealthinfo.org/topics/critical-access-hospitals, Accessed 1/10/2022