Healthcare in Rural America: An Uncertain Future

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The intersection of demographic changes in U.S. population with reductions in healthcare reimbursement is in danger of causing a crisis in rural healthcare. In 2010, the U.S. Census Bureau reported that 59 million people lived in rural areas (19.3% of the population) with 249 million people in urban areas (80.7% of the population).\(^1\) By 2014, the population of the non-metropolitan counties stood at 46.2 million (15% of the population), showing a steady four-year decline. Approximately two-thirds of the counties the Census Bureau considers to be rural lost population in 2013-2014.\(^2\) Rural counties represent approximately 72% of the nation’s land area.

The median age of the rural population is three years older than the nation as a whole. 13% of the nation’s population is over 65, while 16% of the population of rural and small towns is over 65. More than one-quarter of the senior population lives in rural areas and small towns.\(^3\) This population becomes increasingly dependent on the availability of basic healthcare at a convenient location as a safety net for their healthcare needs.

The National Rural Health Association and the North Carolina Rural Health Research Program both collect, track and map data on rural hospital closures since 2010. A total of 59 rural hospitals have closed in 24 states since 2010. In states that have expanded Medicaid, 8.5% of rural hospitals are vulnerable to closure and that number doubles in non-expansion states.\(^4\) The number of rural hospital closings has escalated each year, with 283 rural hospitals considered vulnerable.\(^5\)

In 2014, iVantage Health Analytics worked in conjunction with the National Rural Health Association and reviewed more than 60 performance data characteristics, including costs, charges, quality, outcomes, financial strength, and market share. The results specifically identified 283 rural hospitals at high risk of closure, while also identifying 235 with a high likelihood of success. The following graph tracks those “at risk” facilities:

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1 U.S. Bureau of Census. 2010 figures.
5 Vulnerability Index.
In its report “Vulnerability to Value, Rural Health Performance 2015” iVantage Health Analytics reviewed the impact of the possible closure of 283 rural hospitals nationally in the coming years. These closures would result in 700,000 missed patient encounters, 36,000 lost healthcare positions, 50,000 total positions, and a loss of over $10 billion to the Gross Domestic Product.  

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6 Hospital Strength index, Vulnerability to Value, Rural Health Performance 2015. iVantage Health Analytics.
7 Id.
8 Id.
Rural facilities are often the largest employer in a community and often the employer that offers higher pay-scale, skilled positions. Hospitals can represent as much as 20% of the local salaries and wages, and closure can result in loss of as many as 200 jobs and millions of dollars in annual payroll in a single community.

Rural facilities are faced with multifaceted problems. As one NRHA lobbyist was quoted, “it is death by a thousand cuts.” First, geography delineates most rural facilities as low-volume providers. They have the high fixed costs of an acute care hospital, but the low volume of a rural community environment. Rural hospitals are often required to focus on money-losing medical services which are offered by hospitals, as opposed to the revenue-generating specialty services offered at urban medical centers. Often, the rural population has a payor mix heavily weighted in Medicaid and Medicare. Declining reimbursement under both of those programs has hit rural hospitals hard. The ACA was intended to help, but the failure of over 20 states to expand Medicaid has been particularly hard on rural facilities.

The budget cuts imposed by sequestration under the Budget Control Act of 2011 included a 2% reduction in Medicare beginning January 2013. The 2% Medicare sequestration is estimated to eliminate 1.3 billion dollars in revenue to Critical Access Hospitals nationwide over the next 10 years. These cuts often reduce rural hospitals to a negative operating margin. The Obama Administration has proposed a reduction in the CAH program for several years, and this year’s proposed budget included the elimination of the 1% payment over costs received by CAHs. While eliminating the payment would result in a cost savings of 2.5 billion, it would also result in closing of CAHs and loss of critical healthcare infrastructure in remote areas.

Communities with no hospital will find physician recruitment difficult or impossible. The physician recruiting firm, Merritt Hawkins, reported in July 2015 that only 5% of its search assignments were for independent practice settings, while the remaining 95% were for hospitals, medical groups or urgent care settings. Physician supply in rural communities lags behind its urban counterparts. Approximately 11% of the nation’s physicians work in rural locations and often lack the support of hospitals and other ancillary health facilities. Recruiting and retaining physicians in rural practice locations is challenging and expensive for communities. As a result, primary care availability is a challenge in rural America. While the increased reimbursement available to both Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) helps, it does not solve the problem entirely. Many younger physicians simply prefer to live and raise their families in an urban environment with its associated cultural and social benefits. In fact, there are fewer physicians per capita in rural areas on average, and physicians in rural areas

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tend to be an aging workforce, with a higher percentage of those physicians being over the age of 55.\textsuperscript{10}

Some states are attempting to address the physician shortage issue in rural communities by redefining the scope of practice for allied health professionals or non-physician practitioners, including physician assistants and nurse practitioners. In 2012, there were over 800 bills introduced in state legislatures to redefine scope of practice.\textsuperscript{11} In that same year, 41% of Medicare beneficiaries saw an allied health professional for their primary care, with 17% receiving all of their primary care from a nurse practitioner or physician assistant and 24% receiving some portion of care from these practitioners.\textsuperscript{12}

The future is likely to reveal a shifting landscape for scope of practice. Currently, in all 50 states physician assistants can prescribe and in 40 states they have varying authority.\textsuperscript{13} Nurse practitioners can diagnose, treat and prescribe in 15 states with direct or indirect supervision, all of which can be vital to providing care in rural areas.\textsuperscript{14}

Rural hospitals have traditionally relied on a mixed bag of reimbursement choices to keep the doors open. The most successful rural hospitals have been those that take advantage of every available reimbursement opportunity. Oddly, success in a rural hospital is about minimizing losses on operations and producing gains through multiple reimbursement options. Unfortunately, when those reimbursement options are curtailed, the hospital’s future is jeopardized.

One option is the Critical Access Hospital (CAH) designation. This was created in the 1997 Balanced Budget Act and provides cost-based reimbursement to facilities that meet the designation. A CAH designation requires that a facility:

- have fewer than 25 acute care beds;
- be located more than 35 miles from another hospital (with some exceptions);
- have an average length of stay of 96 hours or less for acute care patients; and

\textsuperscript{10} MedPAC Report to the Congress, June 2012, p. 129.
\textsuperscript{13} American Nurses Association, Medicaid Coverage of Advanced Practice Nursing (Silver Spring, MD: ANA, n.d.), \url{http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/IssuesResources/APRN/MedicaidReimbursement%20.html}.
\textsuperscript{14} National Association of Boards of Pharmacy, Survey of Pharmacy Law, 2012 (Mount Prospect, Ill.: National Association of Boards of Pharmacy, 2012).
• provide 24/7 ER care.

There were 1321 CAHs in 2014, and that number rose to 1333 in 2015, which is most likely the result of some hospitals reducing in size in an effort to switch their payment designation from a prospective payment system (PPS) to Critical Access.\textsuperscript{15} The switch to CAH status is the most recent survival strategy for rural facilities.

A second option is Sole Community Hospital (SCH) status. SCH status is available to PPS hospitals if they are located at least 35 miles from other like hospitals and meet certain criteria that qualify the facility as rural. Medicare makes payments to SCHs based on a formula designed to yield a higher payment to the facility. As of 2009, there were over 400 SCHs. SCHs may also qualify for special low-volume adjustments, which also increase payments.\textsuperscript{16} 529 SCHs qualified for the low-volume adjustment in 2011.

Hospitals not classified as an SCH can be classified as a Medicare Dependent Hospital (MDH). These must be rural, have 100 or fewer beds, not be an SCH, and have at least 60% of their inpatient days or discharges attributable to Medicare Part A for a specific cost report period. MDHs receive enhanced payments for inpatient operating costs.

Both MDHs and low-volume adjustments are set to expire in 2017, and bills are currently in Congress to extend these programs.

A final option, depending upon state law, is local tax support. Many jurisdictions allow the creation of local taxing entities to subsidize healthcare. These local entities can and do provide much needed subsidies to make up for declining reimbursement and low volume or both.

Another important reimbursement benefit for rural providers has been the outpatient hold harmless provision. This provision allowed certain rural facilities with 100 or fewer beds to receive a payment adjustment or a “hold harmless” payment to help ease the transition from the prior cost-based system to an outpatient PPS system. The hold harmless provision expired December 31, 2012, which has had a serious financial impact on hospitals that previously received this benefit. Numerous attempts have been made to renew the hold harmless provision without success.

\textsuperscript{15} Id.
\textsuperscript{16} Rural Health Information Hub at \url{https://www.ruralhealthinfo.org/}
There are proposed legislative solutions. The Rural Emergency Care Hospital Act proposed in 2015 by Senator Grassley (R) of Iowa and Senator Gardner (R) of Colorado would allow hospitals of less than 50 beds to be designated as Rural Emergency Hospitals, and the hospital would maintain an ER, ambulance services and some hospital services, but no acute inpatient care. They may provide skilled nursing care. Medicare would pay 110% of the ER and ambulance services. These facilities would be out of the acute inpatient care business. While this bill is not proceeding, it is at least a discussion starter.

Another solution is in the form of the Save Rural Hospitals Act introduced by Representative Graves (R) of Missouri. This bill would eliminate the Medicare sequestration cuts, and reverse cuts to reimbursement of bad debt for Critical Access Hospitals. The bill also calls for elimination of the 96-hour physician certification requirement for inpatient Critical Access Hospital services. This bill would significantly improve the prospects of many CAHs, both improving their bottom line and expanding clinical care opportunities. This bill is also not progressing, but will hopefully, like the Grassley bill, serve to start a discussion on rural hospital issues and how to best deliver healthcare in rural communities in the future.

While there is no easy solution to the rural hospital issues, there are several undeniable results. The loss of rural infrastructure and the short- and long-term economic effects on rural communities are clear. Many rural communities will be unable to maintain their current facilities. The data continues to tell the story, and some mechanism of alternative delivery of health care must be found to continue to provide services where an acute care hospital is no longer viable.

It is readily apparent that neither state nor national healthcare policy will protect every rural hospital in the future. In fact, it is more likely that a combination of both state and federal policies will continue to place rural hospitals in financial peril and ultimately result in more closures. The future will require creative means to deliver healthcare in rural communities with expanded use of telemedicine, better incentives to locate physicians in rural practice, changes in scope of practice, and the increased use of facilities for urgent care and emergency care. All of these will require new legislation to change payment models to address the changing delivery systems.

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