

Tackling Rural Hospital Closures



BY SAMANTHA SCOTTI

Because of their geographic isolation and other factors, residents in rural communities often face challenges accessing health care services. Providers are increasingly scarce, and many hospitals in rural areas are struggling to keep their doors open. Rural hospitals tend to have low patient volume, a [high portion of patients on Medicare and Medicaid](#), and a [high number of uninsured patients](#), leading to significant financial challenges.

More than 75 rural hospitals have closed since

2010, [according to the Sheps Center](#) at the University of North Carolina. When a rural hospital closes, it not only threatens residents' health, it hurts the local economy. These challenges have driven policymakers to explore various strategies to keep these hospitals open.

State Action

States are exploring innovative solutions—including payment reform, telehealth and coordinating care delivery—to make sure their rural residents receive critical health services.

Did You Know?

- [Over 50 percent](#) of primary care health professional shortage areas (HPSAs) were in rural areas in November 2016, according to the Health Resources and Services Administration.
- Rural areas face a [higher uninsured rate](#) than metropolitan areas.
- Rural hospitals tend to have low patient volume, a [high portion of patients on Medicare and Medicaid](#), and a [high number of uninsured patients](#).

PAYMENT REFORM

Low or declining patient admissions affect the financial well-being of rural hospitals. Under the fee-for-service model, each health care service is paid for separately, so hospitals experience declining payments as patient admissions decrease. Some states have explored shifting away from fee-for-service models (paying for the volume of services provided) toward value-based payments, in which the quality of care is rewarded.

Pennsylvania and the Centers for Medicare & Medicaid Services (CMS), for example, [recently adopted a global budget pilot](#) for rural hospitals in the state. In this model, the hospital receives a fixed amount for all inpatient and outpatient services (for a fixed amount of time; e.g., a year), which is set in advance (based on previous budgets). It is funded by participating payers like Medicaid, Medicare and private insurers. While providing a predictable funding source, this model also aims to control rising health care spending, improve care coordination, invest in quality and preventive care, and increase the financial viability of rural hospitals. Pennsylvania began this initiative in January 2017 with a \$25 million grant from CMS.

TELEHEALTH INNOVATIONS

Hospitals located away from population centers struggle with recruiting and retaining an adequate health care workforce. Rural hospitals across the country have turned toward telehealth—using a variety of technologies to deliver health care and other health services—to increase access to physicians and other providers. Telehealth can provide connections between rural hospitals and specialists located in other areas, offering patients high-quality, high-level care in their own communities without travel and associated costs. Connecting with specialists in areas like behavioral health and cardiology, instead of employing these providers full time, can help save rural hospitals money. Telehealth can also offer access to emergency and critical care for conditions such as strokes, when quick action is critical, by remotely diagnosing and evaluating patients. Remote diagnostic services, such as reading X-rays, can also be facilitated through telehealth.

Rural hospitals also leverage telehealth for consultations between providers. Programs like [Project ECHO](#) (Extension for Community Health Outcomes), which operates in at least 22 states, help retain rural providers and build their capacity by connecting them remotely with specialty care teams. Some state legislatures, such as the Missouri General Assembly, have appropriated funds to sup-

port their ECHO program. State policymakers also are examining policies like [Medicaid and private payer reimbursement](#) and out-of-state licensure to facilitate telehealth in all settings, including rural areas. For example, all states have some degree of telehealth coverage under Medicaid and at least 34 require some type of private payer coverage.

COORDINATED CARE DELIVERY MODEL

By strengthening coordination between rural hospitals and other rural health facilities, states hope to ease the overuse of rural hospital emergency departments while expanding access to health care services. Health care services are delivered in a variety of settings in rural areas, including Federally Qualified Health Centers (FQHCs), rural health clinics, rural school-based health centers and other facilities. Policymakers have looked at ways to expand the relationship between these facilities and rural hospitals.

Georgia's [Rural Hospital Stabilization Committee](#)—comprised of legislators, health care professionals and other stakeholders—issued a final report that [recommended the hub and spoke model](#). The committee's goal is to ensure that rural patients receive the right care in the right setting and expand the network of services and providers. This "hub-and-spoke" model designates a rural hospital as the hub, with other points of care as the spokes (Federally Qualified Health Centers, local primary care offices, school clinics, telehealth-equipped ambulances, etc.). This facilitates coordinated care, directing patients to the most appropriate health care facility and minimizing the use of emergency departments. The Georgia General Assembly has appropriated funds to support various pilot sites for this model.

Federal Action

Congress enacted legislation in 1997 enabling the Centers for Medicare & Medicaid to designate certain rural facilities as [critical access hospitals](#) in an attempt to lessen their financial vulnerability and ensure access to essential health services in isolated areas. To qualify for a critical access designation, the facility must meet certain criteria, such as having 25 or fewer beds and being at least 35 miles away from another facility. Critical access hospitals receive cost-based reimbursement for Medicare patients, and in some cases Medicaid patients, depending on the state. This designation allows critical access hospitals to be reimbursed for 101 percent of their costs for services provided to eligible patients. As of February 2017, [more than 1,300 hospital had been designated as critical access hospitals](#) across the U.S.

Additional Resources

[NCSL report, Improving Rural Health: State Policy Options](#)

[NCSL webinar: Opportunities and Challenges for Rural Hospitals](#)

[NCSL webpage, State Coverage for Telehealth Services](#)

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