Save Rural Health Care: Time for a Significant Paradigm Shift
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Access to health care in the rural United States is becoming increasingly difficult. Since 2005, 118 US rural hospitals have closed and almost 700 more are in danger of closing. The decrease in access has resulted in detrimental health outcomes for people residing in rural communities. Recently, the University of North Carolina tracked United States rural hospital closures and gleaned results from 83 hospitals. The results identify 2 main factors for hospital closures: economics and lack of workforce.

To remedy economic challenges facing rural hospitals, the Save Rural Hospitals Act/HR 2957 was proposed to Congress. However, the bill is not a sustainable solution for resolving economic challenges and the workforce shortage. Over time, we have seen dramatic reductions in lengths of stay, decreased census, and an exodus of health care professionals among other changes in the current rural hospital infrastructure. These changes have affected the osteopathic medical profession, particularly given our tendency to practice in primary care and rural settings. Osteopathic physicians tend to fill the primary care needs of rural communities at a rate 2.3 to 2.5 times higher than our allopathic colleagues.

This article examines current challenges rural hospitals face and offers potential solutions to improve the rural health care delivery model. Implementation of multitiered solutions can improve access to necessary medical care and meet the rural population’s health care needs.

History and Background

Challenges to Rural Hospital Viability
In the 1940s and 1950s, the Hill-Burton Act promoted building relatively large institutions in rural communities to meet the local health care needs. At the time, the majority of the population lived in rural America, and hospital stays were much longer. However, over time, the rural census decreased as the population shifted into more urban areas. Furthermore, with medication and technological advancements, those lengths of stay have significantly decreased with more efficient outpatient and inpatient management. As a result, rural hospitals have decreased revenue, which is the most common reason for closure.

Additionally, decreased economic infrastructure compromises the ability of small towns to keep hospitals open because communities are unable to subsidize them. Interventions have been implemented to prevent closures, such as the Medicare Rural Hospital Flexibility Program in 1997, which preserved hospital infrastructure, creating and subsidizing critical access hospitals. However, even with significant federal and local subsidies, critical access hospitals are struggling financially.

When addressing financial challenges, unintended consequences of implementing the Emergency Medical Treatment and Labor Act of 1986 must be addressed. The act...
guarantees basic screening, treatment, and stabilization in any emergent setting no matter the patient’s ability to pay, and it resulted in a significant increase in emergency department (ED) use often by patients who are uninsured and underinsured.\textsuperscript{10} These ED visits are thus not compensated as charity care.\textsuperscript{10}

Emergency department use also increased because of a decrease in primary care infrastructure. With less access to primary health care professionals, rural patients are left with the ED as the only intervention available to manage disease and chronic illness.\textsuperscript{10} Treating patients in the ED is far more expensive than treating patients in an outpatient setting, which can result in debt or charity care. The operating margins of most rural hospitals are typically less than 2%, and these additional costs often put the hospitals below financial sustainability.\textsuperscript{11}

The Patient Protection and Affordable Care Act was intended to increase insurance access by subsidizing lower-income families. Middle-income families had to purchase costly insurance plans as a mandate, and a significant number of people subsequently purchased insurance with high deductibles.\textsuperscript{12,13} Circumstantially, if a patient’s situation is dire enough, he or she will be transferred from a rural hospital to a tertiary care facility. The larger institution submits the bills after the patient meets his or her deductible at the rural facility, which means the larger hospital gets paid by insurance and the smaller hospital has to collect from the patient.\textsuperscript{12} Forty-six percent of rural hospitals operate below sustainable margins for this and other similar reasons.\textsuperscript{11,13} Proposed recovery mechanisms do not adequately remedy the increased hospital financial burden created by patients who default on hospital bills.

**Workforce Shortages**

Most rural communities have significant shortages of health care professionals and are unable to adequately staff hospitals and clinics because of a ratio mismatch: approximately 20% of people in the Unites States live in rural areas, yet only 10% of physicians practice in those same areas.\textsuperscript{13,14} In 2015, a hospital chief executive officer I interviewed in rural Oregon stated that the hospital was at 23% of the necessary manpower, and most of their practicing physicians were older than 60 years. In a follow-up conversation in May 2018, he stated that his workforce diminished further, making the situation more dire.

In another case, a community hospital in rural Nevada was able to recruit and hire a physician; however, the physician stayed for less than a year because he experienced burnout due to having no backup and was required to be on call 24 hours per day/7 days per week. After his departure, the hospital eventually closed because of the workforce shortage.

During the Rural Training Track Collaborative meeting in Spokane, Washington, in April 2018, a chief financial officer of a critical access hospital in Idaho stated that the hospital’s mean census was only 3 even during the cold and flu season. There was no regional primary care infrastructure to staff the community clinic or the hospital. The hospital was still operating because of community needs and subsidies; however, the operating margin was typically less than 1%. Health care professional shortage was the key concern when attempting to sustain operations, and the hospital had to transfer patients to other hospitals for even routine inpatient illness management.

**Proposed Legislative Solution: Save the Rural Hospitals Act/HR 2957**

The Save the Rural Hospitals Act/HR 2957\textsuperscript{4} addresses 8 issues, mostly focused on financial challenges. The Table breaks down each point in the bill and addresses the targets and challenges. The main issues addressed in HR 2957 are capturing bad debt and maintaining expensive infrastructure. The bill does not address the cost to maintain economic viability and, ultimately, transfers the cost of operations to the patients. It does not address the direct cost of care to patients, which is problematic because medical debt is the number 1 source of personal bankruptcy filings in the United States.
In 2019, an estimated 66.5% of bankruptcies in the United States cited unmanageable debt due to medical expenses.

House Resolution 2957 is not sustainable; it only partially addresses the economic challenges of rural institutions. It does not address the changing climate of rural health care delivery and how interventions are managed at larger tertiary institutions where higher levels of intervention are available and more appropriate. Therefore, my recommendation is to not support this bill as the means to resolve the challenges faced by the rural community hospitals.

Recommendation

The following list provides short-term and long-term solutions to the physician shortage in rural communities: (1) Adjust the Health Professional Shortage Areas (HPSA) guidelines to improve workforce recruitment and retention in rural areas; (2) Increase physician retention by increasing rural health care pipeline programs; (3) Support the community outpatient hospital model; and (4) Change the current payment rules and regulations of Centers for Medicare and Medicaid Services.

Change HPSA Scoring System to Improve Access to Loan Repayment

Currently, the HPSA program uses a designation based on the following scoring system ranging from 0 to 25 to determine a community’s eligibility for provider incentives such as student loan repayment:

- Population-to-Health Care Professional Ratio: \( \leq 10 \) points
- Percentage of Population Below 100% Federal Poverty Level: \( \leq 5 \) points
- Infant Health Index (Infant mortality rate or low birth weight): \( \leq 5 \) points
- Travel Time to Nearest Source of Care Outside of the Region: \( \leq 5 \) points

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<thead>
<tr>
<th>8 Points</th>
<th>Challenges and Discussion:</th>
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<td>1. Reverse cuts to reimbursement for bad debt for critical access hospitals</td>
<td>Supports subsidies to offset bad debt expenses (where the hospital is unable to collect from uninsured or underinsured patients)</td>
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<td>2. Extend payment levels for low-volume hospitals and Medicare-dependent hospitals (MDHs)</td>
<td>Modify the reimbursement levels or create subsidies for services provided at struggling hospitals when current reimbursements are not adequate</td>
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<td>3. Reinstate revised diagnosis-related group payments to MDH and sole community hospitals</td>
<td>Similar to number 2</td>
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<td>4. Delay the application of penalties for a rural hospital’s failure to become a meaningful electronic health record user</td>
<td>94% or all hospitals currently use an electronic medical record: No benefit.</td>
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<td>5. Make permanent increased Medicare payments for ground ambulance services in rural areas</td>
<td>Supports novel emergency services payments to allow for better-equipped and trained emergency responders.</td>
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<td>6. Alter certain supervision requirements for therapeutic hospital outpatient services.</td>
<td>Changes how clinical oversight is done in rural settings, giving nonphysician practitioners more independent practice privileges.</td>
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<td>7. Modify requirements related to the use and payment of recovery audit contractors.</td>
<td>Allows hospitals to more aggressively seek payment reimbursements from patients. Does not address patient cost burdens.</td>
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<td>8. Establish criteria for hospital eligibility for enhanced payment for qualified outpatient services.</td>
<td>Changes payment infrastructure allowing for more outpatient intervention reimbursements</td>
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**Table. Breakdown of 8 Issues and Challenges Addressed by the Proposed Legislative Solution: Save the Rural Hospitals Act (House Resolution 2957)**

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Health Professional Shortage Areas incentives are a tool used to recruit physicians, who are often saddled with significant medical school debt, to settle in a rural community. With this scoring system, many rural communities without a hospital do not score high enough to recruit or retain a physician and are unable to staff the facility to maintain services. If “Travel Time to Nearest Source of Care Outside of the Region” were more heavily weighted, remote communities would be able to offer health care professional HPSA incentives, and which would be a potential short-term solution to the workforce shortage.

Increase Physician Retention by Increasing Rural Health Care Pipeline Programs

Often, once physicians pay off their medical school debt using HPSA incentives, they tend to return to urban areas; however, the same studies show that if a person from a rural community enters a health profession, that person is significantly more likely to return to that rural community to practice. Incentive programs should start early in primary education. Many small communities lack the infrastructure to provide the education needed to get students into health care professions, and developing programs that target those deficits will be the best long-term solution to recruit health care professionals to rural areas.

Support the Community Outpatient Hospital Model (Rural Emergency Acute Care Hospital Act S. 1130)

Another long-term solution is to promote a paradigm shift to the community outpatient hospital model, which has significantly lower overhead expenses. Patients no longer stay in the hospital for extended periods. The current trend for hospitalist-based inpatient care is expensive for rural communities. Instead, we should allow this system to erode and have more sustainable emergency/urgent-care facilities, as well as cost-effective outpatient and prenatal care facilities.

Change Current Rules and Regulations of Centers for Medicare and Medicaid Services

Current Medicare hospital guidelines and rules are limiting because they are based on maintenance of the current infrastructure. Instead of focusing on crisis management, community outpatient hospitals could focus on wellness, prevention, long-term care, and acute-care interventions, which would lead to fewer hospital admissions and reduced cost of maintenance.

Conclusion

Implementing these strategies could provide a long- and short-term workforce with appropriate infrastructure. Rural communities would “grow their own” health care professionals to administer emergency, preventive, and long-term care in financially sustainable outpatient hospitals. (doi:10.7556/jaoa2019.098)

References


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