

THE ISSUE

Approximately 72 million Americans live in rural areas and depend on the hospital serving their community as an important, and often only, source of care. These hospitals face a unique set of challenges because of their remote geographic location, small size, scarce workforce, physician shortages and constrained financial resources with limited access to capital. Congress has previously recognized these vulnerabilities by establishing programs and policies to ensure and protect stable access to health care services for the elderly and others living in rural America. Specifically, it created critical access hospital (CAH), sole community hospital (SCH) and Medicare-dependent hospital (MDH) and Rural Referral Centers (RRC) designations to sustain these unique types of small or rural hospitals. Yet some policymakers are now suggesting cuts to these programs and policies, and the Congressional Budget Office offered a budget cutting option that would eliminate these programs.

AHA POSITION

Reject reductions in Medicare funding for small or rural hospitals.

WHY?

- **The recent economic downturn has already put additional pressure on rural hospitals** as they operate with modest balance sheets and have more difficulty than larger organizations accessing capital to invest in modern equipment or renovate aged facilities. Without the special payments associated with CAH, SCH, MDH and RRC status, many of these hospitals would face dire financial circumstances. Specifically, Medicare cuts would force many facilities to offer reduced services or even close their doors, reducing access to care for rural Americans.
- **Rural communities rely on their hospitals as critical components of the region's economic and social fabric. Reducing Medicare payments for small and rural hospitals will have a severely negative impact on these local economies.** Studies have shown that the closure of the sole hospital in a community substantially reduces per-capita income, and also increases the local unemployment rate. This is because many of a community's health care personnel are either directly employed by or supported by the local hospital. Further, the hospital brings outside dollars into the community via third-party payors, jobs, local purchasing and attraction of industry and retirees.

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KEY FACTS

- The nation's nearly 2,000 rural community hospitals frequently serve as an anchor for their region's health-related services, providing the structural and financial backbone for physician practice groups, health clinics and post-acute and long-term care services. In addition, these hospitals often provide essential, related services such as social work and other types of community outreach.
- Rural community hospitals are typically the largest or second largest employer in the community and often stand alone in their ability to offer highly-skilled jobs. For every hospital job in a rural community, between 0.32 and 0.77 more jobs are created in the local economy, spurred by the spending of either hospitals or their employees. A strong health care network also adds to the attractiveness of a community as a place to settle, locate a business or retire.
- Yet small or rural hospitals face a unique set of demographic and public policy circumstances that already exert considerable negative financial pressure and, for many, threaten their long-term financial sustainability.
- First, their smaller size means they have lower patient volume and provider supply.
 - Lower volume translates into a financial position that is much less predictable, complicating long-range financial forecasting and contingency planning. This makes small and rural hospitals less able to weather financial fluctuations, especially in today's economic environment.
- Rural hospitals also have a difficult time attracting and retaining highly skilled personnel, such as doctors and nurses. One impediment is the lack of commonly available family and social amenities, and other conveniences. As a result, many rural patients must travel a relatively long distance for care, a factor that often creates longer intervals between visits or between diagnosing and treating the original or latent conditions.
- Second, rural communities are self-contained and far from population centers.
 - Public transportation is rare and, if it does exist, it is sporadic. In addition, inclement weather or other forces of nature can make transportation impossible or, at the very least, hazardous. The inability to rely on safe, consistent transportation for many rural residents means that preventative and post-acute care, pharmaceutical and other services are delayed, or in the extreme, forgone entirely, which can increase the overall cost of care once services are delivered.
- Finally, rural areas have a high proportion of Medicare patients.
 - Thus, any payment changes or cuts in the program have a disproportionate effect on rural hospitals.
 - The problem is compounded when coupled with their low volume, because they operate on extremely small margins. They are less able to subsidize losses and to adjust their budget strategy based on our changing patient mix and volume.