FACTSHEET

Rural or Small Hospitals

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), Medicare-dependent hospital (MDH) and Rural Referral Center (RRC) designations to sustain these unique types of rural or small hospitals. Yet some policymakers are now suggesting cuts to these programs and policies. The Congressional Budget Office also offered a budget cutting option that would eliminate these programs altogether. Additionally, The President's Plan for Economic Growth and Deficit Reduction proposes three changes to payments for rural providers of concern to the hospital field. It includes: eliminating add-on payments for hospitals and physicians in low-population frontier states, reducing payments to CAHs and eliminating the CAH designation for hospitals that are fewer than 10 miles from the nearest hospital.

AHA POSITION

Reject reductions in Medicare funding for rural or small hospitals.

WHY?

- **The recent economic downturn already has 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 payment methods associated with CAH, SCH, MDH and RRC status, many of these hospitals would face dire financial circumstances. Specifically, Medicare cuts, or eliminating these programs, 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 rural or small 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 payers, jobs, local purchasing and attraction of industry and retirees.
- **The administration's deficit reduction plan would put rural health care providers in jeopardy.** Further, it puts these many providers, and their patients, in jeopardy in order to achieve a relatively small amount of savings. For example, CAHs account for almost 30 percent of short-term acute care hospitals in the U.S., but only 4 percent of Medicare inpatient and outpatient spending. Such payment reductions would hurt hospitals ability to ensure access to care that is essential to patients in our most remote areas of the country.

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KEY FACTS

- The nation's nearly 2,000 rural community hospi¬tals 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 out¬reach.
- Rural community hospitals are typically the larg¬est or second-largest employers in the commu¬nity 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 at¬tractiveness of a community as a place to settle, locate a business or retire.
- Yet rural or small 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 workforce supply.
- Lower volume translates into a financial posi¬tion that is much less predictable, complicating long-range financial forecasting and contingen¬cy planning. This makes rural and small hospi¬tals less able to weather financial fluctuations, especially in today's economic environment.
- Rural hospitals also have a difficult time attract¬ing 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, sporadic. In addition, inclement weather or other forces of nature can make transporta¬tion impossible or, at the very least, hazardous. The inability to rely on safe, consistent trans¬portation for many rural residents means that preventive and post-acute care, pharmaceutical and other services are delayed, or in the ex¬treme, 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 ex¬tremely small margins. They are less able to sub¬sidize losses and to adjust their budget strategies based on their changing patient mix and volume.
- The AHA supports extending the 340B drug pro¬gram discounts to CAHs, SCHs, RRCs and MDHs for inpatient stays. Currently, CAHs, SCHs and RRCs with a disproportionate share hospital adjustment equal to or greater than 8 percent are eligible for the outpatient dis¬count. These hospitals serve low-income patients in rural areas by providing emergency and health care services and are the sole source of care for patients in their communities.