



IDEAS
ACTION
RESULTS

The Impact of COVID-19 on the Rural Health Care Landscape

CHALLENGES AND OPPORTUNITIES

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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DISCLAIMER

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Glossary of Acronyms

ACO	Accountable Care Organization
AFP	Additional Facility Payments
AIR	All-Inclusive Rate
APM	Alternative Payment Model
APRN	Advanced Practice Nurse
ARP	American Rescue Plan Act
ASPE	Assistant Secretary for Planning and Evaluation
CAA	Consolidated Appropriations Act
CAH	Critical Access Hospital
CARES	Coronavirus Access and Relief Act
CHART	Community Health Access and Rural Transformation
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CoP	Conditions of Participation
DSH	Disproportionate Share Hospital
ERS	Extended Rural Services
FCC	Federal Communications Commission
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HPSA	Health Professional Shortage Area
HRSA	Health Resources & Services Administration
IHS	Indian Health Service
IPPS	Inpatient Prospective Payment System
MACPAC	Medicaid and CHIP Payment Access Commission
MedPAC	Medicare Payment Advisory Commission
MDH	Medicare Dependent Hospital
MIPS	Merit-based Incentive Payment System
MUA	Medically Underserved Area
NHSC	National Health Service Corps
NP	Nurse Practitioner
NTIA	National Telecommunications and Information Administration

NQF	National Quality Forum
OIG	Office of the Inspector General
OPPS	Outpatient Prospective Payment System
PA	Physician Assistant
PHE	Public Health Emergency
PMPM	Per Member Per Month
PPS	Prospective Payment System
PRF	Provider Relief Fund
QPP	Quality Payment Program
REH	Rural Emergency Hospital
RHC	Rural Health Clinic
RRC	Rural Referral Center
SCH	Sole Community Hospital
USCIS	U.S. Citizenship and Immigration Services

Executive Summary

Before the COVID-19 pandemic began, hospital closures were increasing in rural communities across the nation: 116 rural hospitals closed between 2010 and 2019.¹ Over the past two years, federal relief has helped stabilize facilities, and the pace of closures slowed. However, this assistance was temporary, and rural hospitals continue to struggle financially and to recruit and retain nurses and other health care employees.

Against this backdrop, the Bipartisan Policy Center (BPC) conducted a series of interviews over the last year with rural hospital leaders from eight states—Iowa, Minnesota, Montana, Nebraska, Nevada, North Dakota, South Dakota, and Wyoming—as well as with health policy experts from federal and state government, national organizations, provider organizations, and academia. The goal was to gain on-the-ground insights into today’s rural health care landscape, where the population is older, sicker, and less likely to be insured or seek preventive services than in urban areas.

Today in rural America, roughly 1 out of every 3 individuals are enrolled in the Medicare program and nearly 1 in 4 individuals under age 65 rely on Medicaid as their primary source of health care coverage.^{2,3} Although all payers should be part of the solution in ensuring access to quality rural health care, this report largely focuses on strengthening rural health care delivery in Medicare and Medicaid given the outsized role these public programs play in rural communities.

RURAL HEALTH LANDSCAPE AND FINANCIAL OUTLOOK

Health systems in rural communities face ongoing challenges that threaten their financial well-being. Although federal support during the pandemic temporarily helped many struggling facilities, financial challenges remain across rural health care systems. Notably, many rural stakeholders told BPC that once the federal public health emergency (PHE) ends and federal financial relief is no longer available, many of the rural hospitals that were struggling before the pandemic will once again be at risk of closure unless additional action is taken to shore up these facilities.

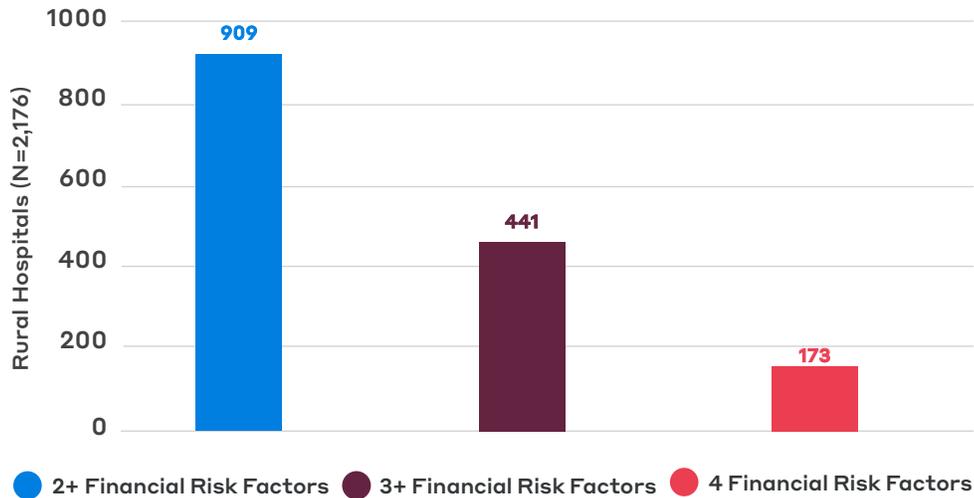
Among the hospital associations BPC interviewed, each indicated negative total operating margins over three consecutive years for at least some hospitals in their state, according to the most recently available cost report data. Hospitals experiencing persistent financial losses ranged from 6% in Nevada up to a high of 38% in Wyoming.⁴ An even greater share of hospitals experience losses on

patient care alone, including half of Iowa’s 115 acute care hospitals over a three-year period.

BPC assessed financial vulnerability across multiple domains and found that out of 2,176 rural hospitals, 441 face three or more concurrent financial risk factors, putting them at risk of service reduction or closure (see Figure 1).⁵ Financial risk factors included: negative total operating margin, negative operating margin on patient services alone, negative current net assets, and negative total net assets.

Rural hospitals that were struggling before the pandemic will once again be at risk of closure unless additional action is taken to shore up these facilities.

Figure 1: Financial stress affects a significant portion of rural hospitals, 2017-2020⁶



Financial risk factors include: negative total operating margin, negative operating margin on patient services alone, negative current net assets, and negative total net assets.

A Minnesota Hospital Association executive said the situation is “simply unsustainable. Rural hospitals in Minnesota had a median operating margin of 1.4% in 2019 and about 30 hospitals reported negative operating margins.”⁷

Stakeholders from Wyoming reported that financial health is always a challenge. All but two of the state’s 28 hospitals are classified as rural. Wyoming is considered frontier with a population density of six or fewer people per square mile and most hospitals are a 60- to 90-minute drive apart. In most cases, the Critical Access Hospitals (CAH) in the state have a 1% to 2% operating margin. A hospital association executive said, “Federal dollars have helped, but some rural facilities continue to sustain financial losses even amidst the federal relief.”⁸

At the same time, over the past decade, most of the states had at least one converted hospital closure, where the facility closes its inpatient unit while continuing to provide other health care services, such as emergency, rehabilitation, or outpatient care.⁹ Approximately 83 hospitals have undergone a converted hospital closure nationally since 2005, compared with 98 hospitals that closed completely.¹⁰

These conversions reflect a trend that is in line with broader federal efforts to offer rural communities other care delivery and reimbursement models that shift the focus away from inpatient care to emergency and outpatient services. One example is the Rural Emergency Hospital (REH) model that Congress created recently, which is discussed at length later in the report. This trend further highlights the need to provide rural providers with workable transformation opportunities that meet community or regional health care needs.

IMPACT OF POTENTIAL RURAL HOSPITAL CLOSURES

Rural hospital closures can significantly reduce access to health care services in the community, particularly in less densely populated places. According to a 2020 report by the U.S. Government Accountability Office (GAO), one-way travel time to health care services increased approximately 20 miles from 2012 to 2018 in communities with rural hospital closures. Travel times for less common services increased even more. For example, in some rural communities that GAO studied, the median travel distance for substance use treatment services rose from 5.5 miles in 2012 to 44.6 miles in 2018 following a closure.¹¹ Closure of facilities also affects the availability of health care workers.¹²

A Nebraska Hospital Association representative conveyed the impact of a 2021 closure, the state's first closure since 2014, this way: A main driver of the closure was the low daily inpatient volume, which forced the hospital to reduce inpatient care. That reduction, in turn, led to further financial losses and placed the hospital under greater stress. "When the hospital closed, roughly 35 hospital employees lost their jobs. Post hospital closure, patients in the community must drive 17 to 20 miles to seek hospital-based services," the representative said.¹³

PROPOSALS TO HELP IMMEDIATELY STABILIZE RURAL HEALTH SYSTEMS

BPC recommends several short-term policies aimed at immediately stabilizing and strengthening access to CAHs and other small rural hospitals and rural health clinic services. The proposals are designed to serve as a bridge as health

care systems exit the pandemic and move toward longer-term reforms. Policy recommendations include:

- Providing rural hospitals full relief from across-the-board Medicare spending reductions, known as sequestration, until two years after the federal PHE ends.
- Taking rural facilities out of the ongoing “extender” and “needing to be renewed” budget cycle, including by permanently authorizing the Medicare Dependent Hospital (MDH) program and making rural low-volume payment adjustments permanent.
- Updating or rebasing Sole Community Hospital (SCH) and MDH payment structures to ensure reimbursement is in line with current costs.

STRENGTHENING THE REH MODEL AND ADVANCING OTHER RURAL DELIVERY TRANSFORMATION MODELS

BPC also recommends advancing and refining new rural care delivery models, including, most notably, the REH model that Congress passed in December 2020 and which becomes available to rural hospitals in 2023. The U.S. Department of Health and Human Services (HHS) is considering how to implement this model. Although the REH model is consistent in many ways with BPC’s previous recommendations, additional steps are needed to ensure its success.

BPC received extensive feedback from rural stakeholders, health system leaders, and rural policy experts about the areas of the REH model that hold promise and areas that require refinement or additional consideration. Not every community or hospital will benefit from the REH model, but improvements to this delivery option would likely result in a higher participation rate among communities and facilities. A primary area of concern for stakeholders is how to structure the new, additional facility payment. Although payments would be made available to REH participants to cover services and supports beyond the typical Medicare reimbursement structure, stakeholders worry that such payments may be set too low or be too restrictive to prove useful to REHs.

The report also highlights other rural health care delivery models that are undergoing testing in certain communities by the Centers for Medicare and Medicaid Innovation (CMMI); examples include the Community Health Access and Rural Transformation (CHART) model and the multipayer global budget initiative that Pennsylvania is testing—the Pennsylvania Rural Health Model—which provides participating rural hospitals a fixed amount of revenue from Medicare and other payers, paid in advance, to cover all inpatient and outpatient care.^{14,15} As CMMI tracks progress for these models and similar

programs, BPC encourages the secretary of HHS to use lessons from the initiatives to establish multipayer global budget initiatives that are tailored to rural communities and to provide additional opportunities for rural providers to transition to value-based care.

PROPOSALS TO ENSURE AN ADEQUATE RURAL HEALTH CARE WORKFORCE

Addressing rural workforce challenges, which were significant even before the pandemic but have worsened over the past two years, is also a priority. Rural health care systems consistently report that retaining workers and ensuring adequate staffing levels is one of their most vexing challenges.

Key problems during the pandemic include staff burnout, the need of providers to leave the workforce to care for family members, and wage pressures that made it difficult for financially strapped rural hospitals to compete with other employers.

Recommendations in this report would extend the capacity of the existing health care workforce and improve the retention of providers in rural areas. Discussed later, BPC outlines several recommendations, including leveraging federal tax credits to encourage health care workers to remain in rural communities and improvements in the rules that allow practitioners trained outside of the United States to practice in underserved areas. Additionally, BPC considers opportunities to reduce administrative burdens, improve reimbursement for rural providers, and restructure health professionals' scope of practice regulations.

PROPOSALS TO SECURE ACCESS TO VIRTUAL CARE IN RURAL COMMUNITIES

Finally, the report sets forth recommendations aimed at further advancing the use of virtual care in all communities, including rural and frontier areas, beyond the temporary federal PHE flexibilities.

During the COVID-19 public health emergency, Congress, the administration, and states temporarily eliminated many historical barriers to telehealth; these policy changes paved the way for unprecedented utilization of telehealth. Most notable for rural areas, CMS waived the clinical site requirement allowing all beneficiaries, regardless of clinical diagnosis, to access telehealth services from their homes. Medicare also began reimbursing telehealth services at parity with in-person care. Many Medicaid agencies and private payers followed suit.

Stakeholders consistently reported that temporary telehealth flexibilities

helped sustain access to clinical services during the public health crisis and will continue to be a valuable tool if certain flexibilities remain in place. This report includes a series of recommendations to build on this success to ensure that rural and frontier communities can continue to benefit from virtual care advancements.

Policy Recommendations

1. Provide Immediate Stabilization for Rural Hospitals, Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHC) (Page 28)

Provide Immediate Stabilization for Rural Health Systems

- Congress should provide full relief to rural hospitals from Medicare sequestration payment reductions until two years after the public health emergency (PHE) ends.
- Congress should increase reimbursement for Medicare CAH services by 3% starting in FY2023.
- HHS should re-establish the CAH “necessary provider” designation process.
- Congress should allow additional flexibility in CAH eligibility criteria.
- Congress should update the Medicare base payment rate for Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH) to ensure that reimbursement reflects current costs.
- Congress and HHS should make available to rural hospitals capital infrastructure grants or loans that they can use to modify services lines or improve structural or patient safety.

Make Certain Rural Hospital Designations or Payment Adjustments Permanent

- Congress should take rural facilities out of the ongoing “extender” and “needing to be renewed” policy cycle.
- Congress should make the MDH designation permanent.
- Congress should make permanent adjustments for rural hospitals receiving low-volume payments.
- Congress should allow SCHs to permanently receive additional payment for outpatient services.

Ensure Continued Access to Care at RHCs

- HHS and Congress should monitor and evaluate the impact of establishing a uniform payment rate for independent and hospital-owned rural health clinics to ensure continued patient access to critical RHC services.

2. Strengthen the REH Model and Advance Other Rural Care Delivery Transformations (Page 34)

Ensure Adequate Funding Levels and Allow Flexible Use of Additional Facility Payments (AFP)

- Congress and HHS should evaluate to what extent higher funding levels or phased-in funding for the AFP would more effectively incentivize rural hospitals' conversion to the REH model. Consider phasing in the AFP with perhaps a higher payment for the first number of years until REHs are fully established in the community.
- HHS should provide REHs the flexibility to use new AFPs to offer extra medical and social support services, such as wellness and preventive care; mental health care; substance use disorder services; oral health services; end-stage renal disease care; and transportation, including for maternal care services and for food or housing assistance.

Consider Alternative Payment Pathways for REHs and Evaluate the REH Reimbursement Structure on an Ongoing Basis

- Congress and HHS should allow or test alternative payment pathways for eligible REHs to increase program participation and access to care for rural residents. One pathway could allow REHs to receive enhanced outpatient payments, plus a per member per month (PMPM) payment, based on the number of anticipated patients, as an alternative. The HHS secretary may also wish to consider some form of cost-based reimbursement—akin to how CAHs are currently paid—for certain services provided at REH facilities. HHS should also provide REHs the opportunity to participate in global payment models that the department is testing or implementing that combine funding from Medicare and other payers.
- Congress and HHS should evaluate the REH reimbursement structure on an ongoing basis to ensure it can support sustained transformation among rural hospitals, particularly in communities that are most at risk of losing all hospital services if the local facility closes.

Determine the Role of Medicaid

- HHS should clarify whether REHs would be eligible to receive Medicaid

Disproportionate Share Hospital (DSH) supplemental payments. The department should also assess whether losing access to such payments would pose a barrier for struggling rural hospitals to transform to an REH.

- HHS should evaluate the role Medicaid reimbursement will play in the REH program.

Address the Need for Additional Capital Infrastructure Investments and Technical Assistance and Support

- To support REH transformation, HHS should ensure the hospitals are eligible for capital infrastructure funding that would enable them to update their facilities and ensure safe and high-quality care.
- Congress and HHS should make technical assistance available to support hospitals in transitioning to an REH and to support ongoing REH operations.

Ensure Continued Access to Inpatient Hospital Care and Allow Communities to Maximize Local Infrastructure and Workforce

- Congress and HHS should allow REHs to have a minimal number of inpatient beds or a specified number of enhanced observation beds in communities with little or no access to inpatient care.
- Congress and HHS should expand REH program eligibility to CAHs or rural hospitals that closed within the past five years, but otherwise meet the REH criterion.
- Congress and HHS should allow the establishment of REHs in areas that previously lacked a rural or critical access hospital, if establishment of such a facility could improve access to health care in the community.
- HHS should establish guidance on how REHs can transform back to another hospital model if the REH model is no longer financially viable or appropriate in the community.
- HHS should allow REHs to establish visiting provider programs to ensure adequate access to critical health care workers.
- HHS should permit co-location of services to increase patients' access to clinical and service offerings.
- The Health Resources & Services Administration (HRSA) should expand eligibility for the National Health Service Corps (NHSC), the Nurse Corps, and other loan repayment programs to REHs to help address rural workforce needs
- Congress should also consider increasing funding for HRSA scholarship and loan repayment programs.

Ensure Quality Rural Hospital Care and That New Rural Models Meet Community Needs

- To increase accountability and improve care in rural communities, Congress and HHS should require hospitals, including new REHs, to report at minimum on a narrow set of rural-relevant quality indicators. When possible and appropriate, such indicators should be risk-adjusted for social determinants of health and include access to care measures.
- Congress and the HHS secretary should evaluate the feasibility of establishing a quality reporting program for RHCs to ensure quality care.
- HHS should encourage communities to complete a community needs assessment—with full participation from stakeholders—to ensure that transformation to new delivery models will improve access to high-quality care in the local area and assist rural communities in taking the findings to develop a hospital transformation action plan.

Ensure Access to Ambulance Care, Virtual Care, and Behavioral Health, and Address Gaps in Maternal Care Services

- The secretary of HHS should allow REHs to tailor emergency medical transfer agreements to meet the local community's need.
- The secretary should clarify rules on ambulance reimbursement within the REH model, and ensure such reimbursement supports the transformation to the REH model and continued access to these critically important services.
- HHS should evaluate the REH reimbursement rate and structure to ensure REH providers can maintain strong virtual and telehealth service capabilities.
- HHS should ensure REHs are eligible to deliver all outpatient mental health and substance use services, as well as support additional service needs that surface during the community needs assessment.
- HHS should ensure funding is made available to REHs from HRSA programs, such as the Title V Maternal and Child Health Block Grant program. In addition, it should encourage states to provide enhanced Medicaid reimbursement for maternal care services that can be provided appropriately in the outpatient REH setting.

REH Alternatives

- The secretary of HHS should use lessons from current demonstrations to inform the establishment of additional multipayer, global budget initiatives that are tailored to rural communities and have the potential to improve care coordination and quality of care while reducing health care costs, where possible.

- Congress and the secretary should establish an Extended Rural Services program that leverages local FQHC or RHC infrastructure.
- The secretary should develop new models that promote increased coordination and integration of rural hospital and clinic services.

3. Ensure an Adequate Rural Health Care Workforce (Page 59)

Improve Utilization of the Currently Available Workforce

- To expand access to behavioral health services, CMS should consider permanently adding behavioral health provider types to the list of Medicare-covered providers (such as peer support specialists).
- To extend the existing workforce's capacity, Congress and the administration should remove federal regulatory and legislative barriers that prevent non-physician providers from practicing at the top of their license.
- Congress and the administration should support ongoing funding for Project ECHO, a distance-learning telementoring model designed to help primary care clinicians provide expert-level care to patients where they live.

Streamline Licensure Requirements

- Congress could permit any physician with a medical license in good standing to deliver services via telehealth to Medicare beneficiaries residing in any state, similar to the exemptions allowed by the U.S. Department of Veterans Affairs.
- Congress could authorize telehealth services for Medicare beneficiaries based on the location of the provider, rather than the location of the patient. This authorization could apply to issues of licensure and provider liability.
- Congress could provide additional federal incentives to increase state participation in licensure compacts, such as increased Medicaid Federal Medical Assistance Percentage (FMAP) funding.

Strengthen the Rural Workforce by Leveraging the Federal Tax System and the Immigration System

- To improve retention of the workforce, Congress should establish a federal tax credit for providers practicing in rural areas.
- Congress should exempt Indian Health Service (IHS) loan repayment funds from federal income tax, as is already done for other federal loan repayment programs.

- Congress should reauthorize and expand the “Conrad-30” J-1 visa waiver program for physicians practicing in rural areas.
- U.S. Citizenship and Immigration Services (USCIS) and the U.S. Department of State should expedite processing H-1B visas and green card petitions for individuals employed in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUA).

Strengthen the Health Resources & Services Administration’s Rural Workforce Programs

- Congress should appropriate funding for the National Health Care Workforce Commission to perform a comprehensive evaluation of the current workforce landscape, develop policy recommendations to ensure federal education and training programs meet critical needs, and provide oversight of federal workforce programs.

Improve Reimbursement for Providers Practicing in Rural Areas and Reduce Administrative Burdens

- CMS should provide a nominal payment update for rural providers reporting data under the Quality Payment Program (QPP) and extend bonus payments for new Advanced Alternative Payment Model (APM) participants.
- CMS should exclude enrolled Accountable Care Organization (ACO) beneficiaries when determining the regional benchmark in rural areas.
- CMS should evaluate Merit-based Incentive Payment System (MIPS) data to ensure that rural providers are not disadvantaged by the program’s structure.
- CMS should utilize readily available claims data to assess quality performance.
- CMS should decrease qualifying participation thresholds for rural providers operating under APMs, RHCs, and FQHCs.

4. Secure Access to Virtual Care in Rural Communities (Page 76)

Ensure Effective Broadband Implementation and Collection of Accurate Broadband Data

- Congress should ensure the effective implementation of the Infrastructure Investment and Jobs Act to make certain broadband access is delivered equitably throughout rural America.
- Congress and the National Telecommunications and Information Administration (NTIA) should ensure effective implementation of the Broadband DATA Act and monitor whether the broadband data collection effort by the Federal Communications Commission (FCC) improves the

accuracy of mapping broadband access.

Ensure New Modalities for Service Access Are Permanently Available in Areas Without Broadband

- Congress should make access to audio-only telehealth services permanent for beneficiaries with established in-person provider relationships.
- HHS should evaluate which services should remain available via audio-only to beneficiaries, especially for those without broadband access and for those with digital literacy or other technology-related barriers.
- HHS should expand asynchronous (store-and-forward) services beyond Alaska and Hawaii demonstrations for Medicare beneficiaries.

Remove the In-Person Visit Requirement Before Accessing Telemental Health Services

- Congress should repeal all in-person visit requirements for telemental health services for Medicare beneficiaries living in rural areas and for those needing crisis services.

Permanently Expand the List of Authorized Sites of Service and Remove Geographic and Site of Service Restrictions

- To ensure equitable access to services, Congress should permanently remove geographic and site of service restrictions for telehealth and audio-only services.
- Congress should permanently authorize FQHCs and RHCs to serve as distant sites by amending section 1834(m) of the Social Security Act.

Extend Telehealth Flexibilities for Two Years Post-PHE and Evaluate the Impact

- Congress should grant the HHS secretary the authority to waive telehealth and audio-only regulatory requirements for two years following the end of the PHE and require the secretary to analyze the impact of the PHE waivers on telehealth and audio-only utilization, health outcomes, and cost across beneficiary populations.
- HHS should develop a payment methodology for audio-only and non-facility-based telehealth services (for example, telehealth services accessed from a patient's home), specifying whether reimbursement for services would be appropriate at in-person payment rates.
- HHS should develop additional guidance for the billing of telehealth and audio-only services to ensure appropriate coding and improved data quality.

Introduction

Before the COVID-19 pandemic began, hospital closures were increasing in rural communities across the nation: 116 rural hospitals closed between 2010 and 2019.¹⁶ Over the past two years, the pace of hospital closures slowed significantly as additional federal relief helped stabilize facilities that were otherwise at risk of downsizing or closing. But despite additional federal assistance, rural hospitals report continuing financial struggles and significant challenges recruiting and retaining nurses and other health care employees. Rural residents also continue to travel long distances to seek care.¹⁷

Against this backdrop, BPC conducted a series of interviews with rural hospital leaders and policy experts over the last year to seek on-the-ground insights into the rural health care landscape. BPC also interviewed leaders of Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) about their challenges during the public health crisis, as these providers are particularly important sources of outpatient care in rural communities.

As of 2021, 5,055 RHCs serve rural communities across the country.¹⁸ Although approximately 550 RHCs closed since 2018, the COVID-19 pandemic has not impacted the total number of RHCs, with 415 new clinics certified in 2020 and 300 in 2021.¹⁹ FQHC growth has also been steady during the pandemic. FQHCs care for nearly 29 million people annually, serving 1 in 5 rural residents.²⁰

Federal financial relief during the pandemic provided an extra cushion to rural health systems and helped stave off hospital closures. Specifically, federal funding made available in 2020 and 2021 included roughly \$11 billion in targeted rural assistance from the Provider Relief Fund (PRF) in the CARES Act (P.L. 116-136).²¹ In addition, the American Rescue Plan (P.L. 117-2) sent nearly \$7.5 billion since November 2021 to rural providers out of a total \$8.5 billion authorized for rural patients.^{22,23} These targeted supports to rural communities, along with funds from the PRF general distributions and other relief funding, have been key sources of revenue to rural providers during the pandemic.

Congress also placed a moratorium on automatic, scheduled Medicare payment reductions, including so-called Medicare sequestration, that otherwise would have imposed a 2% payment decrease for all hospitals, including even the smallest CAHs. According to numerous rural health system executives, this support resulted in fewer hospitals closing than they otherwise projected would occur.²⁴ In 2020, 19 hospitals closed, and in 2021, only two hospitals shut down—a marked reduction from the previous pace of closures.

This report begins with an overview of key findings from interviews with stakeholders in eight states: Iowa, Minnesota, Montana, Nebraska, Nevada,

North Dakota, South Dakota, and Wyoming. Following the overview, the report includes a set of policy recommendations to shore up and strengthen access to health care services as rural communities continue to navigate the public health crisis.

Interviewees highlighted significant care delivery and ongoing budgetary challenges within rural health care systems. Stakeholders also highlighted policy solutions that could help stabilize struggling facilities and provided perspectives on how new rural care delivery programs, such as the Rural Emergency Hospital model, could be refined to ensure their effectiveness. Those interviewed also highlighted the urgent and growing need to address workforce shortages. Finally, stakeholders emphasized the important role that virtual care plays in ensuring access to rural health care during the pandemic, and they expressed a strong interest in continuing to expand access to these services.

This report builds on BPC's foundational work related to strengthening access to rural health care services. In 2018, BPC released [*Reinventing Rural Health Care: A Case Study of Seven Upper Midwest States*](#), which described the challenges around rural health care access and delivery and highlighted opportunities for improvement. The report set forth recommendations around rightsizing health care services to fit community need, creating rural funding mechanisms, building the primary care workforce, and expanding telemedicine services.

BPC convened a Rural Health Task Force in 2019 consisting of stakeholders, former policymakers, and experts to evaluate additional aspects of the rural health landscape and develop policy recommendations to transform rural hospitals and address other critical rural health issues. This work culminated in the 2020 release of a report titled [*Confronting America's Rural Health Care Crisis*](#). The report included detailed policy recommendations on ways to ensure the appropriate provision of rural hospital inpatient and community-based services, address rural workforce shortages, improve access to maternal health care, and optimize the use of technology to increase access to care in rural communities

This current report provides an updated assessment of the rural hospital and health care landscape and offers new policy considerations and recommendations to strengthen the rural health care delivery system. In particular, the report provides insight into four key areas affecting rural health care systems:

- An overview of the current state of rural hospital care and **rural hospital financial health** through the lens of eight states.
- A review of **rural hospital transformation models** that hold promise for shoring up struggling rural hospitals and recommendations for future policy.
- An outline of ongoing **challenges facing the rural health care workforce** and areas for policy consideration.

- An assessment of the **role of telehealth** in increasing access to care in rural America and recommendations for future policy.

The report's recommendations address fundamental and immediate care delivery challenges in rural areas by ensuring viable payment options for hospitals, addressing workforce shortages, and optimizing the use of technology to meet those goals. These policies offer a necessary step forward to stem the steady stream of rural hospital closures and the loss of access to care in remote areas.



Rural Health Landscape and Financial Outlook

RURAL PROVIDER LANDSCAPE DURING COVID-19

As a first step in developing this report, BPC sought to learn how the COVID-19 pandemic has affected the financial health of rural hospitals.

In the years leading up to the pandemic, 116 rural hospitals closed from 2010 to 2019.²⁵ These closures occurred across 31 states and were heavily concentrated among small, Critical Access Hospitals (CAHs).²⁶ Although there are exceptions, most CAHs are 35 miles from the nearest hospital and have no more than 25 inpatient hospital beds.²⁷

Starting in 1983, Congress established a series of special rural hospital programs and designations intended to bolster rural hospitals by providing additional financial protections. These designations include Sole Community Hospital (SCHs, established in 1983),²⁸ Medicare Dependent Hospital (MDHs, established in 1989)²⁹ and CAH (established in 1997).³⁰ Medicare also implemented new payment adjustments for low-volume hospitals in 2005,³¹ and created a Rural Referral Center (RRC) designation in 1984.^{32,33} (See Appendix A for a full description of these designations and rural payment

adjustments.) These programs or designations have allowed certain hospitals to receive enhanced reimbursement under Medicare, if they meet criteria related to geographic location, the number of inpatient beds, and distance to other hospitals, among other items.

These rural designations and programs have helped ensure access to care in rural and frontier communities. Indeed, rural hospitals provide care to roughly one-fifth of the nation's population and are a critical source of care for vulnerable and underserved populations.³⁴ As of 2020, there were 1,352 CAHs, 457 SCHs, and 166 MDHs. (See Appendix B for additional data on acute care hospitals by CMS payment program.)

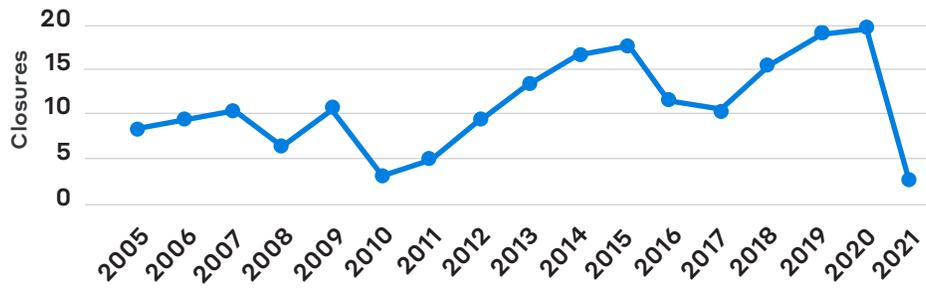
Stakeholders reported that when rural hospitals close, access to health care services in the community can significantly drop. According to a 2020 GAO report, one-way travel time to health care services increased approximately 20 miles from 2012 to 2018 in communities with rural hospital closures. Travel times for less common services increased even more in places with recent hospital closures. For example, in some rural communities that GAO studied, the median travel distance for substance use treatment services increased from 5.5 miles in 2012 to 44.6 miles in 2018 after a closure occurred.³⁵

A study by the Medicare Payment Advisory Commission (MedPAC) highlighted another troubling trend: In communities that experienced hospital closures, patients commonly bypassed the local hospital prior to the facility closing because of a lack of confidence in the care it provided.³⁶ After the hospital closed, the communities studied in the MedPAC analysis focused on maintaining access to emergency department, urgent and primary care, which meant patients may need to travel farther for inpatient care services. In the same communities, FQHCs became an important lifeline to those needing primary and urgent care.

In addition to harming health care access, closures of these facilities also affect the local workforce and economy. According to the GAO, the availability of local health care workers tends to decline in rural counties that experience hospital closures, compared to counties that do not experience closures. For example, between 2012 and 2017, the availability of physicians among counties with hospital closures decreased from a median of 71.2 to 59.7 per 100,000 residents. This compares to a decrease of 87.5 to 86.3 physicians per 100,000 residents in counties without hospital closures over the same timeframe.³⁷

Notably, during the pandemic, the pace of rural hospital closures slowed, due in large part to federal relief provided to hospitals nationwide. In 2021, only two hospitals closed, down from 19 in 2020, marking a significant reduction from the 138 closures between 2010 and 2020 (see Figure 2).

Figure 2: Total Rural Hospital Closures, 2005-2021³⁸



At the same time, over the last decade, most of the states that BPC studied reported at least one converted hospital closure.³⁹ Eighty-three hospitals have made the conversion nationally since 2005, while 98 hospitals closed completely in that time. Such converted closures typically involved the facility shutting down its inpatient unit, while continuing to provide other health services, such as emergency, rehabilitation, or outpatient services within the same physical location.

These conversions reflect a trend that is in line with broader federal efforts to offer rural communities other care delivery and reimbursement models that shift the focus from inpatient care to emergency and outpatient services. One example is the REH structure that is discussed at length later in the report. This trend further highlights the need to provide rural providers with new transformation opportunities that meet community or regional health care needs.

BPC also found that the pace of rural health clinic growth does not appear to be impacted by the COVID-19 pandemic. In 2020, Medicare certified 415 new clinics and 300 in 2021.⁴⁰ As of 2021, 5,055 RHCs serve rural communities across the country. Although approximately 550 RHCs have closed since 2018, the certification of more than 1,300 new RHCs over the same period has offset these losses.⁴¹

FQHCs are community-based health care providers that receive HRSA funds to provide primary care services in underserved areas. They must meet strict requirements, including providing care on a sliding-fee scale based on patients' ability to pay and operating under a governing board that includes patients. Growth in FQHCs has been steady over the past decade—adding health center staff, new locations, and new services (e.g., dental and vision care). FQHCs care for nearly 29 million people annually and almost 40% of their delivery sites are in rural and frontier communities.^{42,43}

WHAT HELPED SUSTAIN RURAL HOSPITALS

According to rural stakeholders, several factors helped stabilize hospitals' financial health since the beginning of the public health crisis. First, providers and policy experts cite recent infusions of federal cash, which they say helped stabilize the financial health of struggling rural hospitals. Two key sources of federal funding were the Coronavirus Access and Relief Act (CARES Act, P.L. 116-136) and the American Rescue Plan Act (ARPA, P.L. 117-2). These laws provided new and vital sources of funding, such as the Provider Relief Fund (PRF) and the Medicare advanced and accelerated loan and grant program. As further described below, these programs have given rural hospitals access to vital funding sources, but administering the dollars has proven very challenging for many rural providers.

During the pandemic, Congress placed a moratorium on automatic, scheduled Medicare payment reductions. Under current law, all hospitals receive an across-the-board payment reduction of 2% on all Medicare services. This 2% payment cut applies even to the smallest CAH facilities. The CARES Act placed a temporary moratorium on the sequestration reductions, which were further delayed in subsequent legislation, including most recently in legislation passed in December 2021.⁴⁴ Such reductions are currently slated to be fully reinstated on July 1, 2022. The eventual return of Medicare sequestration is a point of ongoing concern for rural providers. According to one rural stakeholder, "If sequestration reductions go back into effect, this will undoubtedly result in increased budget pressures and directly impact rural hospitals' ability to recruit and retain rural health staff."⁴⁵

Unrelated to temporary relief during the public health emergency, the Medicaid program has played a critical role in stabilizing access to rural health care, particularly among CAHs. Under current law, rural hospitals are eligible to receive Medicaid supplemental payments. To qualify, a hospital must be designated as a Disproportionate Share Hospital (DSH), meaning it must have a Medicaid inpatient utilization rate of at least 1%.⁴⁶ These funds can be an important source of revenue for small rural hospitals. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), CAHs received \$370 million in Medicaid DSH payments in 2016.⁴⁷

At the same time, gains in health care coverage, including through expansions of Medicaid, have generally improved the financial viability of rural health care providers. One study found that Medicaid expansion in certain rural states has been associated with improved hospital financial performance and lower likelihood of closure, particularly in rural areas that had many uninsured adults before Medicaid expansion.^{48,49}

According to MACPAC, rural areas in states that expanded Medicaid to additional low-income adults, as authorized under the Patient Protection and

Affordable Care Act (PPACA, P.L. 111-148, as amended), experienced larger gains in coverage than those in non-expansion states. In particular, the Medicaid coverage rate among rural expansion states increased from 21% to 26% between 2013 and 2015, while non-expansion states experienced a smaller increase in Medicaid coverage from 20% to 21%. Also, during this same period, the uninsured rate in rural areas within expansion states fell from 16% to 9%.^{50,51}

A Montana Hospital Association executive commented, “When you look at where we are in terms of financial stability—with 49 CAHs in the state, very low net patient revenue that results in 50% of facilities bringing in less than \$10 million in annual revenue—what has sustained these hospitals is Medicaid supplemental payments and recent Medicaid expansions.”⁵²

The rapid transition to virtual care during the pandemic also played a significant role in sustaining access to clinical services. Telehealth was a crucial tool for keeping access to care available and revenue streams viable for many fee-for-service providers. Nearly half (43.5%) of Medicare primary care visits were provided via telehealth in April 2020, compared with less than 1% before the pandemic.⁵³ Specialties such as psychiatry, endocrinology, and neurology had the greatest uptake of telemedicine and experienced the smallest decline of total visits.⁵⁴

PERSISTING CHALLENGES FOR RURAL PROVIDERS

While the above policies helped sustain access to rural health care services during the pandemic, stakeholders report ongoing financial strain among rural health providers and increased workforce shortages. The stakeholders interviewed project that the same rural hospitals that struggled before the public health crisis will again be vulnerable when federal relief ends and workforce shortages persist. They also noted that the smallest critical access hospitals could be particularly at risk for closure or needing to downsize.

Among the rural hospitals that BPC reviewed for this report, each state reported negative total operating margins over three years for at least some hospitals, according to the most recently available cost report data. Total operating margins are calculated based on an individual facility’s total revenues and expenses associated with both patient care and non-patient care. The percentage of hospitals experiencing at least three consecutive years of negative total operating margins ranged from 6% in Nevada up to a high of 38% in Wyoming.⁵⁵

Regarding revenues and costs related to patient care, an even greater number of rural hospitals experienced ongoing financial losses. Among the states BPC studied, 50% of Iowa’s 115 acute care hospitals suffered financial losses related

Stakeholders interviewed project that the same rural hospitals that struggled before the public health crisis will again be vulnerable when the federal relief ends and workforce shortages persist.

to patient services over a three-year period.⁵⁶ At the same time, all the states studied had at least some hospitals with current and long-term liabilities exceeding current assets from 2017 to 2020.

Taken together, this signals that a noteworthy number of rural hospitals continue to experience financial stress. BPC assessed rural hospital financial vulnerability across multiple domains and found that 441 hospitals face 3 or more concurrent financial

risk factors, putting them at risk of service reductions or closure. BPC's analysis included the following financial risk factors: negative total operating margin, negative operating margin on patient services alone, negative current net assets, and negative total net assets (For additional data on the financial health of rural hospitals nationally and among key states, see Appendix B). Other analyses of the financial vulnerability of rural hospitals have shown additional predictors of hospital closure, including case mix, system affiliation, and state-level Medicaid expansion status.⁵⁷

A Minnesota hospital association representative said, "Financial fragility is the continued buzzword among rural hospitals in the state...[These hospitals] had a median operating margin of 1.4% in 2019 with about 30 hospitals reporting negative operating margins. Most facilities with negative margins were CAHs, which tend to have an average daily census of one to two patients. This is simply unsustainable."⁵⁸

A hospital association representative from Wyoming stated that "financial health is always a challenge." All but two of the state's 28 hospitals are classified as rural. The state is considered frontier, with most hospitals a 60- to 90-minute drive apart. In most cases, Wyoming's CAHs have a 1% to 2% operating margin. "Federal dollars have helped," the state reported, "but some rural facilities continue to sustain financial losses even amidst the federal relief."⁵⁹

As noted above, federal aid for health care providers during the pandemic helped offset financial losses, including through the PRF that was authorized in the CARES Act and additional rural payments as authorized by the American Rescue Plan legislation. To date, \$178 billion in federal dollars has been allocated via the PRF program to help eligible health care providers address the coronavirus crisis, including to reimburse health care entities for lost revenue resulting from the pandemic.⁶⁰ Of this amount, roughly \$11 billion has been distributed to rural providers through a targeted rural distribution. Another

\$8.5 billion in American Rescue Plan relief funding has been authorized for rural providers,⁶¹ of which roughly \$7.4 billion has been distributed to rural health providers to-date.⁶²

Although these programs provided critical, near-term financial relief and stability to rural providers, they posed a series of challenges for rural health care systems. Rural health care stakeholders consistently reported significant administrative challenges and burdens associated with receiving these funds, including an ongoing lack of clear federal guidance on allowable use of the funds or on timeframes in which the funding must be spent or returned to the government. The lack of clarity resulted in some rural health care providers returning unspent funds to the government out of concern about allowable uses or failing to apply for funds for which they were eligible because of administrative complexity.

Rural stakeholders also reported ongoing challenges surrounding capital infrastructure improvements and investments. As discussed later in the report, rural hospitals—including those considering converting to the REH model—reported a need to modernize and update aging physical infrastructure, including improving readiness for public health or natural disasters.

Finally, and perhaps most notably, rural stakeholders reported significant challenges surrounding health care staffing. Before the pandemic, rural communities experienced persistent workforce shortages, particularly among primary care doctors and specialists. The pandemic exacerbated these challenges and resulted in rural hospitals cutting back on services because of inadequate staffing levels.⁶³ Now, rural hospitals are also experiencing shortages of nurses and other non-physician staff.



Policy Recommendations

1. PROVIDE IMMEDIATE STABILIZATION FOR RURAL HOSPITALS, RHCS, AND FQHCS

Recognizing the ongoing financial challenges facing rural health systems as they continue to navigate the COVID-19 pandemic, BPC recommends that policymakers consider a set of proposals to immediately strengthen and stabilize access to care.

Outlined below are policies that are short term in nature and are intended to provide a bridge as rural providers exit the public health crisis and move to longer-term rural health care delivery reforms. These proposals build on current rural payment structures; the overarching goal is to strengthen financial viability and improve flexibility around care delivery to rural facilities. Some of these proposals appeared in previous BPC work and continue to hold promise for strengthening and stabilizing access to critical rural health care services.

PROVIDE IMMEDIATE STABILIZATION FOR RURAL HEALTH SYSTEMS

TO PROVIDE IMMEDIATE STABILIZATION, CONGRESS OR THE SECRETARY OF HHS SHOULD:

- Provide full relief to rural hospitals from Medicare sequestration payment reductions until two years after the Public Health Emergency (PHE) ends.
- Increase reimbursement for Medicare CAH services by 3% starting in FY2023.
- Re-establish the CAH “necessary provider” designation process.
- Allow additional flexibility in CAH eligibility criteria.
- Update the Medicare base payment rate for SCHs and MDHs to ensure that reimbursement reflects current costs.
- Make available capital infrastructure grants or loans that rural hospitals can use to modify services lines or improve structural or patient safety.

The Budget Control Act of 2011 (P.L. 112-25) established Medicare sequestration.⁶⁴ This legislation required a 2% payment reduction for Medicare fee-for-service discharges, as well as CAH discharges, beginning April 1, 2013. Congress placed the sequestration policy on hold during the COVID-19 pandemic to ensure health care providers maintained adequate resources and to ensure continued patient access to care during the public health emergency.⁶⁵ On December 12, 2021, President Biden signed legislation (S. 610) that extended the moratorium on Medicare sequestration through March 31, 2022.⁶⁶ But the new law permitted a 1% Medicare sequestration reduction from April 1, 2022, through June 30, 2022. After this date, the full 2% Medicare sequestration payment reduction is slated to go back into effect through 2031.

Rural hospital executives have expressed concern that reimposing Medicare sequestration reductions while the PHE continues will add to the financial strain many are experiencing. To place rural hospitals on a stronger fiscal footing, BPC recommends that Congress halt Medicare sequestration until two years after the end of the public health emergency. To put this in context, the impact of sequestration, as well as other Medicare payment reductions, have contributed to rural hospitals having a Medicare financial operating margin that ranged from roughly -2.5% to roughly -6% in 2019; if alleviated, this could allow rural hospitals to strengthen their finances as health systems emerge from the pandemic.⁶⁷

In line with previous recommendations from BPC's Rural Health Task Force, Congress should increase reimbursement for Medicare CAH services by 3% starting in FY2023. Under current law, CAHs are paid 101% of reasonable costs under Medicare. This proposal would increase CAH reimbursement by an additional 3% to allow CAHs to have a net reimbursement of 104% of cost. This increase would help ensure ongoing hospital solvency and financial stability.

Before 2006, states had the flexibility to allow small rural hospitals that were otherwise ineligible for CAH status to apply for the CAH program through a "necessary provider" designation process.⁶⁸ This proposal would direct the secretary of HHS to re-establish that designation process.

Such proposals would allow eligible rural hospitals to begin receiving Medicare cost-based reimbursement. They would also require hospitals to downsize (25 inpatient beds or fewer, or a total of 25 inpatient plus swing beds) as a condition of converting to a CAH. A swing bed is a hospital bed that can be used for either acute hospital or skilled nursing facility level care.

In addition, the Rural Hospital Closure Relief Act of 2021 (S. 644/H.R. 1639) would allow rural hospitals that meet certain criteria to convert to the CAH program.⁶⁹ Under this legislation, hospitals that serve health professional shortage areas or a high number of low-income individuals and have had financial losses for two consecutive years would be eligible to apply to the CAH program. In making such an application, the facility would be required to have a plan in place to address financial solvency. BPC recommends that Congress consider such a proposal or a similar policy that would allow struggling rural hospitals the option to downsize and remain open.

These proposals would allow struggling, larger rural hospitals to transition to a smaller, CAH model that would ensure continued access to inpatient and other hospital care in the local community.

Medicare currently reimburses MDHs and SCHs based on the greater of the rate an individual hospital would receive through the Medicare inpatient hospital prospective payment system (the "IPPS rate"), or a blended rate based on a statutorily defined base rate year. The MDH and SCH base rate years used in the reimbursement formula have not been updated in more than a decade: The SCH base rate year was last updated in 2002 and the MDH in 2006.

To ensure the continued financial viability of SCHs and MDHs, Congress should revise the statutory base rate year for these critical health care facilities to the most recent year for which data are available. This change would ensure that the base rates used to reimburse these facilities for critical services more accurately reflect current costs. Similar legislation, the "Rural Hospital Support Act (H.R. 1887/S. 4009)", was introduced by Representative Tom Reed (R-NY-23) and Senators Chuck Grassley (R-IA) and Bob Casey (D-PA) in the 117th Congress.

To further strengthen rural facilities, the proposal would direct the secretary of HHS to make capital infrastructure grants or loans available to rural hospitals that they could use to modify service lines or improve structural or patient safety. At the secretary's discretion, the funding would be made available only to those facilities that otherwise do not qualify for funding under other rural health capital infrastructure programs, such as the U.S. Department of Agriculture's Community Facilities Direct Loan and Grant Program.⁷⁰

Legislation pending in Congress aim to provide additional capital infrastructure resources to small rural hospitals. One proposal, for example, would provide \$10 billion in FY2022 to update hospital infrastructure. This money could also improve natural disaster emergency preparedness and strengthen cybersecurity capabilities, among other uses.⁷¹

BPC recommends policymakers make rural providers that have experienced low operating or patient revenue financial margins over consecutive years a particular priority.

MAKE CERTAIN RURAL HOSPITAL DESIGNATIONS OR PAYMENT ADJUSTMENTS PERMANENT

TO IMPROVE RURAL HOSPITALS' FINANCIAL STABILITY, CONGRESS SHOULD:

- Take rural facilities out of the ongoing "extender" and "needing to be renewed" policy cycle.
- Make the MDH designation permanent.
- Make permanent adjustments for rural hospitals receiving low-volume payments.
- Allow SCHs to permanently receive additional payment for outpatient services.

For many of the rural hospital designations or programs (e.g., MDH, SCH, low-volume payment adjustments), Congress must reauthorize or renew certain aspects of their Medicare reimbursement or their entire rural designation every few years. This lack of certainty has contributed to rural hospitals' financial instability.

This proposal would take rural facilities out of the ongoing "extender" and "needing to be renewed" cycle by offering payment and designation stability to rural hospitals, until which time they may decide to transition to a new payment or delivery model.

Under current law, the MDH designation is slated to expire at the end of FY2022.⁷² Under the proposal, MDHs would be required to continue meeting current eligibility rules to maintain the designation, including requiring the hospital to be in a rural area, have 100 inpatient beds or fewer, and have a patient caseload of at least 60% of Medicare patients. According to MedPAC, the cost of maintaining the MDH designation is roughly \$100 million per year above what facilities would receive if they were otherwise subject to and reimbursed under the traditional Medicare inpatient prospective payment system.⁷³ The most recent reauthorization of the MDH program cost roughly \$865 million in Medicare spending over five years.⁷⁴

Under current law, low-volume hospitals receive a sliding scale, low-volume payment adjustment starting at 25% for fewest discharges down to 0% for those with 3,800 or more annual patient discharges. Prior to the Balanced Budget Act of 2019 (P.L. 115-123), the low-volume adjustment was capped at 1,600 patient discharges per year. When the low-volume payment adjustments were capped at 3,800 annual patient discharges, the cost of the low-volume payment adjustments cost roughly \$1.7 billion over five years.⁷⁵ These adjustments have helped stabilize rural hospitals with low-patient volumes but are set to expire at the end of FY2022. BPC recommends allowing rural hospitals receiving low-volume payment adjustments to permanently receive these adjustments, with secretarial discretion to determine the appropriate annual patient discharge threshold and related adjustment that would ensure access to care.

BPC also recommends allowing SCHs to permanently receive additional payment (7.1%) for outpatient services. This payment adjustment was authorized pursuant to a congressionally authorized study, which found that rural SCHs experience substantially higher costs.⁷⁶ Making this adjustment permanent would provide financial stability and is in line with broader policies to support the delivery of outpatient care in rural communities.

ENSURE CONTINUED ACCESS TO CARE AT RURAL HEALTH CLINICS

BUILDING OFF RECENT PAYMENT REFORMS FOR RHCS, HHS AND CONGRESS SHOULD:

- Monitor and evaluate the impact of the recently established uniform payment rate for independent and hospital-owned RHCs to ensure continued patient access to critical RHC services.

In previous work, BPC highlighted closures of RHCs that were occurring among primarily independent, physician-owned RHCs. A key driver of these closures was a disparity in reimbursement between lower-paid independent RHCs and

their higher paid, hospital-owned RHC counterparts. Specifically, independent, physician-owned RHCs received capped Medicare payments at a rate of \$86.31 per visit;⁷⁷ hospital-owned RHCs by contrast received an average uncapped rate of \$206 per visit in 2020.⁷⁸ To qualify for the hospital-owned rate, an RHC must be attached to a hospital with fewer than 50 beds.

Physician-owned RHCs play an important role in medically underserved communities by offering patients access to primary care and preventive services that may otherwise be unavailable. The clinics also help attract physicians, physician assistants, nurse practitioners, and other providers who otherwise may not be in a geographically isolated area and who become even more critical in communities that lose their rural hospital.

Recognizing the importance of maintaining access to physician-owned RHCs, Congress passed legislation in 2020 to reform the RHC payment structure.⁷⁹ This legislation established a uniform payment rate that will apply to all RHCs, except for certain grandfathered clinics. The rate is \$100 per visit starting in 2021 and steadily rises each year to \$190 per visit by 2028. After this date, the rate would be adjusted in line with medical inflation. This legislation provided additional resources to independent RHCs, while also limiting cost growth across the program in future years. The new law is in line with BPC's previous recommendations related to RHC reimbursement. As the RHC payment changes are implemented, BPC encourages the secretary and Congress to monitor and evaluate how these reforms affect clinics' financial viability and patient access to these critical health care providers. In particular, BPC urges the secretary and Congress to ensure the reforms do not result in RHCs cutting back on critical clinical services or in RHC closures in underserved communities.



2. STRENGTHEN THE RURAL EMERGENCY HOSPITAL MODEL AND ADVANCE OTHER RURAL CARE DELIVERY TRANSFORMATIONS

Recognizing that transformation of rural health care delivery must be carefully considered and will take time, the proposals in the previous section offer immediate solutions to mitigate the likelihood of future rural hospital and clinic closures. At the same time, stakeholders and rural policy experts suggest an ongoing need for new rural health care delivery models and programs that are better tailored to the care needs of rural populations now and into the future.

Policymakers have taken steps to create rural care delivery and reimbursement programs that offer health care providers the opportunity to transform into new and sustainable models that better fit their community's needs. Two such examples are the recent establishment of the REH model and the Community Health Access and Rural Transformation (CHART) model.

As described earlier, a host of special designations exist in the Medicare program that are tailored toward rural health care delivery and are intended to bolster rural hospitals by providing additional financial protection from low patient volumes and tight financial margins. These programs or designations have allowed certain hospitals to receive tailored reimbursement under Medicare, if they meet criteria related to geographic location, the number of inpatient beds, and distance to other hospitals, among other items. (See Appendix A for a full description of these designations.)

Although the special rural designations have helped maintain access to hospital care, the need for new and updated rural care delivery and reimbursement models, programs and policies that better align with the needs of rural populations is critical.

RURAL EMERGENCY HOSPITAL MODEL

Congress established a new Medicare provider designation, REH, as part of the Consolidated Appropriations Act of 2021 (CAA, P.L. 116-260). The REH model, which becomes available to rural hospitals in 2023, represents the first time a new rural hospital designation has been added to Medicare since the establishment of the Critical Access Hospital program in 1997.⁸⁰ The REH program has the potential to be a valuable tool as struggling rural hospitals adopt new care delivery and reimbursement models. However, to ensure that hospitals adopt the REH model, important adjustments will be needed.

The Consolidated Appropriations Act of 2021 sets forth specific criteria regarding which types of hospitals are eligible to convert to an REH and what services REHs will be required or allowed to offer. It also established the Medicare reimbursement structure for the program.

Eligibility Criteria: To become an REH, a provider must at the date of enactment of the CAA (December 7, 2020) either already be a CAH or a rural subsection(d) hospital (as defined in section 1886 (d)(1)(B)) with not more than 50 beds.⁸¹

In addition, to become an REH a provider must:

- Be enrolled in the Medicare program on or after January 1, 2023.
- Not provide any acute care inpatient services (other than post-hospital extended care services furnished in a distinct part unit licensed as a skilled nursing facility).
- Have a transfer agreement in effect with a level I or level II trauma center.
- Meet certain licensure requirements and certain emergency department staffing requirements.
- Adhere to staff training and certifications requirements established by the HHS secretary.
- Meet certain conditions of participation (CoP) applicable to hospital emergency departments.

Service Offerings: REHs *must* provide emergency department services and *may* provide observation services, at the election of the REH. REHs *may* also provide other medical and health services on an outpatient basis. However, the secretary has not yet specified which medical or health services (beyond those already covered in the Medicare hospital outpatient prospective payment system) will be allowed in the REH program.

Reimbursement Structure: Hospitals that meet the above criteria and successfully convert to a rural emergency hospital will receive Medicare reimbursement as well as an additional facility payment.

Specifically, starting on January 1, 2023, an REH that provides rural emergency hospital services (as defined in section 1861 (kkk)(1) of the Social Security Act) will receive enhanced Medicare reimbursement. Such enhanced reimbursement will equal the Medicare outpatient prospective payment system rate (as set forth in 1843 (x)(1) of such Act) plus an additional 5%.

REHs will also receive an additional facility payment as set forth in section 1834 (x)(2) of the CAA. REHs will be required to maintain detailed information regarding how the additional facility payments are used.

PROJECTIONS OF RURAL HOSPITAL PARTICIPATION IN THE REH MODEL

Projections of uptake of the new model are mixed, with those hospitals considering the change having recurring negative operating margins and few inpatient beds filled.

As the REH program undergoes design and implementation, several state executives interviewed for this report indicated some level of interest in participation. They suggested that hospitals within their borders were very interested in the REH model, while a smaller number of states indicated interest

was minimal, with perhaps only a few or no hospitals actively considering participation. Many rural stakeholders also commented that states may reconsider REH participation after the COVID-19 pandemic subsidies and health care leaders have additional resources to further evaluate the program.

One [study](#) conducted by the North Carolina Rural Health Research Program provides useful insights into the number and types of rural hospitals that may consider converting to an REH in the coming years. This study posited that hospitals with the following characteristics may be more likely to

“Forthcoming CMS rulemaking and guidance about the requirements for operating as an REH will be critical determinants of uptake and long-term viability of the model.”

GEORGE H. PINK, PH.D.

transition to an REH structure: 1) three years of negative total operating margin; 2) average daily census of fewer than three patients; and 3) net annual patient revenue of less than \$20 million.⁸²

Based on these factors, the researchers projected that 68 rural hospitals would consider converting to the REH model while 1,605 would not. In line with REH eligibility criteria, all hospitals examined in the study were rural hospitals with 50 beds or fewer. The hospitals most likely to convert were government-owned or CAHs and almost half were in four states—Kansas, Texas, Nebraska, and Oklahoma. In addition, hospitals predicted to convert to REHs were in counties with higher median percentages of unemployed individuals and in areas with lower population density.⁸³

Lead author of this research, George H. Pink, Ph.D., noted: “REH could be an important step for preserving access to emergency and outpatient services in rural areas, particularly in communities that face the risk of rural hospital closures. Forthcoming CMS rulemaking and guidance about the requirements for operating as an REH will be critical determinants of uptake and long-term viability of the model. It will be important for CMS to engage with interested hospitals to ensure that the REH regulations and guidance facilitate adoption and implementation of REHs to serve the healthcare needs of rural communities.”

CONSIDERATIONS AND POTENTIAL IMPROVEMENTS TO THE REH MODEL

BPC has received extensive feedback from rural stakeholders about the areas of the REH model that hold promise and areas that require further refinement or additional consideration. Although not every community or hospital will benefit from the REH structure, refinements to the model would likely result in a higher participation rate.

One primary area of interest among stakeholders relates to how the new, additional facility payment (AFP) will be structured. Such payments will be made available to REH participants to cover services and supports beyond the typical Medicare reimbursement structure. However, stakeholders are concerned that the additional facility payment may be set too low or be too restrictive in its allowable use to prove useful to REHs, which could in turn discourage participation in the model. Among issues that will affect the success of the REH model, stakeholders raised a series of questions related to the role of Medicaid in the REH model and the need for technical support as hospitals evaluate and transition to an REH structure.

Against this backdrop, BPC urges the HHS secretary and policymakers to consider the recommendations described below.

ENSURE ADEQUATE FUNDING LEVELS AND ALLOW FLEXIBLE USE OF ADDITIONAL FACILITY PAYMENTS

TO ENSURE ADEQUATE FUNDING AND FLEXIBLE USE OF PAYMENTS, HHS AND CONGRESS SHOULD:

- Evaluate to what extent higher funding levels or phased-in funding for the AFP would more effectively incentivize rural hospitals' conversion to the REH model than the currently established level.
- Provide REHs the flexibility to use new AFPs to offer extra medical and social support services.

Rural stakeholders identified several factors that would impact a hospital's decision on whether to adopt the REH model. Chief among them is how REHs will be reimbursed within the new model, particularly regarding the structure of the additional facility payment. In BPC's conversations, rural stakeholders indicated that the AFP amount and its allowable uses will be a key variable in whether the REH model is financially viable over the long term.

According to HHS, the additional facility payment will be based on the excess (if any) of the total amount that was paid to all CAHs in 2019 over the estimated total amount that would have been paid to all CAHs if they had been reimbursed under the prospective payment system. This excess amount is divided by the total number of CAHs in 2019. After calendar year 2023, the additional facility payment will be modified by the annual hospital market basket adjustment that takes into account changes in prices; REHs will receive the additional facility payment in 12 monthly installments.⁸⁴

According to some rural researchers, the AFP may total \$750,000 to \$2.2 million annually per REH facility.⁸⁵ Rural policy experts and stakeholders

have suggested that this funding level may be too low of an incentive to drive participation in the model, or may not go far enough to financially sustain struggling rural hospitals.⁸⁶ Given this feedback, BPC urges policymakers to further evaluate the additional facility payment and whether higher funding levels would be a more effective incentive. As part of this analysis, policymakers might also consider whether phasing in the additional facility payment—with perhaps a higher

The additional facility payment may be set too low or be too restrictive in its allowable use to prove useful to REHs, which could in turn discourage participation in the model.

payment level in the early years and then gradually cutting back to a more moderate amount as REHs become established and financially stable—would be a workable construct for REH providers.

In addition, rural stakeholders strongly emphasized the importance of avoiding a one-size-fits-all approach so that rural hospitals can tailor the additional facility payment to best meet the health care needs of their community.

To date, the HHS secretary has not yet specified what services will be allowable for reimbursement under the AFP. Stakeholders recommended that rural emergency hospitals be given the flexibility to use the AFP to provide additional critical services. BPC agrees with this advice and recommends allowing rural emergency hospitals to use additional payments to cover a range of services, such as wellness and preventive care; mental health, substance use and opioid use disorder services; oral health services; and end-stage renal disease care. Stakeholders also suggested funds be used to offer social supports, such as transportation, including for maternal care services, and for food or housing assistance. BPC again agrees and urges the secretary to permit flexibility in how the additional flexibility payment is used.

Allowing flexible uses of the additional facility payment may be particularly helpful in providing rural hospitals a new tool to support historically underserved populations. Currently, one in five rural residents identifies as Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or a combination of ethnic backgrounds.⁸⁷ Allowing REHs to offer a flexible range of health care and social support services will strengthen access to care for all rural residents, including minority populations who often experience poorer health outcomes.⁸⁸

CONSIDER ALTERNATIVE PAYMENT PATHWAYS FOR REHS AND EVALUATE THE REH REIMBURSEMENT STRUCTURE ON AN ONGOING BASIS

TO ENSURE ADEQUATE FUNDING FOR REHS, CONGRESS AND HHS SHOULD:

- Allow or test alternative payment pathways for eligible REHs to increase program participation and access to care for rural residents.
- Evaluate the REH reimbursement structure on an ongoing basis to ensure it can support sustained transformation among rural hospitals, particularly in communities that are most at risk of losing all hospital services if the local facility closes.

As described above, eligible REH facilities will be reimbursed an amount equivalent to the Medicare outpatient prospective payment system (OPPS) rate, plus an additional 5% (an enhanced OPPS payment) for applicable REH services. This payment would be separate from the flexible, additional facility payment (a fixed payment) referenced above.

Allowing REHs to receive an OPPS payment that is increased by a set percentage is in line with BPC's previous recommendations on how to create an appropriate payment structure for rural emergency hospitals.

At the same time, BPC urges the HHS secretary to consider allowing—or at minimum testing—other payment pathways for eligible REH facilities. Throughout the course of BPC's rural projects, stakeholders consistently suggested that for hospital transformation to succeed, rural communities and facilities must be offered flexible and varying payment options and reimbursement structures.

As another payment pathway, BPC recommends that the secretary consider offering REHs the option to receive the enhanced OPPS, plus a PMPM payment based on the number of anticipated patients in an expected catchment area. This is another version of a fixed payment; however, the payment would be tied more closely to the number of patients projected to be treated by a given REH. In addition, the secretary may wish to consider whether a cost-based reimbursement option—akin to how CAHs are currently paid—would be an appropriate payment option for REHs or appropriate for certain services provided at REH facilities.

BPC also encourages the secretary to continue testing global payment models that combine funding from all payers. As such global payment models are tested or permanently established, REHs—either solo or in partnership with other rural facilities in their community or state—should be allowed to participate in these models and to take advantage of whatever payment structure and care flexibilities are set forth.

DETERMINE THE ROLE OF MEDICAID

TO MAXIMIZE THE MODEL'S EFFECTIVENESS, HHS SHOULD:

- Clarify whether REHs would be eligible to receive Medicaid DSH supplemental payments and assess whether losing access to such payments would pose a barrier for struggling rural hospitals to transform to an REH.
- Evaluate the role Medicaid reimbursement will play in the REH program.

Another reimbursement issue that has emerged is the potential role of Medicaid payments for REHs. To date, the secretary of HHS has not released guidance regarding the treatment of REHs within the Medicaid program.

For other rural hospitals, such as CAHs, Medicaid is a foundational source of revenue given the number of rural residents who participate in the program. Indeed, Medicaid covers nearly a quarter of individuals under age 65 who live in rural areas, as well as 21% of people who are dually eligible for Medicare and Medicaid live in rural areas.^{89,90} Recognizing that rural hospitals are an important source of health care services, many rural states have established targeted payment policies for critical access and rural hospitals, including Medicaid supplemental payments.

One prevalent payment type is Medicaid's payments to DSHs. DSH payments support uncompensated care costs for hospitals serving Medicaid and uninsured patients. According to MACPAC, Medicaid DSH payments to critical access hospitals totaled \$370 million in 2016.⁹¹ Under current law, CAHs must have a Medicaid inpatient utilization rate of at least 1% to qualify to receive DSH payments.⁹²

As hospitals transform to the REH model, BPC urges the secretary of HHS to clarify whether REHs would be eligible to receive Medicaid DSH payments, given that the REH model does not allow for the provision of inpatient care. BPC also urges the secretary to assess whether losing access to these payments would pose a barrier for rural hospitals that are considering transforming to an REH. Further, BPC encourages the secretary to broadly evaluate the role Medicaid could play in the REH model, including whether policy changes are needed to ensure Medicaid and dual eligible beneficiaries in rural areas maintain access to care.

ADDRESS THE NEED FOR ADDITIONAL CAPITAL INFRASTRUCTURE INVESTMENTS AND TECHNICAL ASSISTANCE AND SUPPORT

TO ENSURE APPROPRIATE INVESTMENTS IN CAPITAL INFRASTRUCTURE AND TECHNICAL ASSISTANCE, CONGRESS AND HHS SHOULD:

- Ensure REHs are eligible for capital infrastructure funding to update rural facilities as necessary to support REH transformation and ensure safe and high-quality care.
- Make available ongoing technical assistance to support hospitals in transitioning to an REH and to support ongoing REH operations.

Beyond the financial and reimbursement issues, rural stakeholders and policy experts have identified the need to support capital infrastructure improvements at, and provide technical assistance for, those hospitals transitioning to the REH model.

A primary consideration cited by many stakeholders is whether potential REH applicants will need to modify, modernize, or construct completely new facilities. One study found that most rural hospital buildings range from 9.5 to 12.4 years of age;⁹³ but some rural stakeholders we interviewed said that the hospitals most likely to convert were much older and require significant financial investments to modernize. Even for those facilities that are newer, most stakeholders suggested that shifting to the REH model would still entail considerable facility renovations and improvements.

As referenced earlier, congressional legislation aims to provide capital infrastructure resources targeted to small rural hospitals. Examples of these proposals include legislation targeted toward struggling rural hospitals and those serving underserved areas and would provide \$17 billion in FY2022 in the form of grants and loans.⁹⁴ Other legislation would provide \$10 billion in FY2022 to update hospital infrastructure. Among other uses, this funding could update and renovate facilities to improve public health and natural disaster emergency preparedness.

As Congress and policymakers consider capital infrastructure funding, BPC urges lawmakers to ensure rural hospitals are eligible for such funding, including hospitals that are applying to the REH program or are currently enrolled in such a program. This funding would provide critical resources to ensure rural hospitals, including REHs, can provide high-quality care.

In BPC's stakeholder conversations, the issue of providing technical assistance and support to rural hospitals was cited often. As was noted by the National Advisory Committee on Rural Health and Human Services and the Rural Policy Research Institute,⁹⁵ among others, when the Critical Access Hospital program was created, Congress also created the Medicare Rural Hospital Flexibility program (or "Flex" program).⁹⁶ This HRSA-administered program provides funding that states use to support communities in the process of converting rural hospitals to CAHs. The Flex program also provides ongoing support to CAHs on efforts to improve quality and performance.

The law that established the REH did not create a similar Flex program to support hospitals transforming to the new model. However, the Consolidated Appropriations Act of 2022 (P.L. 117-103) provided \$5 million in FY2022 to establish a Rural Emergency Hospital (REH) technical assistance program within the Flex program.⁹⁷ BPC recommends the REH technical assistance program be funded beyond the current fiscal year to ensure communities have the necessary resources to support hospitals as they evaluate whether to transition to an REH and as they develop the necessary application materials.

Once a hospital converts to an REH, BPC recommends that technical assistance funds be deployed to support REHs in quality measurement and improvement efforts and also to support REH collaborations with other community health and social service providers.

In addition, the Consolidated Appropriations Act of 2022 gave \$2 million to the U.S. Department of Agriculture to establish a technical assistance-related pilot program for rural hospitals.⁹⁸ Specifically, the funding may be used to help rural hospitals analyze how to improve long-term operations and financial health. This program may also prove to be a resource to rural facilities as they evaluate whether to transform to an REH model.

ENSURE CONTINUED ACCESS TO INPATIENT HOSPITAL CARE AND ALLOW COMMUNITIES TO MAXIMIZE LOCAL INFRASTRUCTURE AND THE WORKFORCE

TO ENSURE ACCESS TO CARE AND EFFICIENT USE OF LOCAL RESOURCES, CONGRESS AND THE ADMINISTRATION SHOULD:

- Allow REHs to have a minimal number of inpatient beds or a specified number of enhanced observation beds in communities with little or no access to inpatient care.
- Expand REH eligibility to allow CAHs or rural hospitals that closed within the past five years but otherwise meet the REH criterion.
- Allow establishment of REHs in areas that previously lacked a rural or critical access hospital, if establishment of such a facility could improve access to health care in the community.
- Establish guidance on how REHs can transform back to another hospital model if the REH model is no longer financially viable or appropriate in the community.
- Allow REHs to establish visiting provider programs to ensure adequate access to critical health care workers.
- Permit co-location of services to increase access to additional clinical and service offerings.
- Expand eligibility for the National Health Service Corps, the Nurse Corps, and other loan-repayment programs to REHs to help address rural workforce needs.
- Consider increased funding for HRSA scholarship and loan repayment programs.

Stakeholders expressed concern about communities' ability to ensure continued access to necessary hospital inpatient services, particularly in underserved or isolated rural communities. As enacted, the REH program does not allow for the provision of any inpatient hospital services. (One exception: post-hospital extended case services furnished in a distinct unit licensed as a skilled nursing facility.) Rural stakeholders and the Rural Health Task Force that BPC convened to inform BPC's 2020 report vigorously debated whether to allow rural emergency hospitals to offer any level of inpatient care.

Ultimately, the task force recommended allowing rural emergency hospitals to offer limited, acute inpatient care—with a 10-bed maximum—if a community needs assessment determined that such services were necessary to ensure adequate access to care and if such services were not available within a certain geographic distance, such as 35 miles. Although the REH program was established to provide a new health care delivery model for facilities that can no longer afford to maintain inpatient care, BPC continues to recommend that the secretary or Congress consider allowing REHs to have a minimal number of inpatient beds—or perhaps a certain number of enhanced observation beds—in situations where a community would otherwise have little or no access to inpatient care. Such flexibility would ensure that rural communities maintain some level of inpatient care, particularly in cases where a community needs assessment demonstrates ongoing access to this care is critical to meet the health care needs of residents.

Another issue that has come to the forefront is how to best repurpose health care facilities that may have closed before the REH program was enacted.

To participate in the REH program, the CAA legislation requires an applicant to either be designated as a CAH or a rural subsection (d) hospital with not more than 50 beds, as of the date of enactment of the CAA legislation (December 27, 2020). BPC recommends that eligibility be expanded to allow CAHs or rural hospitals that meet this criterion, but have closed within the last five years, to participate in the REH program. Allowing recently closed rural facilities—where the physical and perhaps staffing infrastructure may still exist to some extent in the community—to participate would be a wise use of resources that could allow rural communities to convert a shuttered building to a new REH facility. This may allow rural communities to avoid allocating scarce resources to construct a facility and may make it easier to recruit health care staff who may still reside near the previous hospital.

In addition, the secretary of HHS should consider allowing the establishment of REHs in rural communities where a hospital does not otherwise exist, particularly in cases where a community needs assessment demonstrates that establishment of such a facility could improve access to health care.

Some stakeholders also highlighted the importance of allowing facilities that transform to an REH to revert back to a CAH or a prospective payment system facility, if a hospital determines that the REH model is not financially sustainable or if the community requires additional services beyond what the REH is able to provide.⁹⁹ This flexibility is allowed in the REH model and will ensure health care systems are not locked into a structure that is unworkable for the hospital or broader community. As HHS implements the REH model, BPC urges the secretary to establish workable guidance on how REHs can transform back to another hospital designation, when necessary.

For those entities in the REH program, BPC urges CMS to allow participants to establish visiting provider programs to ensure they have adequate access to critically needed workers. In rural areas, these arrangements can play a key role in augmenting access to certain services, such as physician specialty care, that may otherwise be unavailable. Such arrangements could include visiting physician services, time-sharing arrangements, or physician leasing agreements, among other constructs. As policymakers further refine the REH program, BPC recommends that the secretary of HHS provide clear guidance on whether such visiting provider programs are allowed and can offer the broadest range of services deemed appropriate by the secretary. Such guidance should also allow providers to share physical space within the REH, as appropriate.

BPC agrees with recommendations by the National Advisory Committee on Rural Health and Human Services allowing flexible staffing arrangements across various REH clinical areas. As noted in the advisory committee report, the REH model presents an opportunity for the secretary to promote the establishment of co-location of services within rural communities.¹⁰⁰ This could include joint sites consisting of REHs and rural health clinic services, skilled nursing facility services within the REH, dialysis clinics, and other health care services.

Additionally, HRSA should expand eligibility for the NHSC, the Nurse Corps, and other loan repayment programs to REHs. These federal programs place providers in underserved areas in exchange for scholarships and loan forgiveness. While adding facilities raises concerns of increased competition among providers, REHs provide critical care and likely outpatient services in vulnerable rural communities.¹⁰¹ HRSA [reports](#) that while approximately 60% of HPSAs are considered rural, only 36% of NHSC providers serve in rural areas. Congress should consider additional funding to expand the number of loan repayment agreements and scholarship awards available for eligible individuals working in rural HPSAs.

ENSURE QUALITY RURAL HOSPITAL CARE AND THAT NEW RURAL MODELS MEET COMMUNITY NEEDS

TO ENSURE QUALITY CARE THAT MEETS COMMUNITY NEEDS IN RURAL AREAS, CONGRESS AND HHS SHOULD:

- Require hospitals, including new REHs, to report at minimum on a narrow set of rural-relevant quality indicators to increase accountability and improve quality of care.
- Evaluate the feasibility of establishing a quality reporting program for RHCs to ensure quality care.
- Encourage communities to complete a community needs assessment—with full participation from community stakeholders—to ensure that transformation to new delivery models will improve access to high-quality care in the local area and assist rural communities in taking the findings to develop a hospital transformation action plan.

Over the course of BPC’s rural work, stakeholders and policymakers have expressed two additional goals: improving quality and basing transformations on community needs.

The first goal involves ensuring rural health care providers are given the necessary incentives and tools to improve the quality of care. Under current law, CAHs and some small rural hospitals are not required to report on quality performance and, therefore, payment is not tied to tracking quality performance or to quality of care delivered.¹⁰²

Historically, rural hospitals have not reported on quality because of statistical issues involving low volume or lack of rural-relevant measures in the field; however, rural hospital quality measure reporting has increased in recent years. As of 2019, 99% of CAHs report information on at least one quality measure, and 93% report on at least three measures.¹⁰³ In addition, quality measurement has advanced. For example, the National Quality Forum (NQF) recently approved a rural-relevant set of quality measures,¹⁰⁴ creating a clear pathway for rural-specific quality measurement as part of the new REH model.

In 2018, an NQF report identified 20 measures that a multi-stakeholder group cited as a potential starting place for rural hospitals and clinicians to begin tracking and reporting on quality. The measures were required to be relevant across rural settings; to be NQF-endorsed; and to be resistant to measurement challenges in instances of low-case volume. The report recommended specific measures related to mental health, substance use, medication reconciliation,

diabetes, hypertension, and hospital readmission, among other items.¹⁰⁵ To date, Congress has not directed the secretary of HHS to require rural hospitals to report on the identified measures.

The secretary should require rural hospitals, including new REHs, to report on—at minimum—a narrow set of rural-relevant quality measures to increase accountability and advance quality of care in rural communities.

In establishing quality reporting requirements, BPC encourages the secretary to evaluate measures and differentiate among those which are uniquely appropriate to apply in an REH setting relative to other hospital sites. These measures should be risk-adjusted for social determinants of health, where possible and appropriate, and include access to care measures, where available. In addition, rural measures should be aligned across Medicare, Medicaid, and other payers to minimize reporting burdens on rural facilities.

The secretary should assess on an ongoing basis whether topped-out measures—such as those that are no longer useful for larger or urban providers to report because they are successful on the metric and there is little room left for gain—should remain in the system for purposes of rural reporting. Finally, reporting of such measures should be done in a way that is not administratively burdensome to REHs or other rural providers. The secretary should provide technical assistance to support rural providers in establishing tracking and reporting systems on quality measurements.

Congress and the HHS secretary should evaluate the feasibility of establishing a quality reporting program for RHCs to ensure patients receive high-quality care. To participate in the Medicare program, RHCs must adhere to conditions of participation (CoP) rules. Current Medicare CoPs require RHCs to conduct an annual program evaluation, which must include an assessment of the utilization and appropriateness of clinical services provided within the RHC. The CoP requirement is the only information RHCs must currently submit related to their performance and quality measurements.

In 2016, the Maine Rural Health Research Center published a policy brief related to a pilot test of RHC quality reporting.¹⁰⁶ Key findings included the importance of establishing a core set of relevant quality measures on primary care. These measures should focus on RHC clinical issues, such as immunization rates, diabetes and blood pressure management, and tobacco use interventions, among others. The study also documented key barriers to RHC quality reporting, including difficulty extracting quality data from electronic health records and limited availability of staff to collect and report data.

ENCOURAGING COMMUNITIES TO ASSESS LOCAL HEALTH CARE NEEDS

An important component of any rural hospital transformation will be establishing a protocol for ensuring that the conversion aligns closely with the community's needs. To that end, the HHS secretary should encourage rural communities to conduct a community needs assessment that includes comprehensive input from stakeholders as they evaluate whether to transform to an REH model or consider modifications to the local health care delivery system.

A community needs assessment can provide valuable information that rural communities can use as they consider transforming a local hospital to an REH. The assessment can also more broadly inform efforts to improve or maintain access to local health care services, strengthen the quality of care, or better coordinate care across the local or regional health care delivery system. Such an assessment would serve as an important tool for longer-range planning, including informing community health care leaders and policymakers on the financial and human resources needed to stabilize or strengthen the local health system. In communities that are experiencing attrition among the health care workforce or difficulty attracting new providers, the assessment and plan may send a strong signal about the local communities' commitment to shore up the health system.

Some communities may need to transform to an REH quickly to avoid a local hospital closure and maintain access to critical services. However, it would still be of a value to complete such a community needs assessment in tandem with this transformation or even after an REH is established. This assessment would likely be particularly useful as rural communities exit the COVID-19 pandemic and need to examine capabilities and address projected community needs going into the future.

Where possible, BPC further urges the HHS secretary to assist rural communities in taking findings from community needs assessments to develop a hospital transformation action plan. Such a plan would help determine which health care delivery models can improve health and increase access to necessary care for local residents and potentially the larger region.

Finally, to support the development of a community needs assessment and action plan, the HHS secretary should provide technical assistance funding and support to rural communities through HRSA grants or Medicare revenues, as appropriate.

ENSURE ACCESS TO AMBULANCE CARE, VIRTUAL CARE, AND BEHAVIORAL HEALTH, AND ADDRESS GAPS IN MATERNAL CARE SERVICES

TO ENSURE REHS HAVE ACCESS TO A FULL COMPLEMENT OF NEEDED SERVICES, HHS SHOULD:

- Allow REHs to tailor emergency medical transfer agreements to meet the local community's need.
- Clarify rules around ambulance reimbursement within the REH model and ensure such reimbursement supports the transformation to the REH model and continued access to these critically important services.
- Evaluate the REH reimbursement rate and structure to ensure REH providers can maintain strong virtual and telehealth service capabilities.
- Ensure REHs are eligible to deliver all outpatient mental health and substance use services, as well as support additional service needs that surface during the community needs assessment.
- Ensure funding is made available to REHs from HRSA programs, such as the Title V Maternal and Child Health Block Grant program. In addition, encourage states to provide enhanced Medicaid reimbursement for maternal care services that can be provided appropriately in the outpatient REH setting.

Policymakers will need to determine how to effectively incorporate key service offerings into the REH model that the enacting legislation did not address.

AMBULANCE SERVICES

Rural stakeholders cited a critical need to determine the role and structure of ambulance services within the REH program and related emergency medical transfer rules. The most important questions focused on how ambulance availability will be affected if rules require ambulances to remain onsite or nearby in “ready to transport” mode—a service for those patients who are under observation and may need to be transferred to another hospital for inpatient care. In rural areas with limited ambulance capacity, longer wait times to transport REH patients could affect access to emergency transport services in the broader community.

In addition, stakeholders raised concerns about the types of hospital transfer agreements required in the REH program. In the REH model, hospitals must have transfer agreements with a level I or level II trauma center. According to the American Hospital Association, in some rural communities the nearest level I or level II trauma center may be hundreds of miles away.¹⁰⁷ Although it is important to have transfer agreements in place to ensure patients can receive immediate, complex, and specialty care, BPC urges the secretary of HHS to allow REHs to tailor transfer agreements to meet the local community's needs. Such tailoring could include allowing REHs to have transfer agreements with level III or level IV trauma centers if such centers are more geographically accessible. Another option could be to allow REHs to have a limited transfer agreement with a level I or level II center as well as additional transfer agreements with other trauma centers based on the individual circumstances in each community.

Finally, stakeholders are seeking clarity on whether the additional facility payment (described earlier) can be used to support ambulance services. Also, for CAHs that owned ambulance services and were eligible for cost-based reimbursement for ambulance care, stakeholders note a lack of clarity around whether these facilities can continue to receive cost-based reimbursement in the REH model. BPC urges the secretary to clarify rules around ambulance reimbursement and ensure such reimbursement supports transformation to the REH structure and continued access to these critical services.

VIRTUAL CARE

As CMS weighs the conditions of participation for REH providers, the HHS secretary should evaluate the REH reimbursement rate and structure to ensure it is set at an appropriate level so REH providers can maintain strong virtual and telehealth service capabilities. As workforce models change, rural health professionals should be equipped with the tools necessary to provide quality virtual care to patients.

Research has documented higher mortality rates for patients at rural or remote emergency departments compared with those with similar conditions in urban settings.¹⁰⁸ In part, these disparities exist because rural hospitals struggle to attract and retain providers who can adequately staff facilities, and they lack specialist support needed to triage, stabilize, and treat higher acuity patients.

Telehealth access can help bridge these gaps and improve health care delivery in rural areas. Using two-way interactive technology, REHs have the potential to deliver care that is comparable in quality to in-person physician staffed services.¹⁰⁹ Telehealth capabilities are especially important when an emergency demands urgent management and intervention to minimize adverse patient outcomes. Tele-stroke care (where a local emergency medicine provider is

connected virtually to an expert for acute stroke care) is shown to improve care and patient outcomes compared to traditional interventions. Patients in lower-volume hospitals, rural residents, and patients 85 years and older see the greatest benefits.¹¹⁰

Through telephone or videoconferencing consultations, telehealth improves collaboration between referring hospitals and receiving hospitals, and this collaboration might reduce the need for secondary triage and optimize patient management within community hospitals. For critical patients, telehealth has reduced morbidity and mortality rates, hospital admission time, and the cost of patient care.^{111,112}

Telehealth can also be an important tool in the provision of non-critical emergency care at REHs. Hub-and-spoke type models have been found to be effective in the remote diagnosis and management of patients. Providing remote diagnosis and disease management assistance can minimize the need for unnecessary patient transfers and allow REHs to treat more patients locally.¹¹³

Financing telemedicine in low-volume hospitals can be challenging given the upfront costs for equipment and ongoing costs for internet connectivity and maintenance. The HHS secretary should evaluate the cash flow needed to invest in telemedicine for REHs and determine whether the current financing proposed is sufficient.

BEHAVIORAL HEALTH CARE

REHs can play an important role in helping to address the significant unmet need for behavioral health services in rural areas, as well as bolster communities' ability to handle behavioral health crises. Indeed, about half of adults with mental health conditions are not receiving the help they need, and the number is closer to 90% for people with substance use disorder. A growing proportion of emergency department visits are for individuals with mental health and substance use-related diagnoses;¹¹⁴ these visits require more staff resources and often last four or more hours compared with visits for adults without a mental health disorder.¹¹⁵

The HHS secretary should therefore consider making all outpatient mental health and substance use services eligible in the REH model, as well as any additional services that the hospital's community needs assessment identify as necessary.

Adequate access to behavioral health professionals, especially in rural areas, is an ongoing barrier to necessary patient care. A community needs assessment with broad stakeholder input would allow communities to identify services that beneficiaries may otherwise lack access to if an REH does not provide them.

For example, some communities may need mobile crisis services or an opioid treatment program. In such instances, the REHs should have the option to include these services as part of their scope, and CMS should evaluate whether current REH financing mechanisms ensure adequate reimbursement to provide such services.

MATERNAL CARE

REHs could help alleviate the alarming dearth of maternal care in rural areas. BPC's previous report focused heavily on recommendations to improve access to quality maternal care in these areas and supported funding obstetric care training for primary care providers as well as improving maternal mortality data surveillance. Rural stakeholders note the importance of determining the appropriate role of maternal care in rural emergency hospitals and understanding the unique challenges of providing such care in rural communities.

The issue of maternal care and maternal mortality and morbidity has been a key focus of policymakers in recent years. The United States continues to have a higher rate of maternal mortality than other industrialized nations, with approximately 700 women dying annually from pregnancy-related complications.¹¹⁶ The cause of this is multifactorial, but evidence shows that a recent loss of obstetric services correlates directly with poor clinical outcomes and increased infant and maternal mortality.¹¹⁷ For rural communities, this loss is a significant problem. Rural hospitals have continued to close obstetric units, leaving fewer than half of rural counties with access to hospital-based obstetric care.¹¹⁸ Decreasing access to obstetric units can make it increasingly difficult for rural residents to access needed maternal care services. One [study](#) surveyed 306 rural hospitals across nine states and found that women can travel up to 65 miles to receive prenatal care after their local obstetric unit closes.¹¹⁹

Against this backdrop, the outpatient and emergency care nature of REHs will, by definition, likely be ill-equipped to offer robust maternal care services. However, HHS can encourage rural emergency hospitals to play a greater role in offering outpatient pre- and post-natal services, including primary care-based services to pregnant women, new mothers, and their babies.

To ensure access to maternal care, the HHS secretary should make funding available to REHs through HRSA programs, such as the Title V Maternal and Child Health Block Grant program. Such funding could provide critical obstetric training for health care providers who, while not obstetricians, could still be a source for maternal care services in rural communities. These primary care-based services could include prenatal care, diagnostics, and training on appropriate referral guidelines for maternal care, such as high-risk maternal services. BPC also urges the secretary to consider offering additional incentives

to REHs to provide obstetric, maternal, and other services—including via remote patient monitoring—that are deemed particularly at-risk in a given community.

In addition to addressing the shortage of maternal care providers, more funding is needed. In most communities, Medicaid is the dominant payer for maternal care, covering 50% to 60% of all births in the rural United States.¹²⁰ However, the National Rural Health Association estimates that Medicaid reimbursement for obstetric services is one-half the rate of commercial insurance and falls short of covering costs.¹²¹

As CMS implements the REH program, the HHS secretary should provide incentives to states to offer higher Medicaid reimbursement for maternal care services that can be appropriately provided in the outpatient REH setting. Higher reimbursement could include increased federal matching payments to states; this would help close the current Medicaid funding gap and provide REHs with the needed resources to offer maternal care services in their communities. In addition, the secretary should require REHs to provide pregnant women and new mothers information on where maternal care services can be obtained within the broader community, if such services are not otherwise available at the REH.

REH ALTERNATIVES

TO ENSURE RURAL HOSPITALS HAVE MULTIPLE VIABLE TRANSFORMATION OPTIONS, HHS AND CONGRESS SHOULD:

- Use lessons from current demonstrations to inform the establishment of additional multipayer, global budget initiatives that are tailored to rural communities and have the potential to improve care coordination and quality of care while reducing health care costs, where possible.
- Establish an Extended Rural Services program that leverages local FQHC or RHC infrastructure.
- Develop new models that promote increased coordination and integration of rural hospital and clinic services.

Recognizing that the Rural Emergency Hospital model may not work for all communities or for all hospitals that are interested in transformation, the HHS secretary should continue to refine other rural care delivery models. Several other hospital transformation models are either underway or proposed and are described below.

CHART MODEL

CMMI is administering the Community Health Access and Rural Transformation (CHART) model's Community Transformation Track. The CHART model's Accountable Care Organization (ACO) track was similarly envisioned to transition rural-focused ACOs into advanced value-based payment arrangements, but CMMI removed this track in February 2022.¹²²

In the fall of 2021, CMMI awarded cooperative agreement funding to four entities under the CHART Community Transformation Track: University of Alabama Birmingham; South Dakota Department of Social Services; Texas Health and Human Services Commission; and Washington State Healthcare Authority. Lead organizations within a state are expected to work with rural community hospitals to develop a transformation plan. Participating hospitals will receive more flexible funding and additional operational and regulatory flexibilities.

BPC spoke with several CHART model lead organizations, local stakeholders involved in the planning process, as well as CMMI to understand the effects of overlapping model options available for rural hospitals—especially given that both the CHART and REH models officially go live beginning January 1, 2023.¹²³

CHART awardees are working with participating hospitals to develop their health care redesign strategies for their communities. CMMI's intention is for the CHART and REH models to complement each other; however, the full details of the models and their financial effects on hospitals are still unknown. This uncertainty may lead some hospitals to defer participation decisions until more information is available. Stakeholders noted that CMMI's removal of the CHART ACO track helped to decomplicate the options that hospitals needed to weigh.

CHART awardees have the critical responsibility of recruiting participating hospitals into new value-based payment models. These decision points present high stakes for struggling rural hospitals, and stakeholders raised concerns about when hospitals would be able to see realistic projections for how much money they could receive from Medicare's new payment methodology. Hospitals need time to evaluate their projected payments, share the information with their boards, and receive executive sign-off.

ADVANCE NEW MULTIPAYER, GLOBAL BUDGET MODELS

The HHS secretary should continue developing and testing proposals that incentivize multiple payers and providers—on the local, state, and regional levels—to come together in rural communities to advance health care

transformation and reduce health care spending.

Over the last decade, CMMI and a handful of states have begun testing multipayer, global budget models. These models focus on improving care coordination across providers and services, as well as improving health care quality outcomes while also controlling expenditures.

One example is Maryland, which established an alternative payment system for hospital services more than 30 years ago. A Medicare waiver made this system possible by exempting Maryland hospitals from the Medicare inpatient and outpatient prospective payment systems. Under this system, the state sets hospital payment rates that are then adopted by all parties.¹²⁴

Building on this model, CMMI established the Maryland All-Payer model in 2014. This initiative aimed to go beyond rate setting by testing a model focused on total cost of hospital care on a per capita basis. The initiative tested global budgets for certain Maryland hospitals, as well as set goals for quality improvement, hospital readmission, and hospital-acquired conditions, among other metrics.¹²⁵

In 2019, CMMI undertook the Maryland Total Cost of Care (TCOC) initiative. This model expands beyond hospital care by holding the state accountable for Medicare services provided to all Maryland beneficiaries, including primary care services and other non-hospital services. Under this model, per capita cost growth in the state is capped and quality incentives are included. This initiative is set to sunset on December 31, 2026.¹²⁶

CMMI also authorized the start of a new multipayer global budget model in Pennsylvania in 2017.¹²⁷ The Pennsylvania Rural Health Model is a six-year demonstration that provides a global budget payment for rural acute care hospitals and CAHs in the state. The multipayer model will help rural hospitals remain financially viable while making the necessary investments in care redesign to improve quality and lower overall costs. The global budget includes inpatient and outpatient services, as well as swing beds for CAHs. CMS began funding the initiative in 2018 for model preparation and provides biweekly payments to participant hospitals based on historical costs.

In this model, hospitals must have 75% payer participation in performance year 1 (2019) and 90% participation in years 2-6. The state must achieve \$35 million in Medicare savings over the course of the demonstration and prevent costs from exceeding the rural national growth rate for Medicare beneficiaries. All-payer costs must not exceed the state's historical compound annual growth rate of 3.38%.¹²⁸

The model also aims to improve access to care, lower mortality related to substance use, increase preventive care, and improve chronic disease management. To date, 18 hospitals are participating in the model, and no results have yet been posted.¹²⁹

As CMMI continues to track progress in these models and similar programs, the secretary should use lessons from these initiatives to establish multipayer, global budget initiatives that are tailored to rural communities, with the goal of improving care coordination and quality of care. Such models also offer new opportunities for increased rural participation in value-based care initiatives as well opportunities to reduce health care costs.

EXTENDED RURAL SERVICES PROGRAM

The HHS secretary may also wish to establish additional care delivery options that utilize existing care structures, such as federally qualified health centers or rural health clinics. Specifically, the secretary could establish a new Extended Rural Services (ERS) program. This program would allow rural FQHCs and certain RHCs to begin offering hospital-level services that otherwise may not be available because of a recent hospital closure or a local hospital's reduced capacity. Rural hospitals could also be eligible to participate in the ERS program if they form an FQHC or eligible RHC, either before or in tandem with applying for this new program.

The ERS program would aim to utilize existing rural infrastructure by allowing services to be added to FQHCs and RHCs or allowing communities to repurpose rural hospital buildings that have closed or are downsizing. Such a program may also provide opportunities to retain health care providers who may otherwise leave the community when the local rural hospital closes. The program could be established as a new section of the Public Health Service Act and would not amend Section 330 program rules under the act or financing related to FQHCs, or current law that governs RHCs.¹³⁰

Today, FQHCs serve roughly one in five rural residents.¹³¹ As noted previously, approximately 5,000 rural health care clinics are serving rural communities nationwide.¹³²

Under this program, eligible entities would include:

- **Federally Qualified Health Centers** (as defined in Section 330 of the Public Health Service Act¹³³) that are in rural areas.
- **Rural health clinics.**
- **Rural hospitals** that are struggling or have closed within the past five years and are willing to form a FQHC or eligible RHC prior to, or in tandem with, applying to the ERS program.

All organizations applying to the ERS program could be required to demonstrate that they or their community are in the process of, or have completed and submitted, a community needs assessment and plan. The HHS

secretary could deny an application if the organization fails to submit an assessment or plan, or if the plan does not adequately demonstrate community need to transform to the ERS model.

Under the program, participating entities could be required to provide at least one of the following services but may also provide all of them. These services could include urgent care; 24/7 emergency room care; observation stays; and certain specialty services, as determined appropriate by the secretary. Eligible entities could have up to a maximum of 10 beds for observation stays, if the relevant community needs assessment and plan identify the need for such a use.

Eligible entities could be required to make all services available to all patients, regardless of ability to pay; charge a sliding-fee scale to uninsured and underinsured patients below 200% of the federal poverty level; and have in place a quality assurance program.

For participating ERS entities, grant funding and Medicare and Medicaid reimbursement could be made available. All payments related to ERS services would be separate and distinct from any current law payments for FQHCs or RHCs.

To support communities in determining whether and how to design a sustainable ERS program, the secretary could be directed to make available one-time planning grants. Entities could be eligible to apply for these grants at the same time a community needs assessment is being done or after one is completed. These grants could be used to assist in planning costs, to support community engagement in decision-making, and for general business planning purposes. Entities would be eligible to receive this funding upfront, but not required to apply to participate in ERS if they determine such a model is not feasible.

For those entities that participate in the ERS program, the secretary may provide either reimbursement from the Medicare hospital inpatient prospective payment system (IPPS) for any current hospital services provided by an ERS participant, or establish a new Medicare prospective payment system (PPS) for this purpose. The secretary may consider providing Medicare Disproportionate Share Hospital payments to ensure grant funds are properly targeted and not diverted to offset any Medicare shortfalls.

For Medicaid payments, the secretary could be directed to develop a payment system that reflects reasonable costs in the geographic area for which services are provided. Such payments may include Medicaid DSH payments.

The secretary might also establish grant funding to cover the costs of serving the uninsured and underinsured. Such funding could be calculated based on historical levels of treating uninsured and underinsured patients for similar services in the local geographic area and can be calculated on a projected per capita basis.

Finally, eligible ERS participants could receive benefits under the Federal Torts Claims Act, which means ERS providers would not need separate malpractice insurance to participating in the program. ERS participants could also be eligible to participate in the 340B drug discount program as it relates to the services provided in the ERS model.¹³⁴

PROMOTE CMMI INITIATIVES TO INCREASE COORDINATION AND INTEGRATION OF RURAL HOSPITAL AND CLINIC SERVICES

Across the country, rural hospitals, RHCs, and FQHCs are seeking opportunities to better coordinate or integrate care across rural communities so that they can leverage scarce workforces and other resources and increase service offerings. Although models to increase integration hold promise, providers face many barriers to fully integrating rural hospitals and rural health clinics or FQHCs because of different statutory, regulatory, and governance structures.

BPC encourages the secretary to develop and test new models that would reduce barriers to integration, where appropriate, and improve coordination across rural services. Such models would allow communities to maintain the current rural hospital, while also potentially streamlining and improving access to necessary rural health services.

In addition, the secretary should consider requiring participating entities to submit a community needs assessment and plan as part of any CMMI collaboration model or demonstration to ensure that collaboration will increase access to care and quality in a given rural community or region.



3. ENSURE AN ADEQUATE RURAL HEALTH CARE WORKFORCE

Before the COVID-19 pandemic began, health care workforce shortages across all professions and specialties were a persistent challenge in rural and underserved communities. The federal government and many other organizations have long supported programs designed to strengthen the health care workforce and address these shortages.

The rural health workforce problem is multifaceted. An aging workforce is partly to blame. In 2019, 44.9% of all physicians in the United States were ages 55 or older.¹³⁵ The nursing workforce faces similar challenges, with almost one in five nurses 65 years and older.¹³⁶

While the number of students entering primary care residencies has continued to grow year over year, the majority of future physicians choose to train in specialties and subspecialties rather than primary care, and most of them do not choose rural America as their home.¹³⁷ The primary care shortage is echoed across provider types, including registered nurses (RN), nurse practitioners (NP), physician assistants (PA), dentists, pharmacists, and behavioral health professionals.¹³⁸ Compounding the problem, rural communities have far fewer providers per capita than urban communities, particularly when it comes to specialists (see Figure 3).

Figure 3. Rural Areas Have Far Fewer Health Professionals per Capita Than Urban Areas, 2008-2010¹³⁹

Occupation	Health professionals per 10K, Rural	Health professionals per 10K, Urban
Dentists	2.9	4.3
Registered Nurses	65.3	93.6
Licensed Practical Nurses/ Licensed Vocational Nurses	25.1	20.6
Physician Assistants	8.1	10.2
Physicians (MDs)	10.9	30.8
Physicians (DOs)	1.8	2.4
Primary Care Physicians	5.3	7.9
Total Physicians	12.7	33.3
Nurse Practitioners	6.5	8.1
Advanced Practice Registered Nurses	6.5	8.1
Nurse Anesthetists	1.2	1.6

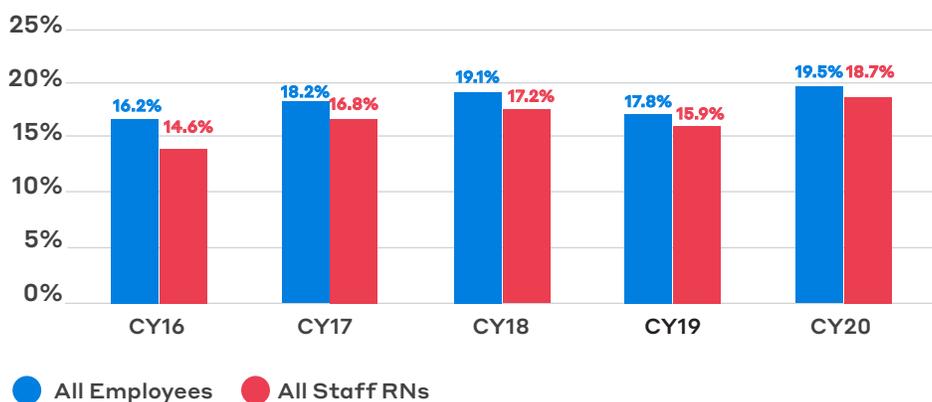
Against this backdrop, the impact of the COVID-19 pandemic on the health care workforce has been staggering. Throughout the pandemic, the federal government deployed military and National Guard resources to mitigate hospital staffing shortages.¹⁴⁰ The strain has been particularly acute in rural areas that have long struggled to recruit and retain providers.

HEALTH CARE WORKFORCE ATTRITION AND TURNOVER

Stakeholders from rural states consistently report that retaining health care workers and ensuring adequate staffing levels are among the top and most vexing challenges facing health care systems. Nationally, hospital employment fell slightly in 2021, but unlike the ambulatory care setting where employment levels bounced back, job declines in hospitals remained 1.8% (or 96,000 jobs) below pre-pandemic levels.¹⁴¹ According to a 2021 survey conducted by NSI Nursing Solutions of more than 3,000 hospitals across the country, the turnover rate for staff RNs increased 2.8% from 2019 to 2020 and currently stands at 18.7% (see Figure 4).¹⁴² Registered nurses working in behavioral health and emergency medicine experienced high turnover rates nationally.

The cost of staff turnover can have a profound impact on hospital margins. According to the same survey, the average turnover cost for a bedside RN is \$40,038 and an additional \$270,800 per year for each percentage increase in turnover. Another analysis found that hospital labor costs are up by an average

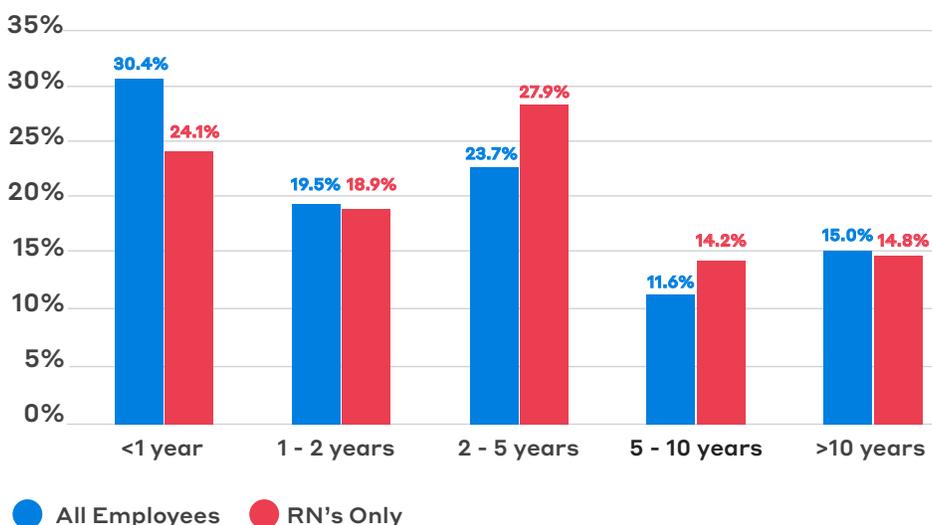
Figure 4. Rates of Hospital Staff and RN Turnover, 2016-2020¹⁴³



of 8% per patient day from a pre-pandemic baseline period in 2019. For the average 500-bed facility, this translates to \$17 million annually since the pandemic began.¹⁴⁴

According to interviews with rural hospital associations, attrition was present across every level of the health care system—from CEOs and top executives, to physicians, nurses, radiation technologists, surgical technicians, dietary staff, and operational staff, including custodial, environmental services, and administrative employees. Hospital surveys show that the majority of those leaving have less than one year of service (see Figure 5). This may point to a critical period for readying new nursing graduates for the bedside. Formal preceptorships or other training investments could minimize first-year turnover rates. Among staff who remain at rural health systems, rural stakeholders reported ongoing challenges with staffing overnight shifts, weekends, and holidays.¹⁴⁵

Figure 5. Hospital Staff and RN Turnover by Length of Employee Tenure, 2021¹⁴⁶



STAFF MENTAL WELL-BEING AND BURNOUT

Several factors accelerated workforce attrition during COVID-19; key among them was staff burnout. The pandemic placed unprecedented stress on nurses, doctors, physician assistants, behavioral health providers, nursing home workers, and other support staff. The pandemic's effects were particularly traumatic for frontline staff who faced the loss of co-workers due to COVID-19, self-isolation from their families, and overwhelming loss of patient life. Because patients' families were unable to be present due to strict hospital protocols, nurses were often the last person to see dying patients.¹⁴⁷

Many staffers retired early or left health care altogether: In August 2021 alone, more than half a million individuals left the health care and social assistance workforce.¹⁴⁸ A McKinsey survey of health care workers found that in November 2021, 32% of RNs said they may leave their current direct-patient-care roles, an increase of 10 percentage points in under 10 months.¹⁴⁹ The strongest drivers of intent to leave included insufficient staffing levels, the desire for higher pay, not feeling listened to or supported at work, and the emotional toll of the job, according to the survey.

A North Dakota hospital executive commented that maintaining an adequate workforce “has always been a challenge within the state, but the pandemic has made it that much harder now. A concern is burnout of health care staff as we continue to fight COVID-19. We are also concerned if the pandemic has discouraged younger generations from entering the health care field.”¹⁵⁰ In addition, workers needed to stay home to care for children while schools were closed or to care for family members affected by COVID-19.

In February 2022, Congress passed the Dr. Lorna Breen Health Care Provider Protection Act (H.R. 1667). It requires HHS to distribute grants to hospitals, medical professional associations, and other health care entities to promote mental health and resiliency among health care providers.¹⁵¹ Additionally, the bill requires HHS to conduct a campaign to encourage health care providers to seek treatment for mental and behavioral health concerns and to disseminate best practices to improve mental well-being among providers.

IMPACT OF VACCINE MANDATES

States reported that COVID-19 vaccine mandates played a role in attrition of health care staff. Ultimately, staff threats to quit over the vaccine mandate did not match actual departures. Multiple health systems across the country approved more religious or other vaccine exemptions than they did for other vaccine requirements. However, many health systems let staff go who did not meet the new mandate requirements, and the impact on smaller communities was disproportionate.¹⁵²

Although unvaccinated adults account for a shrinking percentage of the U.S. population, the gap between rural and urban vaccination rates has grown. According to a CDC [report](#), despite the increased availability of vaccine doses, only 59% of eligible Americans in rural counties had received at least one dose of the vaccine, compared with 75% in urban counties. The disparity between urban and rural vaccination rates doubled between April 2021 and January 2022.¹⁵³

In markets already facing staffing shortages, the loss of employees can be the difference between a hospital offering services or not. One hospital in upstate New York halted maternity care after staff resigned over the vaccine mandate in 2021.¹⁵⁴ Beyond credentialed staff, hospitals were equally concerned about non-clinical staff shortages, including cafeteria workers and environmental services staff.

One Montana hospital executive said, “Vaccine mandates are a major cause for worry because losing just one hospital employee can have a big impact in small towns and lead to a reduction in services.” This executive predicted that “most medical staff are likely to get vaccinated, but service employees, such as janitors or cafeteria workers, may choose to get jobs elsewhere where vaccines are not required. States with low vaccination rates are not surprisingly the same states struggling with the impact of vaccine mandates.”¹⁵⁵

SUPPLY OF AFFORDABLE HOUSING

Rising housing costs and supply shortages in rural communities also directly impact health systems’ ability to recruit and retain health care staff. Even before the pandemic, rural hospital executives reported a shortage of housing for prospective employees. During the pandemic, migration from cities to rural areas drove up housing prices in smaller and rural communities, and the limited housing supply became less affordable for lower-income workers. Rural hospitals reported that a lack of affordable housing directly affected their ability to recruit new staff and fill open jobs.¹⁵⁶

TIGHTENING LABOR MARKET AND STAFF RETENTION

As workforce challenges increased during the pandemic, rural stakeholders implemented a variety of initiatives to attract, support, and retain health care staff amid fierce competition.

Many stakeholders provided retention bonuses to incentivize health staff to remain in their position. One small rural hospital in Vermont invested roughly \$4 million in new wage incentives, a significant investment given its already strained finances.¹⁵⁷ Some rural health systems suggested that federal relief

from the CARES Act and ARPA enabled them to raise wages and benefits. As the pandemic wanes and federal relief funding ends, many stakeholders raised concerns about whether facilities could maintain their higher investments in staffing.

Rural hospital executives also reported the need to turn to contract employees, particularly nurses, to fill open positions. Although hiring contract employees was common before the pandemic, hospitals typically used these workers as a stopgap in response to a tightened labor market. In 2020, travel nursing grew 35% over the previous year.¹⁵⁸ Some hospitals reported doubling their contract staff, with one facility estimating that contract employees made up 10% to 15% of its staff during the pandemic.¹⁵⁹ Not only was this costly to hospitals, who pay higher rates for contract employees, the differential pay between contract nurses and existing staff also affected staff morale.

Contract staff played a critical role in filling vacancies and ensuring continued patient access to services, but their use was expensive and policymakers have taken note. One group of lawmakers said that nurse staffing agencies may be inappropriately increasing prices and profits. They have received reports that nurse staffing agencies are “vastly inflating prices by two, three, or more times the pre-pandemic rates, and then taking 40% or more of the amount being charged to the hospitals for themselves in profit.”¹⁶⁰

To that end, lawmakers asked HHS and federal agencies to launch a comprehensive review to determine whether nurse staffing companies’ pricing activities are anti-competitive and to better understand these agencies’ ownership structure. Lawmakers are also seeking greater clarity on whether, and to what degree, increased costs to hospitals are translating into higher wages for the contract nurses. Also, importantly, policymakers have raised concerns about the impact of pricing increases on access to and quality of care in rural and underserved communities.

PROPOSALS TO STRENGTHEN THE RURAL HEALTH CARE WORKFORCE

Today’s health care workforce challenges are multilayered and have been exacerbated by the pandemic. Rural hospitals across the country are struggling to maintain sufficient staffing to run facilities safely. The long-term effects on the health care workforce remain to be seen; however, decades of research have established that inadequate nurse staffing in hospitals is associated with increased patient morbidity and mortality.¹⁶¹

As rural communities, health care systems, and policymakers continue to grapple with the many issues driving workforce shortages, BPC’s recommendations focus on strengthening the rural health care workforce in the near term. The most expedient options tap into the existing supply of workers

by eliminating regulatory and administrative barriers to providing care. Long-term solutions will require a greater focus on pipeline and training programs that have been demonstrably effective in sustaining a rural workforce. BPC will continue to study the complexity of the national health care workforce challenges as well as explore potential solutions.

IMPROVE UTILIZATION OF THE CURRENTLY AVAILABLE WORKFORCE

TO MAXIMIZE UTILIZATION OF THE EXISTING HEALTH CARE WORKFORCE, CONGRESS AND CMS SHOULD:

- Consider permanently adding additional behavioral health provider types to the list of Medicare-covered providers (such as peer support specialists).
- Remove federal regulatory and legislative barriers that prevent non-physician providers from practicing at the top of their license.
- Support ongoing funding for Project ECHO tele-training.

The growing workforce shortage highlights the need to expand the supply of care providers. Historically, the most straightforward way to accomplish this goal is to train new providers and enlarge the pipeline. Alternatively, however, policymakers can expand the supply by adding additional provider types to the list of approved Medicare providers, loosening state scope of practice restrictions, and training and supporting primary care providers to treat more conditions within the context of primary care.

The secretary of HHS should assess the impact of permanently authorizing Medicare reimbursement for additional provider types, such as pharmacists and peer support specialists. Additional provider types should be assessed in terms of both cost and the potential to improve outcomes. The evaluation should clarify the total value created by covering additional providers and the effect of state limitations on the ability of these providers to utilize the full extent of their training. Based on these findings, the secretary should make the determination for which providers should be reimbursed.

To expand access to mental health care in rural communities, BPC previously recommended making mental health providers with graduate training eligible to provide services in RHCs. Marriage and family therapists and licensed mental health counselors have master's- or doctoral-level training for treating mental and behavioral conditions and at least two years of clinical experience. Marriage and family therapists currently provide care in more than one third of rural counties in the United States and are included, with mental health

counselors, in the Public Health Service Act. They may receive placement through the NHSC, yet Medicare does not reimburse them for their services.

Regulatory and legislative barriers also can keep the available workforce from fully performing certain tasks that are within their training, education, and experience. Patients in rural areas often rely on non-physician providers for a significant portion of their care. Advanced practice clinicians, such as NPs and PAs, and social workers can address unmet need when a more highly trained workforce is unavailable. Despite generally uniform professional educational and training requirements, as well as patient outcomes on par with physicians in primary care settings, non-physician providers may still be limited in the services they can provide. A growing number of states (24) plus the District of Columbia allow NPs full practice authority. Eleven states, mostly in the Southeast, restrict NPs' scope of practice; state law requires career-long supervision, delegation, or team management by another health provider in order for the NP to provide patient care.¹⁶² Congress should provide clear directives to the secretary of HHS to clarify regulations and incentivize states to enable non-physician providers to practice at the top of their license.

Another opportunity to improve the utilization of the currently available workforce is to support programs like Project ECHO (Extension for Community Healthcare Outcomes). Project ECHO is a distance-learning telementoring model designed to help primary care clinicians provide expert-level care to patients when specialists are unavailable. Begun in 2003, the model leverages video-conferencing technology to train, advise, and support primary care or other community providers. Project ECHO increases access to specialty treatment in rural and underserved areas for a variety of complex conditions, such as Hepatitis C, diabetes, and substance use disorder.

The program has positive outcomes, with an increasing number of studies finding that the ECHO model increased the number of buprenorphine-waivered physicians who treat opioid use disorder, reduced the number of patients treated with opioids for chronic pain compared to a control group, and lowered the number of opioid prescriptions per patient.¹⁶³ One evaluation found that patients with Hepatitis C who received care under the model had similar outcomes to those who received care in academic medical centers.¹⁶⁴ As of January 2022, Project ECHO has created an extensive peer-to-peer learning network for real-time information-sharing; the network has participants in all 50 states and more than 100 countries.

Despite receiving financial support from federal, state, and local government grants, Project ECHO has no ongoing federal funding stream. The success of the model rests on the ongoing ability of providers to invest in and continue learning within the program to maintain better quality outcomes. In 2019, the Center for Health Care Strategies released a report outlining the possible pathways for sustainable funding, including embedding funding for Project ECHO in HRSA health center grants.¹⁶⁵

STREAMLINE LICENSURE REQUIREMENTS

TO MAXIMIZE CROSS-STATE MOBILITY OF THE HEALTH CARE WORKFORCE, CONGRESS COULD:

- Permit any physician with a medical license in good standing to deliver services via telehealth to Medicare beneficiaries residing in any state, similar to the exemptions allowed by the U.S. Department of Veterans Affairs.
- Authorize telehealth services for Medicare beneficiaries based on the location of the provider, rather than the location of the patient. This could apply to both issues of licensure and provider liability.
- Provide additional federal incentives to increase state participation in licensure compacts, such as increased Medicaid Federal Medical Assistance Percentage (FMAP) funding.

Early in the pandemic, nearly all states and HHS approved unprecedented flexibilities in licensing rules to improve interstate mobility for health care professionals. The lifting of restrictions on out-of-state practitioners significantly aided the response to the crisis by expanding telehealth, bolstering care in underserved areas, increasing access to mental health services, and providing relief to overstressed hospitals and health systems losing health care workers.

Maximizing licensure flexibilities long term could help ease some of the staffing shortages that hospitals are facing. In a recent [report](#), BPC outlined several opportunities for federal leadership on licensure. Although states have always maintained the authority to license and regulate health care providers, critics argue that this limits provider competition and innovation in health care.

One of the first major expansions of provider licensure occurred when Congress passed the Veterans E-Health and Telemedicine Support (VETS) Act of 2017, removing state licensure requirements for U.S. Department of Veterans Affairs (VA) physicians. VA policies allow a federal employee to hold a license in one state and practice in any jurisdiction. In the first year under VETS, more than 900,000 veterans used telehealth to access services, a 17% increase.¹⁶⁶ Two-thirds of services were for telemental health visits.¹⁶⁷ In November 2020, the VA issued an interim final rule confirming its authority to allow VA health care professionals to practice their professions, “consistent with the scope and requirements of their VA employment, notwithstanding any state license, registration, certification, or other requirements that unduly interfere with

their practice.”¹⁶⁸ The VA’s approach effectively bypasses state licensing boards and asserts federal control over their providers.

Congress could similarly consider passing legislation to permit any physician with a valid medical license in good standing to deliver services via telehealth to Medicare beneficiaries residing in any state. Lawmakers could authorize telehealth services for Medicare beneficiaries based on the provider’s location, not where the patient lives. This could apply to both issues of licensure as well as provider liability. Such a policy would necessitate additional guardrails to ensure bad actors in one state could not maintain good standing in another and continue to practice. State licensing boards could receive additional incentives to monitor the National Practitioner Data Bank, a Web-based repository of reports concerning medical malpractice payments, as well as certain adverse actions related to health care practitioners, providers, and suppliers.

Another approach has been to expand licensure compacts, which are formal, binding, legislatively enacted agreements between two or more states.¹⁶⁹ Licensure compacts are currently available for physicians, nurses, emergency medical service professionals, physical therapists, psychologists, and audiology and speech language pathologists. While each compact has its own unique structure, participation can promote mutual recognition models and licensure reciprocity.

Despite increased interest in licensure compacts since the start of the pandemic, gaps in state participation remain. Most notably, California and New York, two of the most heavily populated states, are nonparticipants in all existing health professional compacts. The first licensure compact was created for nurses; as of 2021, it holds the highest level of state participation, with 37 states plus Guam.¹⁷⁰ Congress could promote state participation in licensure compacts more aggressively, possibly through an enhanced federal Medicaid matching funds to offset state costs and encourage uptake.

STRENGTHEN THE RURAL WORKFORCE BY LEVERAGING THE FEDERAL TAX SYSTEM AND THE IMMIGRATION SYSTEM

TO STRENGTHEN RURAL PROVIDER RETENTION, CONGRESS AND THE ADMINISTRATION SHOULD:

- Establish a federal tax credit for providers practicing in rural areas.
- Exempt Indian Health Service (IHS) loan repayment funds from federal income tax, as is done for other federal loan repayment programs.
- Reauthorize and expand the “Conrad-30” J-1 visa waiver program for physicians practicing in rural areas.
- Expedite processing H-1B visas and green card petitions for individuals employed in health care settings in Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA).

Retaining providers in rural areas is an ongoing challenge. Although loan repayment programs, such as the NHSC, help recruit providers, they have been less effective at retaining them longer term. Policymakers have long used tax credits and relief from income taxes as direct incentives for various policy objectives, and they could employ these tools to bolster the rural health workforce.

Congress could institute a federal rural practitioner tax credit to augment the efforts of other federally administered HRSA programs. Two states, New Mexico and Oregon, developed successful rural workforce retention programs leveraging the tax system. Drawing on the lessons of these programs, a five-year annual federal tax credit could be offered to physicians and advanced practice clinicians who choose to work in rural HPSAs. Under this model, federal dollars could only be spent if providers practice in rural HPSAs. The federal tax credit (e.g., \$10,000, \$15,000, and \$20,000) could be tiered based on provider type or distance from a metro area. To ensure a consistently targeted benefit for underserved rural areas, the rural HPSA designation should be updated every five years.

Oregon’s Rural Practitioner Tax Credit was established in 1989 and offers an average of \$8.5 million annually in tax credits for providers practicing in rural areas.¹⁷¹ The \$3,000, \$4,000, or \$5,000 annual tax credit is tiered, with those working farthest from an urban center receiving the maximum amount. A 2016 [review](#) of relevant workforce programs in Oregon demonstrated that, while the

NHSC loan repayment program attracted providers to the area, it had minimal effect on retention.¹⁷² Conversely, the Rural Practitioner Tax Credit has a sizable effect on retention, increasing the likelihood that a provider would stay in the area, but it was not a significant tool for recruitment.¹⁷³ Notably, the report suggested that the combination of the two programs had a synergistic effect on provider recruitment and retention.

Additionally, providers whose student loans are repaid in return for placement in IHS facilities must pay federal income tax on those funds. In contrast, NHSC placements are exempt from federal and state income tax. IHS clinics provide substantial direct care to American Indian and Alaska Native people. The GAO reported that in 2017, IHS had an overall 25% vacancy rate for health care providers and faced ongoing challenges filling vacancies.¹⁷⁴ Congress should pass a tax exemption for IHS providers similar to the one for NHSC providers. Such a change is included in the bipartisan Indian Health Service Health Professions Tax Fairness Act of 2021 (S.2874).¹⁷⁵

Leveraging the immigration system provides another opportunity to strengthen the rural workforce.^{176, 177} Expanding opportunities for foreign-educated doctors on J-1 visas to stay in the United States after their residencies can attract providers to rural practice. Currently, foreign medical graduates completing U.S. residencies on J-1 exchange visitor visas must return to their home country for two years after their residency has ended before they can apply for another visa or green card. The Conrad 30 federal program provides each state with up to 30 J-1 visa waivers; these waivers allow international medical graduates to apply for a waiver of the 2-year foreign residence requirement upon completion of the J-1 exchange visitor program.¹⁷⁸ This allows them to stay in the United States, converting to H-1B visas for an additional three to six years to practice in HPSAs.

Between 2001 and 2010, 41 states gave waiver priority to primary care slots.¹⁷⁹ However, the need for primary care continues to increase and the current workforce is insufficient to meet that need, particularly in rural areas. Given the growing physician shortage, Congress should increase state waivers to 50 with priority given to rural areas.

The Conrad State 30 & Physician Access Reauthorization Act (H.R. 3541, S.1810) would reauthorize the program and increase state waivers from 30 to 35 per state, if a certain number of waivers are used the previous year. The legislation also provides further adjustments depending on demand.¹⁸⁰ It is important to raise or adjust the cap based on demand to allow states to maximize the benefits of the J-1 visa program. Increasing state waivers does not necessitate more federal funding.

Moreover, the State Department should address the backlog of immigrant visas for eligible foreign-trained nurses who are trying to work in rural areas. Currently, temporary work visas are not available for most nurses, but many foreign nurses apply each year for green cards using special procedures that

waive the requirement for domestic recruitment. However, delays in processing these petitions at the U.S. Citizenship and Immigration Services (USCIS), the Department of Homeland Security agency responsible for immigration benefit process, and the State Department, where foreign nurses must be interviewed and granted a visa before traveling to the United States, have resulted in a large backlog. Expediting the processing of green card applications and visa interviews for individuals employed in health care settings in HPSAs and MUAs can increase the health care workforce supply in rural areas. To do this, both USCIS and the State Department should place RNs seeking visas in the first tier of the department's priority for processing. The bipartisan Healthcare Workforce Resilience Act (H.R. 2255, S. 1024) would use unused green cards from previous years and make them available to RNs and physicians during the COVID-19 emergency.

STRENGTHEN THE HEALTH RESOURCES & SERVICES ADMINISTRATION'S RURAL WORKFORCE PROGRAMS

TO EVALUATE THE EFFICACY OF EXISTING RURAL WORKFORCE PROGRAMS, CONGRESS SHOULD:

- Appropriate funding for the National Health Care Workforce Commission to perform a comprehensive evaluation of the workforce landscape, develop policy recommendations to ensure federal education and training programs meet critical needs, and provide oversight of federal workforce programs.

HRSA administers multiple programs that support the recruitment and retention of qualified health professionals in rural areas. An independent panel of experts should be convened to evaluate existing programs and determine which investments and educational opportunities are most effective.

The PPACA included the establishment of a National Health Care Workforce Commission, a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy.¹⁸¹ However, as of March 2022, Congress has not appropriated the necessary funding for the Commission to be convened.

Congress should appropriate funding for the Commission to:

- Perform an analysis of the national health care workforce—in coordination with HHS and other relevant departments and agencies within the federal government—to identify the most critical workforce gaps.

- Quantify the comparative effectiveness of federal workforce recruitment and retention programs to reverse critical shortages and create sustained improvements for meeting future demands.
- Consider how the nonphysician and public health workforce as well as technology and telehealth can expand workforce capacity, provide ongoing training for providers, and facilitate the integration of health and health care.
- Recommend actions to address high-priority workforce shortages, ensure adequate training faculty, and consolidate the currently siloed federal workforce programs.
- Review and recalibrate workforce priorities every five years.

IMPROVE REIMBURSEMENT FOR PROVIDERS PRACTICING IN RURAL AREAS AND REDUCE ADMINISTRATIVE BURDENS

TO ADVANCE RURAL PROVIDER PARTICIPATION IN VALUE-BASED PAYMENT MODELS AND IMPROVE RETENTION, CMS SHOULD:

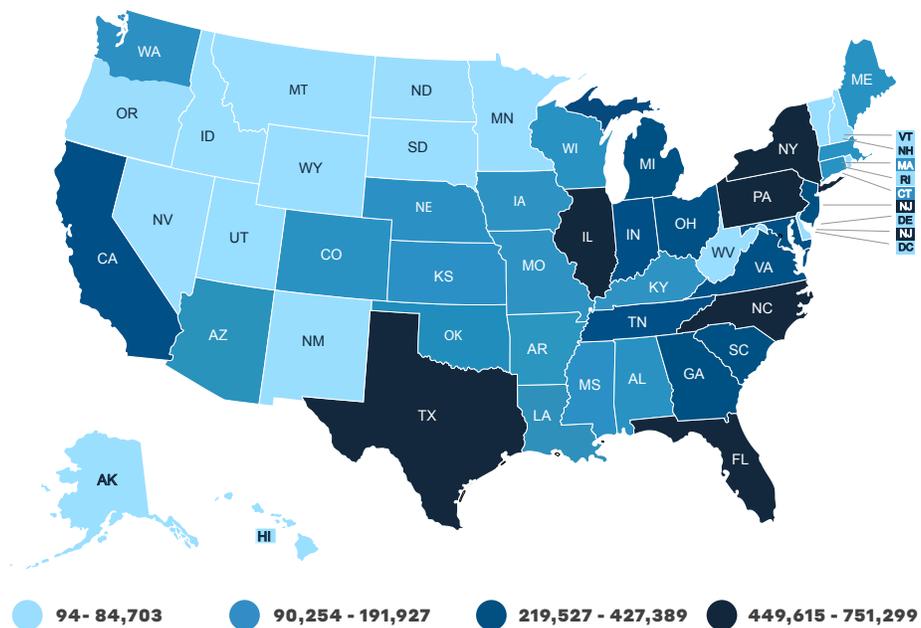
- Provide a nominal payment update for rural providers reporting data under the Quality Payment Program (QPP) and extend bonus payments for new Advanced Alternative Payment Model (APM) participants.
- Exclude enrolled Accountable Care Organization (ACO) beneficiaries when determining the regional benchmark in rural areas.
- Evaluate Merit-based Incentive Payment System (MIPS) data to ensure that rural providers are not disadvantaged by the structure of the program.
- Utilize readily available claims data to assess quality performance.
- Decrease qualifying participation thresholds for rural providers operating under Advanced Alternative Payment Models (APM), RHCs, and FQHCs.

CMS expects that by 2030 all traditional Medicare beneficiaries will be treated by a provider participating in a value-based model with accountability for quality and total cost of care.¹⁸² This audacious goal rests on CMS's ability to entice clinicians practicing in rural areas into new value-based payment models. Over the last decade, providers participating in value-based models such as ACOs had fewer Medicare beneficiaries from underserved and rural populations in their care (see Figure 6). Few CMMI models address the unique

characteristics of rural patient populations, and opportunities to participate in value-based care are severely limited in rural settings. To bring all Medicare beneficiaries into accountable care, CMMI has committed to addressing barriers to participation for providers serving a high proportion of underserved and rural beneficiaries.¹⁸³

To advance CMS's value-based payment participation goals and improve provider retention, CMS should introduce a 0.25% nominal payment update for rural providers who are required to participate in the QPP or choose to voluntarily report data. Medicare providers billing under the Physician Fee Schedule no longer receive an annual payment update. Only mandatory and voluntary participants of the QPP have the potential to receive payment increases. In 2026, a 0.25% nominal payment update will be reintroduced for QPP providers reporting under MIPS.

Figure 6. ACO-Assigned Beneficiaries, Medicare Shared Savings Program, 2018¹⁸⁴



Payment adjustments under the 2019 payments for year 1 of the QPP ranged from +1.88% to -4%. Although a majority of participants received positive adjustments, small practices received only 19% of all negative payment adjustments. Small rural practices in lower-volume settings may be ill-equipped to participate successfully in the MIPS.¹⁸⁵ The costs of the additional staff and technology necessary for participation are felt more acutely, and these practices face a greater risk of receiving a negative payment reduction.

The Medicare Access and CHIP Reauthorization Act of 2015 instituted a 5% incentive payment for advanced APM participation in the first six years of

the program. The intent was to offset the upfront investment and ongoing administrative costs of participation and make advanced APM participation more attractive than reporting under MIPS. However, there has been a lag in the development of advanced APMs. The bonuses are in effect only through the 2022 performance year, which does not offer sufficient time to incentivize participation, particularly for inexperienced, rural providers facing significant start-up costs. To encourage greater adoption of advanced APM models, the HHS secretary or Congress should offer new advanced APM participants bonus payments for a set period (e.g., six years) from the time of enrollment in the model or consider providing rural participants a higher bonus payment (e.g., 6%) to better reflect increased costs of implementation in rural areas.

An ACO is a provider-led organization that assumes financial responsibility for the care of a defined population. ACOs are less likely to enter rural markets—one reason is they are disadvantaged in areas where a greater percentage of the population is attributed to them. This is because spending reductions achieved by ACOs can be significant enough to lower regional costs, which can in turn impact ACOs' performance benchmarks. Current performance benchmarks do not adequately capture or reward efficiencies and care improvements. A recent change to the benchmarking methodology partially addressed this “rural glitch” by averaging national and regional inflation. Congress should direct the secretary to exclude attributed beneficiaries from the regional spending benchmark. Previously introduced legislation, the Rural ACO Improvement Act ([S. 2648](#)) and the Accountable Care in Rural America Act ([H.R. 3746](#)), contemplated such a change.^{187,188}

Reimbursement at the clinician level may also be flawed for rural providers. Early data from the QPP show that rural providers who were required to participate in MIPS received a disproportionate share of negative payment adjustments.¹⁸⁹ Further examination of this data is necessary to assess the extent to which inherent program components place rural participants at a disadvantage (e.g., practice size). Moreover, mandatory rural participants should receive a temporary exemption from negative payment adjustments until the evaluation and necessary program updates are complete. Many providers are required to perform burdensome quality measure collection that is tied to reimbursement. However, current submissions of data reflect the way care is delivered and neglect to account for variations among practices. The requirements reward administrative reporting rather than patient outcomes.

Clinicians required to participate in the QPP are not responsible for reporting data for the cost performance category because CMS can generate the additional information necessary. Similarly, there should be a shift of responsibility for quality data reporting from the provider to CMS. Under this proposal, CMS should leverage quality data and other inputs to provide clinical performance feedback to rural clinicians.

CMS already does this for providers participating in a Medicare Shared Savings Program ACO as well as for MIPS clinicians receiving payment for certain defined episodes of care, such as joint replacement. These clinicians receive relative performance data, including complications, emergency department visits, and hospitalizations, which may highlight decreasing quality of care. However, a provider who is unable to participate in these models does not receive feedback and may remain ignorant of any need to change care delivery. Provider performance data are necessary to ensure continuous quality improvement, and data's value extends to all care delivery, regardless of the payment mechanism.

CMS will begin a new MIPS Value Pathway (MVP) that will incorporate claims data; this pathway will provide additional feedback beginning in the 2023 performance year.¹⁹⁰ However, the MVP does not sufficiently decrease the complexity and reporting burden facing providers. The secretary should further simplify the QPP, while continuing to support quality improvement. Once providers have received feedback and been given sufficient time to make improvements, CMS should use this information to apply tiered annual payment updates. These updates would be commensurate with performance, without requiring additional reporting.

Providers who treat a sufficient volume of patients through an Advanced APM, RHCs, or FQHCs are exempt from MIPS reporting requirements.¹⁹¹ However, the qualifying participation threshold for exemption is difficult to meet in areas with a lower volume of patients and fewer opportunities to increase patient volume. To decrease the reporting burden, the secretary should lower qualifying participation thresholds for rural providers offering services through APMs, RHCs, or FQHCs.



4. SECURE ACCESS TO VIRTUAL CARE IN RURAL COMMUNITIES

At the onset of the public health emergency, Congress, the Trump and Biden administrations, and states temporarily eliminated many historical barriers to telehealth. These policy changes paved the way for an unprecedented utilization of telehealth services, which peaked at more than 32% of Medicare claims in April 2020 and leveled off to 13% to 17% of claims by July 2021.¹⁹² Although rural Americans historically had greater access to telehealth before the pandemic, the new flexibilities improved access to care in rural and frontier areas.

IMPACT OF NEW TELEHEALTH FLEXIBILITIES IN RURAL AMERICA

Before the pandemic, telehealth services were authorized only for a subset of Medicare beneficiaries—those living in rural areas—and for a limited set of services, including tele-stroke care (FAST Act),¹⁹³ tele-substance use disorder and co-occurring mental illness treatment (SUPPORT Act),¹⁹⁴ and telemental health (Consolidated Appropriations Act).¹⁹⁵

In 2020, Congress expanded access to telehealth services through the Coronavirus Preparedness and Response Supplemental Appropriations Act and the CARES Act.¹⁹⁶ The secretary of HHS also issued temporary blanket

waivers expanding telehealth service types, eligible providers, and loosening licensure requirements. By lifting site of service requirements, Congress allowed all beneficiaries to access telehealth services from their homes. This convenience was noted by multiple rural stakeholders as a policy that significantly increased the rural population's access to care.

Marshfield Clinic Health System, a rural health system in Wisconsin, found that access to telehealth services from home saved their patients an estimated 1.4 million driven miles from September 2019 to August 2020.¹⁹⁷ In addition to saving both travel time and money, patients missed fewer appointments and had significantly fewer cancellations across service types, according to multiple studies.^{198, 199, 200, 201, 202}

CMS also allowed the use of audio-only services during the pandemic, telehealth without live video, providing another flexibility that greatly benefited rural Americans. Older, rural, poorer, and minority populations are disproportionately affected by barriers to accessing Web-based services and have been more likely to rely on audio-only services during the pandemic.²⁰³ Stakeholders noted that access to audio-only services was critical for residents without broadband, or who had difficulty accessing and using video. However, multiple provider stakeholders raised concerns about audio-only visits occurring outside of an existing patient/provider relationship.

Importantly, CMS incentivized providers to increase their use of telehealth by reimbursing them for these services, including audio-only services, at parity with in-person care; many state Medicaid agencies and private payers followed suit.

BALANCING ACCESS TO VIRTUAL CARE AND FURTHER STUDY

The telehealth flexibilities are temporary and linked to the federal public health emergency which began January 27, 2020.²⁰⁴ HHS has renewed the PHE through July 15, 2022. In addition, the [FY2022 omnibus appropriations package](#) extended several critical telehealth provisions for an additional five months beyond the end of the PHE, including the temporary removal of geographic and site of service restrictions and use of audio-only services.

Rural stakeholders want telehealth and audio-only flexibilities to continue. However, MedPAC and other experts suggest that long-term changes to permanent telehealth policy are ill-advised until more research is undertaken

CMS allowed the use of audio-only services (telehealth without live video) during the pandemic, providing another flexibility that greatly benefited rural Americans.

on telehealth’s effectiveness and costs. Policymakers have also expressed concerns that telehealth could be overused without appropriate oversight. Pandemic-related telehealth flexibilities, while serving to maintain access to care during the pandemic, have yet to be fully understood in terms of their effects on cost, quality, equity, and clinical outcomes.

To strike a balance, BPC recommends permanent telehealth policy changes, where the evidence exists and continued analysis for others. Policymakers must ensure that patients do not experience a telehealth “cliff” where access to services drops off unexpectedly when the PHE ends.

ENSURE EFFECTIVE BROADBAND IMPLEMENTATION AND COLLECTION OF ACCURATE BROADBAND DATA

TO CERTIFY BROADBAND ACCESS IS IMPLEMENTED AS EQUITABLY AS POSSIBLE, CONGRESS, THE FCC, AND THE NTIA SHOULD:

- Ensure the effective implementation of the Infrastructure Investment and Jobs Act to make certain broadband access is delivered equitably throughout rural America.
- Ensure the effective implementation of the Broadband DATA Act and monitor whether the FCC broadband data collection effort improves the accuracy of mapping broadband access.

On November 15, 2021, the president signed into law the Infrastructure Investment and Jobs Act.²⁰⁵ The \$1.2 trillion investment in our nation’s infrastructure included \$65 billion in broadband investments—the largest broadband investment in U.S. history.²⁰⁶ The law aims to improve Americans’ access to internet services and reduce the digital divide for rural areas, low-income families, and tribal communities. It largely expands internet access by awarding grants to states.

According to the FCC’s 2019 *Broadband Deployment Report*, approximately one-quarter of rural Americans and one-third of those living on tribal lands lacked broadband access, compared with 1.7% of urban Americans. In 2017, the FCC estimated the cost of expanding broadband to 98% of Americans would be \$40 billion; it would cost an additional \$40 billion to reach the final 2%.^{207,208}

Given the great need for high-speed internet that emerged during the pandemic, such as for remote work, virtual school, and telehealth, Congress has shown a sustained interest in increasing the accuracy of broadband data

and mapping. Rural areas struggle with tremendous broadband gaps. While effective implementation of the Infrastructure Investment and Jobs Act will help mitigate these gaps, they will likely persist long term.

On March 23, 2020, Congress enacted the Broadband Deployment Accuracy and Technological Availability Act, also known as the Broadband DATA Act (P.L. 116-130). It required the FCC to change the way broadband data are collected, verified, and reported. The act codifies many components of the FCC's data collection process. Before passage of the Broadband DATA Act, internet service providers self-reported broadband coverage data based on census block data. Census block data as a unit of geography allowed internet service providers to report the entire area as able to obtain broadband even when only one person in that area was covered. The self-reporting methodology contributed to inaccurate broadband mapping and ultimately less broadband access for rural Americans.

The Broadband DATA Act required the FCC to collect granular broadband service availability data and organize a competition for independent data collectors to challenge FCC broadband coverage data. Additionally, it tasked the FCC with creating requirements on data collection conducted by broadband providers.

Effective implementation of the Broadband DATA Act is crucial for improving access to broadband in rural areas. It ensures that policymakers and other stakeholders have an accurate depiction of broadband services and capital expenditures to help rural areas most in need. Although the main responsibility for mapping broadband availability lies with the FCC, Congress provided funding to the NTIA to develop a National Broadband Availability Map to help augment the FCC's mapping data. As of December 27, 2021, the National Broadband Availability Map includes 38 states, two U.S. territories, and five federal agencies.²⁰⁹

Congress should monitor whether the FCC broadband data collection effort appears sufficient to alleviate existing broadband mapping issues; Congress should also consider adding variables in the FCC's Fixed Broadband Deployment Map.²¹⁰ The potential benefits and burdens of gathering and providing additional data could be assessed through a targeted pilot program.

ENSURE NEW MODALITIES FOR SERVICE ACCESS ARE PERMANENTLY AVAILABLE IN AREAS WITHOUT BROADBAND

TO STRENGTHEN ACCESS TO CARE IN AREAS WITH LIMITED INTERNET CONNECTIVITY, CONGRESS AND HHS SHOULD:

- Make access to audio-only telehealth services permanent for beneficiaries with established in-person provider relationships.
- Evaluate which services should remain available via audio-only to beneficiaries, especially for those without broadband access and for those with digital literacy or other technology-related barriers.
- Expand asynchronous (store-and-forward) services beyond the Alaska and Hawaii demonstrations.

Audio-only telehealth services, while more limited in their clinical utility, continue to be critical for a subset of vulnerable Medicare beneficiaries who lack broadband access or face technology barriers. BPC recommends that Congress permanently incorporate audio-only telehealth services into the definition of telehealth and that HHS ensures audio-only services remain accessible for a subset of beneficiaries within the context of established provider relationships. In the 2022 Physician Fee Schedule Final rule, CMS stated, “For services for the diagnosis, evaluation or treatment of mental health conditions, we are finalizing a policy to revise the definition of ‘telecommunications system’ for purposes of section 1834(m) of the Act to allow the use of audio-only technology under certain circumstances.” This definition should apply to additional services beyond mental health.

At the beginning of the pandemic, many providers and patients preferred telephone visits because it was a familiar technology and was simpler to navigate when the majority of provider offices suspended in-person care. Over time, audio-only use decreased, as patients and providers became more comfortable with video technology.

However, vulnerable populations with limited internet access, low digital literacy, or other technology-related barriers need alternative options to access care. Studies show that more than one in three U.S. households headed by a person 65 or older does not have a desktop or laptop computer and fewer than half have a smartphone device.²¹¹ According to a 2020 [study featured in JAMA](#), 38% of the elderly were not ready to participate in telehealth visits because of unfamiliarity with technology or physical or cognitive difficulties.²¹²

Older, more rural, and minority populations are disproportionately affected by barriers to accessing Web-based services and are more likely to rely on audio-only services.

Although audio-only services can reach more vulnerable groups, research also shows that telephonic care is not as robust in certain clinical contexts.²¹³ For example, while audio-only psychological therapy sessions were clinically effective, they were significantly shorter than those conducted face-to-face.²¹⁴ Also of concern is the potential for audio-only services to worsen health disparities by creating lower quality access points of care used predominately by marginalized or disadvantaged populations. Several studies found significant disparities among subgroups in terms of audio-only versus video telehealth use. In 2021, video telehealth rates were lowest among those without a high school diploma, adults 65+, and Latino, Asian, and Black individuals.²¹⁵ Additionally, a retrospective study found that Hispanic and Black adults were nearly twice as likely to complete a phone telehealth visit rather than a video visit compared with non-Hispanic white adults.²¹⁶

BPC recommends that individuals with attested barriers to broadband access, low digital literacy, or other technology-related barriers have the option of using audio-only services. Additionally, interactions over the phone are most valuable when beneficiaries have established in-person provider relationships, with the exception of audio-only telemental health services for which patients can establish a provider relationship via two-way video. Therefore, audio-only visits should be reimbursed only in the context of existing patient-provider relationships and based on patient-attested need and preference. Providers who deliver audio-only telehealth services must have the capability for and be available to conduct video visits. The patient's medical record must also document the patient's need and preference for these services. In rural areas without broadband access, the in-person established patient requirement can be waived if the provider attests that the risks and burdens of the in-person requirement outweigh the benefits for a given patient. Additionally, HHS should continue to evaluate the quality and equity impact of audio-only service coverage and established patient requirements.

Store-and-forward, or asynchronous telemedicine, is the electronic transmission of medical information to a practitioner at a distant site, usually a specialist, who uses the information outside of a live interaction with a patient. For example, photographs of a patient's skin lesion can be sent to a specialist for review to confirm a diagnosis or to help direct a treatment plan; the provider at the distant site can review the medical case without the patient being present.

In many states, telehealth services must occur in real time, automatically excluding store-and-forward technology. However, asynchronous telemedicine services are particularly well suited for consultation with a specialist and for reviewing imaging and other diagnostic studies. Although 22 state Medicaid

programs currently reimburse for store-and-forward services, Medicare only allows store-and-forward through telehealth demonstration projects in Alaska and Hawaii.^{217, 218}

Specialist shortages are pervasive throughout rural America: only 11% of physicians practice in rural communities even though 20% of the U.S. population lives in in these places. Until adequate broadband connectivity and specialist access is available nationwide, audio-only telehealth services and care provided via store-and-forward technology should be permitted in rural areas.²¹⁹

REMOVE THE IN-PERSON VISIT REQUIREMENT PRIOR TO ACCESSING TELEMENTAL HEALTH SERVICES

TO ENSURE CONTINUED ACCESS TO MENTAL HEALTH SERVICES FOR VULNERABLE COMMUNITIES, CONGRESS SHOULD:

- Repeal all in-person visit requirements for telemental health services for Medicare beneficiaries living in rural areas and for those needing crisis services.

The pandemic exacerbated mental health and substance use issues in the United States, making access to mental health services even more critical. According to the Kaiser Family Foundation, approximately 4 in 10 adults reported symptoms of anxiety and depression—nearly four times as many as before the pandemic started.²²⁰ More than a quarter of young adults and 22% of essential workers have reported suicidal thoughts.²²¹ With mental health worsening, wide gaps in access to behavioral health providers persist nationally, especially in rural America (see Figure 7).²²²

Figure 7: U.S. Counties Without Behavioral Health Providers by Urban/Rural Divide, 2015²²⁵

Census division	Psychiatrists		Psychologists		Psychiatric NPs	
	Provider/100,000 population	% of Counties without provider	Provider/100,000 population	% of Counties without provider	Provider/100,000 population	% of Counties without provider
Overall U.S.	15.6	51	30.0	37	2.1	67
Metropolitan	17.5	27	33.2	19	2.2	42
Non-metropolitan	5.8	65	13.7	47	1.6	81
Micropolitan	7.5	35	16.8	19	2.1	60
Non-core	3.4	80	9.1	61	0.9	91

In December 2020, Congress imposed new conditions on telemental health coverage under Medicare. Legislation created an in-person visit requirement alongside coverage of telemental health services at the patient's home (Consolidated Appropriations Act of 2021). CMS finalized the 2022 Physician Fee Schedule final rule on in-person visit requirements for Medicare coverage of telemental health services. The rule is set to go into effect five months after the federal PHE ends.

Under the rule, Medicare will cover a telehealth service while the patient is located at home if the provider conducts an in-person visit at least six months before the initial telehealth service; the telehealth service is for purposes of diagnosis, evaluation, or treatment of a mental health disorder (other than for treatment of a diagnosed substance use disorder (SUD) or co-occurring mental health disorder); and the provider conducts at least one in-person service every 12 months of each follow-up telehealth service.

CMS outlines several exceptions to the in-person requirement, including if the patient is located at a qualifying originating site in an eligible geographic area (e.g., a practitioner office in a rural HPSA), or if SUD is diagnosed or the patient has co-occurring mental health disorders. (The SUPPORT Act already made the patient's home an eligible originating site for such services.) Last, the in-person visit requirement will not apply for a 12-month period if the patient and practitioner agree the benefits of an in-person, non-telehealth service outweigh the risks and burdens associated with an in-person visit, and if the basis for that decision is documented in the patient's medical record.

While CMS has created flexibility around the in-person telemental health requirements, evidence shows telemental health visits are comparable in quality to in-person mental health visits. Therefore, the requirement creates an unnecessary administrative burden for providers to document and justify the exceptions, for little gain in return. One review found that telepsychiatry videoconferencing produced no significant differences in symptom reduction compared with treatment delivered in-person.²²³ Additionally, the burden of this requirement falls disproportionately on those living in rural areas who lack access to behavioral health providers, must travel longer distances for care, or face the stigma of accessing in-person behavioral health services in small communities.

Marshfield Clinic Health System, a large rural health system in Wisconsin, commented, "Adjustments to telehealth policy that let people access care from the privacy and comfort of their homes allowed us to deliver services to some of the hardest to reach areas during the pandemic. This included many people who had never accessed behavioral health services before. For example, farmers who said telehealth was the only way they would have ever received mental health services due to the stigma of walking into a clinic, especially in a farming community."²²⁴

This sentiment was repeated by multiple rural stakeholders and points to reticence among rural residents to seek out in-person behavioral health care services.

PERMANENTLY EXPAND THE LIST OF AUTHORIZED SITES OF SERVICE AND REMOVE GEOGRAPHIC AND SITE OF SERVICE RESTRICTIONS

TO ENSURE EQUITABLE ACCESS TO CARE FOR VULNERABLE COMMUNITIES, CONGRESS SHOULD:

- Permanently remove geographic and site of service restrictions for telehealth and audio-only services.
- Permanently authorize FQHCs and RHCs to serve as distant sites by amending section 1834(m) of the Social Security Act.

Although telehealth was initially intended to expand health care access in rural settings by linking patients to providers in urban hubs, its use during the pandemic shows that urban settings also have a strong need for video and audio services.

The COVID-19 pandemic highlighted racial inequities in the nation's health care system, including gaps in access and disparities in outcomes. For example, minority populations had higher COVID-19 mortality rates than white populations. Evidence also demonstrates that racial and ethnic minorities, low-income earners, and individuals with chronic conditions face difficulties accessing care, regardless of where they live. These impediments can include appointment availability or an inability to miss work or secure transportation.

Telehealth is already increasing access to care for communities of color. According to [CMS data](#), 58% of Black beneficiaries and 64% of Hispanic beneficiaries had a telehealth visit between March 1, 2020, and February 28, 2021, compared with 51% of white beneficiaries. Notably, [survey data](#) from the Pew Research Center found that Black respondents were most likely to report using telehealth during the pandemic. These data indicate that leveraging telehealth to deliver appropriate care has the potential to reduce health care disparities. Moreover, because FQHCs and RHCs serve vulnerable populations, including these health centers as distant site providers will increase access to care for racial and ethnic minorities and other populations.

BPC recommends that Congress amend Section 1834(m) of the Social Security Act to permanently remove geographic and site of service (originating site)

restrictions for telehealth and audio-only services. Legislation is required to permanently remove these restrictions from statute.

Congress should also amend Section 1834(m) of the Social Security Act to ensure that FQHCs and RHCs permanently qualify as distant site providers for telehealth beyond the expiration of the public health emergency. CMS included a new interpretation of audio-only and live video telemental health services provided by FQHCs and RHCs in the 2022 Physician Fee Schedule final rule, whereby these services were not regarded as “telehealth” by CMS, because only a legislative change can make them distant site providers.

Removing geographic and site of service restrictions for telehealth could also enhance access to culturally competent care. Studies show that resolving language barriers, understanding patient values and beliefs, and providing access to racially concordant providers improves patients’ experiences and outcomes. Telehealth gives consumers the ability to identify providers who may be better suited to their needs, even if they are not located in their immediate area. Additionally, health care practices could select culturally competent providers to serve certain patient populations remotely.

EXTEND TELEHEALTH FLEXIBILITIES FOR TWO YEARS POST-PHE AND EVALUATE IMPACT

TO SUPPORT EVIDENCE-BASED POLICYMAKING, CONGRESS AND HHS SHOULD:

- Waive telehealth and audio-only regulatory requirements for two years following the end of the PHE and analyze the impact of the waivers on telehealth and audio-only utilization, health outcomes, and cost across beneficiary populations.
- Develop a payment methodology for audio-only and non-facility-based telehealth services (for example, telehealth services accessed from a patient’s home); specify whether reimbursement for services would be appropriate at in-person payment rates.
- Develop additional guidance for the billing of telehealth and audio-only services to ensure appropriate coding and improved data quality.

To ensure evidence-based policy, policymakers must understand how telehealth and audio-only services are and will be used before making permanent decisions. An analysis of claims data two years post-PHE expiration would enable researchers to better understand new utilization patterns outside of a public health emergency.

Last month, Congress extended telehealth flexibilities for five months post-PHE and required the compiling of several reports evaluating telehealth flexibilities by June 15, 2023.²²⁶ First, MedPAC must conduct a study on the expansion of telehealth services, including the effects on utilization, expenditures, quality, and access to care. Second, OIG must evaluate program integrity risks associated with Medicare telehealth services. Finally, the secretary of HHS must make Medicare telemedicine claims data publicly available on a quarterly basis.

Although this was an important step, BPC supports a full two-year extension of waiver flexibility following the end of the PHE to give the secretary time to collect sufficient claims data on telehealth's effects, without disrupting access to care. Extending the secretary's authority, including the initiation or sunset of waivers, would also give the secretary the flexibility to respond to emerging risks related to new telehealth and audio-only policies. During this time, HHS should develop a payment methodology for audio-only and non-facility-based telehealth services, specifying whether reimbursement for services would be appropriate at in-person payment rates. Additional considerations could include differential payment for credentialed telehealth programs—for example, reimbursing at a higher rate for providers who are trained specifically in providing care via distance.

[MedPAC's March 2022 report](#) to Congress recommended that HHS require health care organizations to report more information on telehealth use to help policymakers weigh the future of virtual care.²²⁷ Specifically, the report called out that there is currently no information on Medicare claims to indicate whether a telehealth service was delivered by an audio-only interaction or an audio-video interaction. Consequently, CMS and others are unable to use claims data to assess the impact of many audio-only services.²²⁸

To generate reliable evidence, Congress and the administration should work to simplify telehealth billing and educate providers on billing practices. Providers face myriad billing codes and modifiers when seeking reimbursement for telehealth services. Given the dramatic increase in the number of providers delivering telehealth and audio-only services since the pandemic began, every effort should be made to educate providers and ensure billing accuracy for these services. CMS recently introduced new audio-only modifiers and providers will require additional guidance on how to use them.

An additional opportunity to improve claims data for analysis and future policymaking is to begin differentiating between primary care and medical specialties for advanced-practice nurses and physician assistants. Although this issue is not limited to telehealth services, Medicare categorizes advanced practice clinicians as primary care providers regardless of their actual specialty. For example, PAs and NPs in surgical settings are classified as primary care providers; this may interfere with HPSA determinations and

workforce needs by overestimating the number of primary care providers in an area. The secretary should direct CMS to assign a specialty classification to these providers. Another distinction that will require billing guidance is how providers should navigate billing Medicare virtual check-ins versus audio-only visits in the future.

Conclusion

Even before the COVID-19 pandemic began, rural communities struggled with hospital closures, an older and sicker population, difficulty recruiting and retaining health care providers, and a lack of broadband access.

COVID-19's surge over the past two years has disproportionately affected rural areas, not the least of which being that rural Americans are dying of COVID-19 at double the rates of their urban counterparts.²²⁹ The pandemic has also deepened workforce challenges for rural hospitals by stoking unprecedented rates of burnout among emergency and front-line staff. On the other hand, broad telehealth flexibilities afforded during the public health emergency made substantial inroads in the convenience, user experience, and utility of virtual care.

BPC's recommendations are evidence-based, viable solutions to the health care crisis in rural America. Recommendations are derived from dozens of interviews of rural stakeholders and build on the previous work of BPC's bipartisan 2020 Rural Health Task Force. These recommendations seek to stabilize rural health care systems, strengthen the newly created Rural Emergency Hospital model, ensure an adequate workforce, and broaden access to virtual care in rural America.

The recommendations address fundamental and immediate problems in rural areas. These policies offer a necessary step forward to shore up rural hospitals and stem the loss of access to care. BPC's leaders thank Congress and HHS for making rural health a priority and look forward to continued work on rural health issues.

Appendix A

RURAL PROVIDER DESIGNATIONS AND PAYMENT ADJUSTMENTS

Facility Type	Statutory Definition	Medicare Payment Rate
Rural Hospital Designations		
Critical Access Hospital (CAH) ²³⁰	CAHs must be in a rural area and more than 35 miles from the nearest hospital, with some exceptions; must have 25 or fewer inpatient beds or 25 or fewer total inpatient plus swing beds; have an average annual length of stay of 96 hours or fewer; and have 24-hour emergency care service using on-site or on-call staff.	CAHs are paid 101% of reasonable costs for most inpatient and outpatient services. CAHs are not paid under IPPS.
Sole Community Hospital (SCH) ²³¹	Hospitals can qualify based on various criteria, including: located at least 35 miles from nearest IPPS hospital; located 25-35 miles from other hospitals and is the exclusive provider in the area or less than 50 beds; is rural and 15-25 miles from a hospital that is inaccessible; is rural and travel time to nearest hospital is at least 45 minutes.	SCHs are paid on the higher of the IPPS rate or a base year federal rate.

Facility Type	Statutory Definition	Medicare Payment Rate
Rural Hospital Designations		
Medicare Dependent Hospital (MDH) ²³²	Must be in a rural area; 100 inpatient beds or fewer; not be otherwise classified as a Sole Community Hospital; at least 60% of its inpatient discharges were Medicare Part A patients (this is a key criterion that identifies these facilities as “Medicare dependent”).	MDHs are paid based on the higher of the IPPS rate or a blended rate based on a statutorily defined based year.
Rural Referral Center (RRC) ²³³	Rural or urban tertiary hospitals that receive referrals from surrounding rural acute care hospitals. Any acute care hospital can be classified for Medicare purposes as an RRC if it meets one of several qualifying criteria based on location, bed size, and/or referral patterns. Some RRCs may also be Sole Community Hospitals or Medicare-Dependent Hospitals.	RRCs get certain advantages, such as being exempt from the cap on Medicare operating DSH payments applicable to other rural hospitals.
Rural Payment Adjustments		
Low Volume Payment Adjustment ²³⁴	A hospital must have fewer than 3,800 total patient discharges per year and be located more than 15 miles from the nearest hospital.	Low-volume hospitals receive a sliding scale, per discharge add-on payment. This is then added to their IPPS rate.
Disproportionate Share Hospital (DSH) ²³⁵	SSA Section 1886(d)(5)(F) provides additional Medicare payments to hospitals serving a significantly disproportionate number of low-income patients.	DSH hospitals receive a Medicare DSH payment adjustment that is typically calculated based on the share of the hospital’s low-income patients. Each Medicare DSH-eligible hospital gets an uncompensated care payment based on its share of uncompensated care costs compared with all Medicare DSH-eligible hospitals.

Facility Type	Statutory Definition	Medicare Payment Rate
Other Rural Providers		
Indian Health Service Hospital ²³⁶	IHS is an agency within HHS and responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and executive orders.	On an annual basis, the IHS calculates and publishes reimbursement rates applicable to reimbursement methodologies primarily under the Medicare and Medicaid programs.
Federally Qualified Health Centers (FQHC) ²³⁷	A health center that receives grant funding from the HRSA Bureau of Primary Health Care under the Health Center Program, as authorized by Section 330 of the Public Health Service (PHS) Act. Most awards provide support for the provision of comprehensive primary care services to underserved communities (or service areas) and specific underserved populations as mandated in the Section 330 authorization, such as migratory and seasonal agricultural workers, persons experiencing or at risk for homelessness, and residents of public housing.	Medicare pays FQHCs based on the FQHC PPS for medically necessary primary health services and qualified preventive health services. Medicare pays claims at 80% of the lesser of the FQHC charges based on their payment codes or the FQHC PPS rate. CMS annually updates the FQHC PPS base payment rate using the FQHC market basket. For CY2021, the market basket update under the FQHC PPS is 1.7% and the FQHC PPS base payment rate is \$176.45.
Rural Health Clinics (RHC) ²³⁸	To be certified as an RHC, a clinic must meet all state and federal requirements, including location, staffing, and health care services requirements. RHCs must also have a quality assessment and program improvement program.	Medicare pays RHCs a bundled payment, or All-Inclusive Rate (AIR) per visit, for qualified primary care and preventive health services. As of January 1, 2021, Medicare subjects the AIR to a payment limit per visit, meaning an RHC won't get any payment beyond the specified limit amount per visit.

Appendix B

RURAL PROVIDER LANDSCAPE

	Iowa	Minnesota	Montana	Nebraska	Nevada	North Dakota	South Dakota	Wyoming	National
Acute Care Hospitals (by CMS payment program) ²³⁹									
Critical Access Hospitals (CAH)	82	78	49	64	13	36	38	16	1,352
Sole Community Hospitals (SCH)	7	15	5	5	2	2	6	9	457
Medicare Dependent Hospitals (MDH)	4	0	0	0	0	0	0	0	166
Rural Referral Center (RRC) only	4	2	3	2	1	2	3	0	519
Indian Health Service (IHS)	0	1	1	0	0	2	2	0	29
Prospective Payment System (PPS) Hospitals	18	30	4	16	20	2	7	1	2,079
Total Acute Care Hospitals	115	126	62	87	36	44	56	26	4,602
Additional Facilities ²⁴⁰									
Certified Nursing Facilities	431	367	70	196	66	80	104	36	15,327
Community Health Centers	14	16	14	7	8	4	4	6	1,375
Rural Health Clinics (RHC)	206	98	60	141	17	54	58	26	4,799
Hospital Beds ²⁴¹									
Hospital Beds	9,459	13,901	3,614	6,038	6,309	3,323	4,222	1,990	787,995
Hospital Beds per 1,000 people	3	2.46	3.38	3.12	2.05	4.36	4.77	3.44	2.4
Intensive Care Unit (ICU) Beds	622	1,277	248	548	1,118	278	150	102	85,247
ICU Beds per 10,000 people	2	2.30	2.40	2.90	3.70	3.80	1.80	1.80	2.7
Rural Hospital Closures ²⁴²									
2005-2010	0	2 (1 converted)	0	0	1 (converted)	1 (converted)	2 (converted)	0	43
2010-2020	0	4 (3 converted)	0	1 (converted)	1	0	1 (converted)	0	138
2021	0	0	0	1 (converted)	0	0	0	0	2

	Iowa	Minnesota	Montana	Nebraska	Nevada	North Dakota	South Dakota	Wyoming	National
Acute Care Hospitals (by CMS payment program) ²³⁹									
Rural Hospitals at Risk ²⁴³									
Negative Total Margin Three-Year Average	30	28	16	21	2	10	11	10	799
Financial Losses on Patient Services Three-Year Average	57	35	27	30	6	19	16	8	1,008
Current Liabilities Exceed Current Assets (Current Net Assets)	10	10	3	7	0	4	13	1	384
Current and Long-term Liabilities Exceed Current Assets (Total Net Assets)	42	34	17	18	4	14	15	8	764

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- 240 Kaiser Family Foundation, “Total Number of Certified Nursing Facilities,” 2020. Available at: <https://www.kff.org/other/state-indicator/number-of-nursing-facilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

See also: Kaiser Family Foundation, “Community Health Center Delivery Sites and Patient Visits,” 2020. Available at: <https://www.kff.org/other/state-indicator/community-health-center-sites-and-visits/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Note: Includes FQHCs which meet federal health center requirements and receive federal grants under Section 330 of the Public Health Service Act. Other community health centers known as “look-alikes,” which also meet federal health center requirements, but do not receive Section 330 grants, are not included. There were 87 look-alikes nationwide as of 2020.

See also: Kaiser Family Foundation, “Number of Medicare Certified Rural Health Clinics,” 2020. Available at: <https://www.kff.org/other/state-indicator/total-rural-health-clinics/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

- 241 Kaiser Family Foundation, “Total Hospital Beds,” 2020. Available at: <https://www.kff.org/other/state-indicator/total-hospital-beds/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- 242 Cecil G. Sheps Center for Health Services Research, University of North Carolina, “Rural Hospital Closures,” 2014. Available at: <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

Note: A facility that no longer provides health services is considered a “complete hospital closure.” A facility that closed its inpatient unit but continued to provide other health services, like emergency, rehabilitation, and/or outpatient services, at the same physical location would be considered a “converted hospital closure.”

243 BPC Analysis of CMS Provider of Services and Hospital Cost Report files, downloaded from: Center for Healthcare Quality and Payment Reform, “Data on Rural Hospitals: Assets Available to Cover Losses,” 2022. Available at: <https://ruralhospitals.chqpr.org/Data5.html>.

Note: Average Margins show the profitability of the hospital during the three most recent years for which Cost Reports are available. In most cases, the averages are based on either 2018-2020 or 2017-2019 data. The Patient Service Margin represents the profit or loss from revenues and costs associated with health care services delivered to patients. The Total Margin includes revenues and costs that are not directly tied to patient care as well as revenues and expenses on patient services.

See also: BPC Analysis of CMS Provider of Services and Hospital Cost Report files, downloaded from: Center for Healthcare Quality and Payment Reform, “Data on Rural Hospitals: Assets Available to Cover Losses,” 2022. Available at: <https://ruralhospitals.chqpr.org/Data5.html>.

Note: Hospital Assets: Current Net Assets is calculated by subtracting the hospital’s Current Liabilities (e.g., accounts payable) from its Current Assets (e.g., cash and accounts receivable). Total Net Assets (excluding Fixed Assets) is calculated by subtracting the hospital’s Current Liabilities and Long-Term Liabilities (e.g., long-term debt) from the sum of its Current Assets and Other Assets (e.g., investments). Fixed Assets (e.g., the hospital building) are not included since using fixed assets to pay for financial losses would require sale of parts of the hospital facility.



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