Letter on Rural Hospital Issues: July 21, 2014

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The Honorable Sylvia M. Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Burwell,

The National Advisory Committee on Rural Health and Human Services would like to congratulate you on your confirmation as Secretary of the Department of Health and Human Services (HHS). Having grown up in rural West Virginia, you have first-hand knowledge of the impact of health policies on rural communities and their access to affordable, quality health care. With your impressive background and broad range of experience, we are honored to work with you and look forward to your leadership.

The Committee is finishing work on two policy briefs from a recent meeting in Nebraska and Iowa focused on premium pricing under the Health Insurance Marketplaces and rural homelessness. The Committee also discussed a range of other issues at this meeting and wanted to raise concerns about a number of recent policy proposals and regulatory changes by HHS that affect small rural hospitals and the communities they serve. The Committee's primary focus is on ensuring access to quality health care services in rural communities. We are hopeful that the expansion of health insurance coverage will greatly benefit rural communities, but those coverage gains may be undermined by a growing number of rural hospital closures, particularly in the Southeast.

In its 2012 policy brief Options for Rural Health Care System Reform and Redesign, the Committee identified several key concerns for rural communities that resulted from changes in the Affordable Care Act.

This letter echoes the questions posed in the policy brief about how short-term incremental policy changes driven by budgetary concerns may disproportionately affect rural health care providers.

For example, several Committee members representing rural hospitals cited the examples of increased costs and reduced access as a result of CMS' requirements for direct supervision of outpatient therapeutic services at CAHs and small rural PPS hospitals. This comes on top of the expiration or repeated short-term renewal of certain statutory rural payment provisions in recent years, which adds to the financial difficulties of many small rural facilities. The Committee is concerned that rural providers, which have traditionally operated on very thin margins, are struggling to maintain economic sustainability and provide the same level of access to their communities as a result of these policy changes.

The Committee is concerned that the rural health care environment is becoming increasingly unstable. A number of the hospital administrators the Committee met with noted that many of the newly insured are choosing high-deductible plans, creating concerns that this will add to rural hospitals' bad debt burden, as well as decreasing access to care as the new deductibles and copays may be largely unaffordable for low-income populations. One Committee member from Montana noted that a recent change by CMS to CAH participation in Graduate Medical Education supported resident training will reduce the number of residents training in small rural hospitals and affect his community's ability to attract needed physicians. Other Committee members noted that CMS' regulatory changes to clarify status of short-stay patients have led to a great deal of uncertainty at CAHs, especially when considered in conjunction with the statutory 96-hour length of stay (LOS) payment requirement. Admitting practitioners at CAHs must now certify that each admitted patient will spend at least two midnights in the hospital yet will be ready for discharge within four days. That is a significant challenge when caring for acutely ill, elderly Medicare patients with multiple chronic conditions.

The Committee understands that each of these policies individually was implemented with a purpose, and that several were statutory. That is not the case, however, with the 96-hour LOS issue. The Committee believes Congress explicitly changed this requirement. The original hard limit of 96 hours was tying the hands of clinicians in small rural hospitals and, in some cases, necessitating the transfer of patients to another hospital with a subsequent DRG payment. The Committee believes it is inconsistent for CMS to link the statutory change only to the condition of participation and not to the payment condition.

Moving forward, the Committee urges the Secretary to make sure that HHS leadership examine how the effects of these policies are being felt cumulatively by rural providers and the communities they serve. We welcome the opportunity to work with HHS to help policy makers better understand the cumulative effect of Departmental policy on access to care in small rural communities. The challenges of implementing regulatory changes in rural areas also provide opportunities for innovation and improvement among rural health care systems. Our goal is to continue to respond to our charge to advise you on rural policy issues. Toward that end, we will

continue our work to assess the impact of the Affordable Care Act on rural communities and to offer our collective perspective on other key policy issues in rural America.

Sincerely,

The Honorable Ronnie Musgrove
Chair