A Passionate Voice for Compassionate Care

RURAL HEALTH CARE

Approximately 46 million Americans live in a rural area. These individuals and families face increasing hospital closures, declining economic opportunities, lack of access to quality and affordable health care and an ongoing struggle to recruit health care workers. Rural hospital closures in many areas of the country continue to put increasing pressure on local communities and public health. Of the rural hospitals that closed between 2005 and 2017, 43% were more than 15 miles away from the next closest hospital.[1] These closures have forced patients in rural areas to travel ever increasing distances to receive primary or emergency health care and left communities struggling to face the consequences of a closed hospital.

The impact of these closures is particularly acute as overall economic and community health continues to decline across many rural communities. In addition to having fewer health care options, rural communities have higher rates of suicide and are more likely to have higher rates of smoking and obesity as well as lack access to healthy food options. Because of the resulting health disparities people living in rural areas are more likely than urban residents to die prematurely of heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke. [2]

In confronting this reality, rural health care providers must confront the challenge of serving an increasingly vulnerable and diverse community stretched across a wide geographic service area, while also facing staffing shortages in many care settings including hospitals and long-term care facilities. The increased need coupled with the increasing cost and challenge of operating a full-service hospital and long-term care facility in a rural community has left health care providers with difficult choices. These challenges are further exacerbated by a decrease in rural health infrastructure investments and a health care reimbursement model which favors quantity of services provided over quality of care.

MINISTRY TRADITION

With 207 rural hospitals as of 2018 (an increase of 7 hospitals since 2012) and 233 Catholic continuum-of-care and long-term care providers, the Catholic health ministry continues to work to meet the needs of rural communities. The first principle in CHA's *Vision for U.S. Health Care* affirms our call to pay special attention to the needs of the poor and the vulnerable and those most likely to lack access to health care, including those in rural communities. We are inspired by the wisdom of the social doctrine of the Church, which teaches that each person is created in the image of God; that each human life is sacred and possesses inalienable worth; and that health care is essential to promoting and protecting the inherent dignity of every individual regardless of socioeconomic status or residency. This commitment is why the Catholic health ministry continues to work to ensure access to care to meet the needs of rural communities and to advocate for changes in health care policy so that all people have access to quality and compassionate care.

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[1] Meagan Clawar, Kristi Thompson, George Pink. *Range Matters: Rural Averages Can Conceal Important Information*. NC Rural Health Research Program, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. January 2018. Available at: https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/RuralAveragesConcealInfo.pdf

[2] Centers for Disease Control and Prevention National Center for Chronic Disease Prevent and Health Promotion, Preventing Chronic Diseases and Promoting Health in Rural Communities Factsheet, 2021 available at https://www.cdc.gov/chronicdisease/pdf/factsheets/Rural-Health-Overview-H.pdf

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CHA'S POSITION AND ACTIVITIES

CHA continues to advocate for policy changes which address the underlying systemic challenges facing rural health care providers while at the same time advocating increasing investments in community and public health so that rural communities have access to quality, affordable and compassionate care. These policy changes include:

Supporting rural health providers responding to the COVID-19 pandemic – Rural health care providers are facing overwhelming challenges in the ongoing COVID-19 pandemic to meet the health needs of rural communities while at the same time mobilizing resources to ensure Americans living in rural communities have access to COVID-19 vaccines. We therefore support:

- Additional resources for testing, personal protective equipment and COVID-19 vaccines to protect patients and their providers and help vacation efforts in rural communities;
- Additional funding for the COVID-19 Provider Relief Fund (PRF) to help rural hospitals and long-term care providers prepare for and treat COVID-19 patients but also ensures that rural providers have the support they need to serve their communities;
- Additional funding for programs like the National Health Service Corps and the Nurse Corps Loan Repayment Program to bolster staffing;
- Eliminating the 2% Medicare sequester cuts for providers through the end of the COVID-19 public health emergency to provide the stability and financial security rural hospitals need to continue to meet the urgent demands of the pandemic.

Improving health and expanding access to health care in rural communities - Comprehensive public and private health care coverage, including for behavior and mental health, remains a priority for improving broader rural health and the COVID-19 crisis has demonstrated the profound positive impact that providing telehealth to rural communities can have in expanding access to care, particularly mental and behavioral health care. We support:

- Continuation of the telehealth flexibilities and financing provided during the COVID-19 pandemic as well as increased investments in broadband and point-of-service telehealth technologies to ensure greater access to care especially for individuals living in rural areas.
- Enhancing Medicaid federal funding to support increased Medicaid enrollment and to encourage state expansion of Medicaid coverage under the Affordable Care Act in states which have yet to expand coverage.
- Continued robust funding of the Supplemental Nutrition Assistance Program and housing assistance programs to support those most in need in rural communities.

Strengthening the rural health safety net – Medicare and Medicaid each pay less than 90 cents for every dollar spent on caring for a patient. With rural hospitals forced to meet minimum staffing and service needs to serve a smaller, often older, and poorer populations, reimbursement rates should be updated to reflect the cost or providing healthcare in rural communities. We support:

- Reinstatement of the *necessary provider designation* for the Critical Access Hospital (CAHs) program which provides a waiver of 35-mile limit for CAH designation so that these providers can receive cost-based Medicare reimbursement for services.

- Removal of the 96-hour physician certification rule for Critical Access Hospitals (CAHs) enabling them to serve patients needing critical care who have lengths of stay greater than 96 hours. These changes reflect the need for congress to prioritize innovative strategies for providing cost effective and quality health care for rural communities.
- Making the Medicare-dependent Hospital (MDH) & Low-volume Adjustment (LVA) programs permanent to ensure the financial viability of these hospitals and continued access to care.

Addressing health disparities and access to maternal and obstetric health in rural communities – Access to mental, behavioral, and maternal health in rural communities continues to be an increasing challenge across the country. As a result of hospital closures, fewer than 50% of rural women have access to prenatal services within 30 miles of their home and 10% have to drive 100 miles or more for these services. This reality affects access to care before, during and after pregnancy and has a disproportionate impact on Black, Hispanic and indigenous American communities, and low-income women.[3]

- The American Rescue Plan Acts' extension of postpartum Medicaid coverage from 60 days to one year as a state option is an important first step in improving maternal health and addressing maternal health disparities. However, making the policy mandatory and permanent will have a profound impact on ensuring all women have access to continuous health care coverage during and after pregnancy.

Supporting the rural health workforce - Rural communities continue to struggle to recruit and maintain sufficient number of health professionals and specialists to meet their community's needs. Congress can make meaningful and sustained investments in addressing our rural health workforce shortage by:

- Increasing the number of Graduate Medical Education Medicare funded residency slots in rural settings;
- Expanding and extending the Conrad State 30 J-1 vista waiver program for J-1 visa holding physicians, who agree to work for three years in a designated underserved area, and
- Supporting workforce policies which improve recruitment and retention of health care professionals and allows them to practice at the top of their license.

[3] Centers for Medicare and Medicaid Services, *Improving Access to Maternal Health Care in Rural Communities – Issue Brief*, 2019, pg. 5.

Catholic Health Association Supported Rural Health Care Legislation

Legislation we Support	Rural Health Care Impact	Status
H.R. 1319- American Rescue Plan Act of 2021	- $500 million grant program for non-profit health care providers for vaccine distribution, medical supplies, telehealth costs and other COVID-19 response activities -$8.5 billion for the Health Care Heroes Sustainability Fund (HCHSF) for rural health providers and clinics - Funding for the National Health Service Corps ($800 million) and the Nurse Corps Loan Repayment Program ($200 million) - $80 million towards Mental Health training, and $40 million in funding to support the Mental Health professional workforce in rural and underserved communities	Signed into law on March 11, 2021
Resident Physician Shortage Reduction Act (S. 834)	- This legislation would gradually raise the number of Medicare-supported Graduate Medical Education (GM)E positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals in rural areas, hospitals serving patients from health professional shortage areas, hospitals in states with new medical schools or branch campuses and hospitals already training over their caps.	Introduced in Senate by Senators Menendez (D-NJ), Boozman (R-AR) and Schumer (D-NY)
Rural Hospital Support Act (Bill number pending)	- Makes permanent the Medicare-Dependent Hospital (MDH) program and enhanced low-volume Medicare adjustment for small rural prospective payment system hospitals. -Allow sole community hospitals and MDHs to choose an additional base year from which payments can be calculated.	Introduced in House by Reps Sewell (D-AL) and Reed (R-NY)
Rural America Health Corps Act (S.924)	-Creates NHSC Rural Provider Loan Repayment Program demonstration program to provide educational loan repayments to health professionals working rural communities.	Introduced in Senate by Senators Durbin (D-IL), Blackburn (R-TN), Murkowski (R-AK) and Smith (D-MN)
Rural Behavioral Health Access Act	- Ensure Critical Access hospitals (CAH) are able to retain crucial flexibility to provide behavioral health services through telehealth after the end of the COVID-19 pandemic.	Introduced in House by Reps Dan Kildee (D-Mich.) and Brad Wenstrup (R-Ohio)