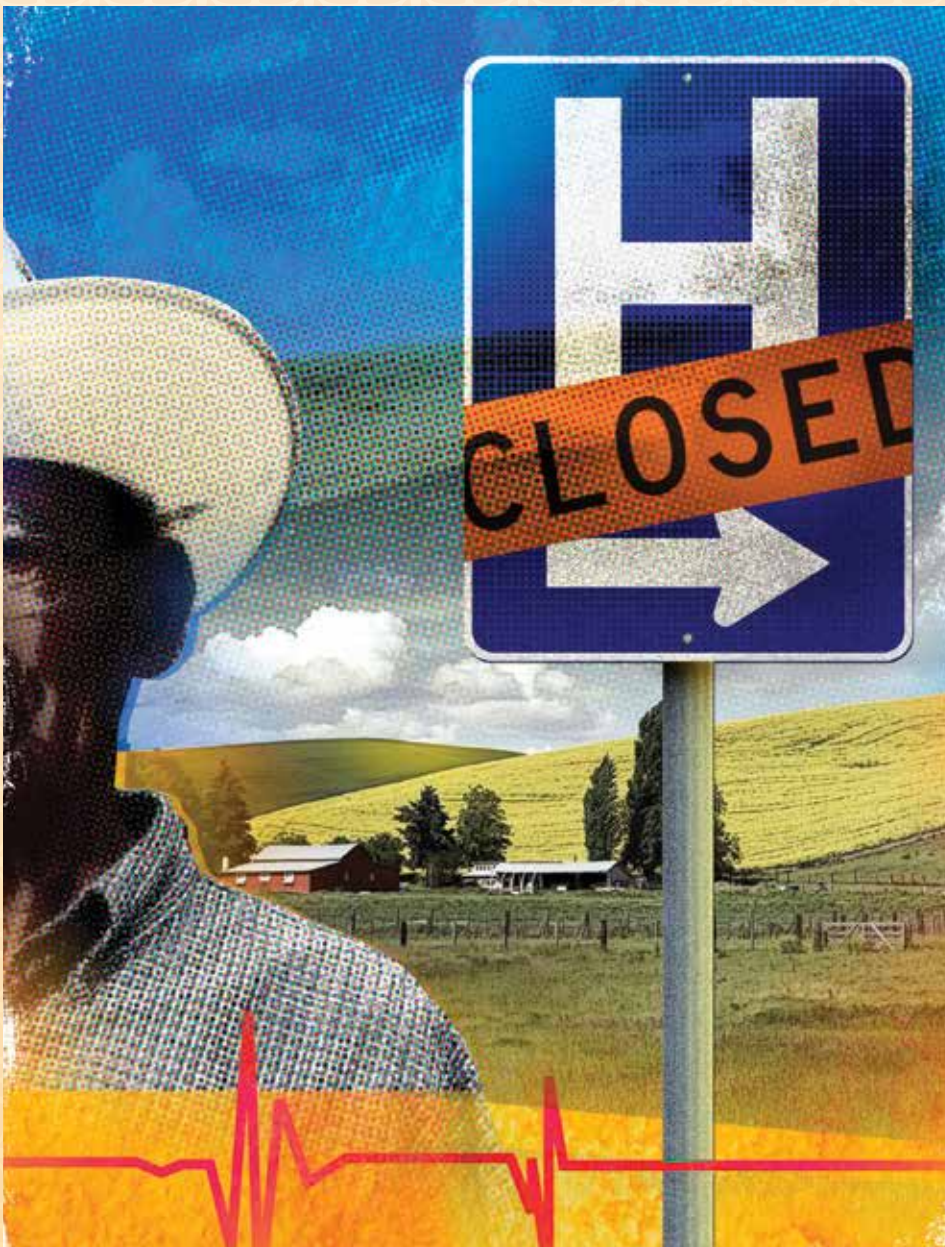


Can Public Policy Save Rural Health Care?



A Guide
for Group
or Personal
Reflection



A Passionate Voice for Compassionate Care®

This *Health Progress* Reflection Guide looks at the article “Can Public Policy Save Rural Health Care?” by Rachel C. Tanner, vice president of regulatory affairs and state relations for CommonSpirit Health. The article addresses the increasing challenges to rural health care due to financially strapped hospitals, communities losing population and resources, and conditions of Medicare payment that are out of sync with current realities. Hospitals are closing and services offered by those still open are being reduced. Tanner describes the conditions that threaten rural health care and suggests actions to be taken by health systems in carrying out Catholic health care’s responsibility to advocate for better policies around Medicare and physician placements. How Catholic health care as a whole can push for revisions to policy and incentives to address the shortage of clinicians in rural areas will make the ministry truer to its universal mission.

This Reflection Guide provides a process to encourage thoughtful discussion of the article’s central themes. The process is designed to be used by individuals or groups as a topic for reflection, as part of personal formation or as an exercise for participants in senior leader formation programs. We have prepared the guide for use by executives, managers, mission leaders, clinical and nonclinical associates, board members, sponsors, ethics committee members and others.

Suggested Reflection Process

1. Begin your reflection with prayer — one is provided.
2. Read the Executive Summary of the article.
3. Review the Questions for Discussion and note their concepts, but don’t answer them yet.
4. Read the article.
5. Return to the Questions for Discussion:

- A. Consider each question thoughtfully, jotting down any responses, considerations or questions that come to you.
 - B. If you are working through this by yourself, consider discussing your responses with a colleague — get her or his thoughts on the questions; see if the person agrees with your thoughts or has different viewpoints to offer. If you are discussing as part of a group, take your written notes to the meeting. For group use, it might be helpful to assign the reading and then convene later for group discussion.
6. Close with prayer — a concluding reflection is provided.

Please let us know any suggestions or insights about this or the series of Reflection Guides in general.

To share comments, contact Mary Ann Steiner, *Health Progress*, at masteiner@chausa.org.

PRAYER FOR THE COMMON GOOD AND THE REIGN OF GOD

Opening Prayer and Reading

Leader: The City of God, the new Jerusalem, is our heavenly home, but it is foreshadowed in our earthly city through the common good. Since health care is a prominent aspect of the common good, let us reflect on this city, here and in the presence of God.

Reader 1: A reading from the Revelation to John

“Then I saw a new heaven and a new earth; ... And I saw the holy city, the new Jerusalem, coming down out of heaven from God, prepared as a bride adorned for her husband. And I heard a loud voice from the throne saying, ‘See, the home of God is among mortals. He will dwell with them; they will be his peoples, and God himself will be with them.’” (Rev. 21:1-3)

Silent Reflection

“The only absolute is God with whom human beings enter into full relationship only in the heavenly Jerusalem, the City of God. But the political domain has the potential to become a practical embodiment of this full human Good when it seeks greater human solidarity, not just toleration or the protection of individuals in their solitude. The quality of this republic will be proportional to the quality of the loves found among its citizens ...”¹

Silent Reflection

Reader 2: “Central to the common good is the group’s social well-being and development ... [and] authority’s proper function is to arbitrate between various particular interests in society. Essential to this is ensuring the accessibility to each person of ‘what is needed to lead a truly human life: food, clothing, health, work, education and culture, health care, the right to establish a family, and so on.’” (Catechism #1908)

Silent Reflection

Everyone has responsibility for the common good as an embodiment of charity and justice. “The more we strive to secure a common good corresponding to the real needs of our neighbors, the more effectively we love them. Every Christian is called to practice this charity, in a manner corresponding to his vocation ...” (Benedict XVI, *Caritas in veritate*, #7)

Prayer

Please respond: *Lord hear us.*

Lord, you have shown us the vision of the Holy City Jerusalem as our home. Help us to imitate that city in the world we inhabit, we pray ...

All: Lord, hear us.

Lord, political life helps us create an earthly city that brings justice and equity and an end to suffering. Give our politicians and civil leaders prudence, good judgment and a firm commitment to just distribution of the goods of the earth, we pray ...

All: Lord, hear us.

Help us in our own lives to reject fear and to prefer solidarity with others over the security of individual solitude, we pray ...

All: Lord, hear us.

May our health care ministry be a sign to the world of God’s heavenly city, we pray ...

All: Lord, hear us.

Leader: Bless us with the gift of solidarity and justice. Help us to be a holy, transforming presence in the world around us, especially as we care for the sick and improve social conditions that lead to illness and hasten death.

We ask this of you who live and reign forever, with your Son and in the unity of the Holy Spirit.

All: Amen.

¹ Portions of this were inspired by David Hollenbach, *The Common Good and Christian Ethics* (Cambridge: Cambridge University Press, 2002), 127-36.

EXECUTIVE SUMMARY

Across the United States, rural communities are facing enormous pressure to survive. Employers are shutting down. Younger generations are leaving to find economic opportunity elsewhere. The remaining population is aging, and health care providers and facilities are stretched nearly to the breaking point. In fact, more than 160 rural hospitals have closed since 2005, and 21% of all rural hospitals are at high risk of closure due to financial instability.

How can Catholic health care help? The answer may lie in public policy. While rural communities face serious policy hurdles, such as workforce sustainability, a challenging payer mix or overly burdensome regulations, we may be able to impact change through advocacy.

Under-reimbursement by Medicare is only part of the problem. Rural communities face higher rates of unemployment, and thus lower access to employer-based insurance, than their urban counterparts. In these areas, expanded access to government insurance is key.

Rural medical practices and hospitals need generalists in an era of medical specialty. They need greater leeway to use advanced practice providers for general medical services. The federal government could

utilize greater student loan paybacks to entice clinicians to rural areas. Loosening some of the regulatory burden around workforce would help reverse the trend of physicians opting for urban over rural practices.

QUESTIONS FOR DISCUSSION

Rural communities are facing numerous threats to their survival, and the health care they need is at significant risk. More than 160 rural hospitals have closed since 2005; many more are in danger of closing because of financial instability. Rachel Tanner of CommonSpirit Health poses the question of what can and what should Catholic health care do to help the communities, patients and clinicians in such vulnerable situations. While the challenges seem overwhelming, Tanner thinks there are opportunities to update policy decisions, especially around the Medicare Conditions of Payment, to reflect the current realities of rural communities and their providers.

1. Rural communities may be served by either small, rural hospitals or crucial access hospitals — both of which struggle with Medicare Conditions of Payment. What could your system do to help rural facilities deal with the lack of funding they face? What kinds of community benefit support could help offset the inequitable Medicare conditions?
2. Many recently licensed clinicians prefer to take positions in urban rather than rural settings. What educational support or residencies does your system offer to make rural placements more attractive? What ideas do you have in terms of tuition tradeoffs, paid internships, job security or other opportunities for new clinicians to help bring new talent to rural hospitals?
3. What do you think of Tanner’s view of rural health care as an issue of justice at the ministry level (Catholic Health care), the health care system level (your system and how it is advocating for its rural facilities) and the individual level (what you can bring to the table and how you can speak to your state senators and representatives)?



Can Public Policy Save Rural Health Care?

RACHEL C. TANNER, MJur

Across the United States, rural communities are facing enormous pressure to survive. Younger generations are leaving to find economic opportunity elsewhere, employers are shutting down, the remaining population is aging, and health care providers and facilities are stretched nearly to the breaking point. In fact, more than 160 rural hospitals have closed since 2005, and 21% of all rural hospitals are at high risk of closure due to financial instability.

One question must follow: if rural communities are facing such difficult challenges, how can Catholic health care leaders help? The answer may lie in public policy. While rural communities face serious policy hurdles, such as workforce sustainability, a challenging payer mix or overly burdensome regulations, we may be able to impact change through advocacy. By contacting our federal elected officials, federal regulators and state leaders, people both in and out of rural America can fight for changes that will shore up rural health care.

WHY RURAL MATTERS

You may be asking yourself why the plight of rural health care is important to people who live in urban or suburban areas. If we set aside the financial implications of closing hospitals, including the overall economic impact to the community, we recognize that the need for care does not go away, but simply shifts to urban and suburban facilities. We must embrace our mission and recognize that people living in rural communities are as much our brothers and sisters as anyone else living on this planet. They often do not have the number of voices needed to advocate for important policy changes, but we can bolster them with

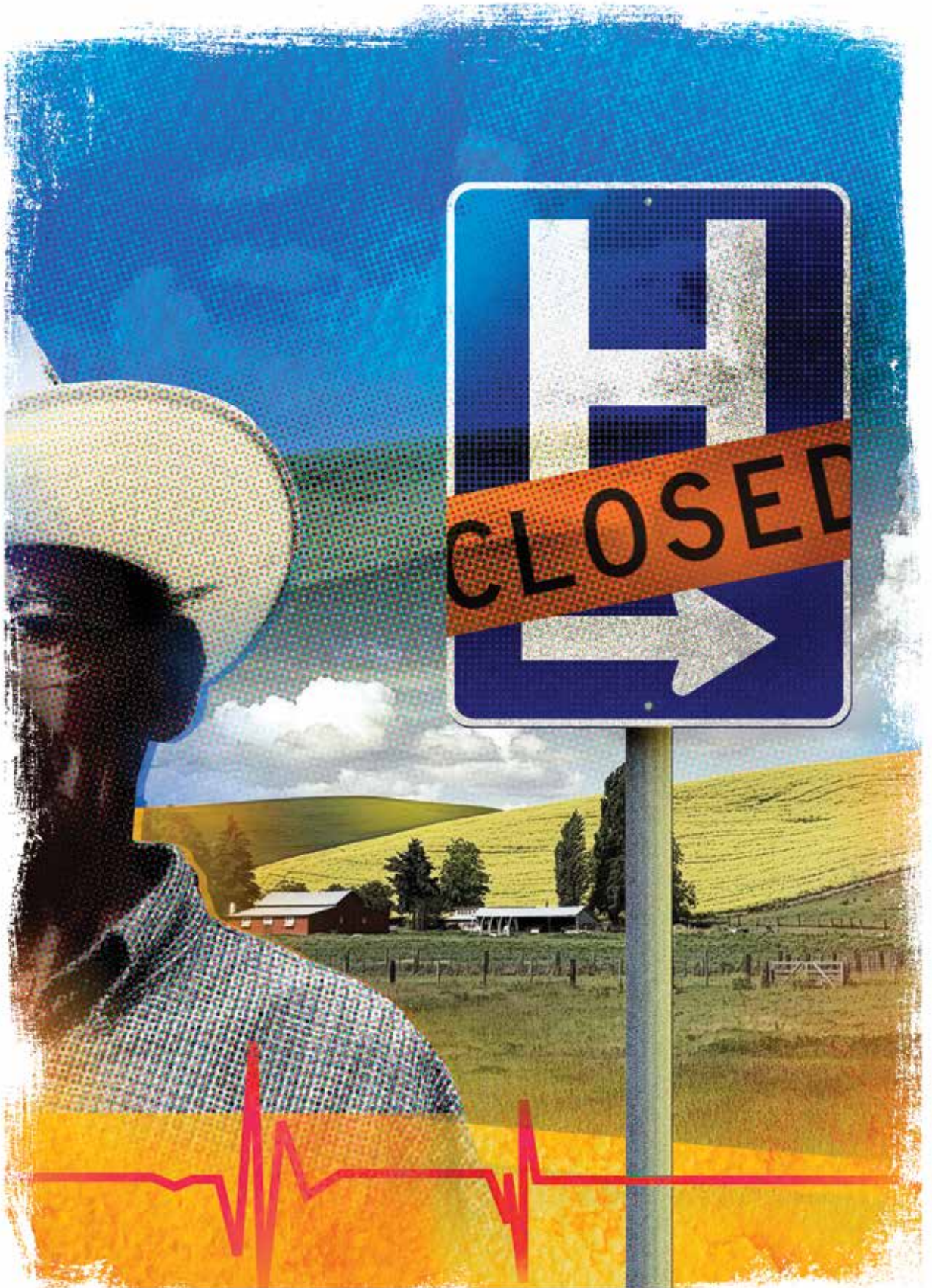
the influence of broader health care ministry.

Indeed, many of the founding congregations of Catholic health systems started in rural areas. The women religious looked across our country and saw a need for education, housing, child services and health care. They went where they were needed, regardless of the hardship or economic opportunity. As leaders in Catholic health care, we have a chance to continue that vision and advocate for public policies that serve the vulnerable people and communities found in rural America.

STATE OF RURAL HEALTH CARE

The challenge is daunting. As individuals move away from rural areas to more economically

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viable cities and suburbs, rural hospitals and health providers are becoming less financially stable and more at risk of closure. *Politico* reports that since 2005, 162 rural hospitals have closed across 35 states, with a large concentration in southeastern states.¹ Sadly, the rate of hospital closures is increasing: more rural hospitals closed in 2019 than in any year since 2005. And it isn't only hospitals that face closure. According to *The Washington Post*, over the last decade rural communities have lost 250 maternity wards, 3,500 primary care doctors, 2,000 medical specialists and hundreds of nursing homes.²

When a rural hospital closes, the entire community suffers. Hospitals often are the first- or second-largest employer in a small community, providing a vital economic boost to the local community. A hospital makes communities feel safer and provides much-needed community-based primary care, outpatient therapies and other health services. Local hospitals allow people to receive care closer to home, which is vitally important for seniors, people who do not have transportation, or people who cannot miss work for a doctor's visit. Additionally, larger employers who may want to invest in or relocate to a community may choose to go elsewhere if adequate health services are not available, thus perpetuating the cycle of economic decline for both the town and the hospital.

PUBLIC POLICY CHALLENGES AND OPPORTUNITIES

Perhaps the greatest burden faced by rural health care facilities is the regulatory burden placed on them by the Medicare Conditions of Payment and Conditions of Participation. For example, rural critical access hospitals must have a physician certify in advance that an admitted patient is expected to leave the hospital within 96 hours. Additionally, since a large percentage of new med-

ical school graduates do not want to practice in rural areas, rural providers are disproportionately disadvantaged by the nationwide shortage of doctors, which exists largely because of the 1997-level limits on Medicare-funded residency slots that remain in place today. Further, rural providers are much more likely to face difficulty navigating the complex and disparate systems governing fraud and abuse rules, particularly as they relate to physician employment, patient transportation distance limits, and value-based bundled payment programs.

Many rural hospitals were built decades ago when the communities they served were larger, younger and healthier. Over time, rural hospitals have cobbled together new services to aid their aging patient base, closed floors or entire wings of their buildings, or made other changes to try to meet the needs of their patients. Unfortunately, however, there is no regulatory pathway for hospitals to downsize even further.

The two main types of rural facilities are small, rural hospitals and critical access hospitals. Both types have some special consideration given to them based on their status as pillar institutions within their rural communities. For example,

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small rural hospitals that have fewer than 100 beds may be classified as a "Medicare Dependent Hospital," based on their payer mix, or as a "Sole Community Hospital," based on the hospital's distance in relation to other hospitals. Both designations carry special Medicare reimbursement mechanisms. Critical access hospitals are unique in that they must have fewer than 25 beds, be located a specific distance from any other hospital, and operate under special Medicare reimbursement and Medicare conditions of participation. Critical access hospitals generally are paid at 101% of Medicare costs, minus the 2% withhold due to budget sequestration since 2013. For Medi-

care eligibility purposes, critical access hospitals must maintain an annual average length of stay of 96 hours or less for acute care patients. However, they are granted greater flexibility than traditional hospitals in their staffing requirements, such as the requirement that a physician must be available within 30 minutes in the case of an emergency.

Many small, rural hospitals would like to transition to critical access hospital status, but there is no easy path to do so under Medicare's guidelines. Critical access hospitals often were created through a governor's designation as a "necessary provider," but states have not been allowed to use that designation since 2008. Further, to transition to a critical access hospital, the hospital must be located in a state that has established a State Medicare Rural Hospital Flexibility Program, which a few states still have not done.

Additionally, some critical access hospitals would like to transition to become an even smaller facility, such as an emergency department with one or two inpatient beds, but, again, there is no mechanism to allow for this change without risking their current cost-based reimbursement. Instead, both types of rural hospitals are left operating in a manner appropriate to the situation they were built for decades ago rather than the situation they face today.

Rural hospitals need flexibility to meet the needs of their communities today, not the onerous requirements of Medicare or the needs of their communities in past decades. And we have opportunities! The Trump Administration has made regulatory relief a priority in its first three years, with calls for comments on antitrust rules, quality measurement requirements, nursing scope of practice and more. Engaging in public policy to help lift the regulatory burden could provide a way for rural hospitals to "right size" their facilities and services.

Many of the issues facing rural health care providers often tie back to one main problem: lack of available funding. The financial reality of critical access hospitals highlights the problem. American health financing is built largely on the idea that Medicare, Medicaid and other government

payers will under-reimburse hospitals (and other providers) because the hospital can recoup these losses from the rates paid by private payers. But what if you do not have enough private payers?

For CommonSpirit Health, which was formed in February 2019 through the merger of Catholic Health Initiatives and Dignity Health, the Medicare population accounts for approximately 35% of acute care days in our hospitals, but the Medicare population accounts for an average of 60% of acute care days in our critical access hospitals. And while critical access hospitals are reimbursed differently by Medicare due to their special status, these hospitals do not get nearly enough reimbursement to cover the true cost of care. With significantly more than half of inpatient days paid through a system that under-reimburses provid-

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ers, it is no surprise that the average critical access hospital in the U.S. operates with a total margin around 1.5%.

Public policy advocacy is the only way this dynamic will change. We can all use the resources of our system advocacy teams, national advocacy groups like the Catholic Health Association or American Hospital Association, and other membership organizations to ask our members of Congress to fully fund Medicare, to stop cutting reimbursement for providers and to support rural health care specifically. Additionally, we can ask for an end to budget sequestration cuts, which have reduced Medicare reimbursement by 2% for all hospitals, including rural facilities with cost-based reimbursement, since 2013.

Of course, under-reimbursement by Medicare is only part of the problem. Rural communities face higher rates of unemployment, and thus lower access to employer-based insurance, than their urban counterparts. In these areas, expanded access to government insurance is key. For example, in rural areas of states that have



expanded Medicaid eligibility under the Affordable Care Act,³ the uninsured rate is 4 to 8 percentage points higher than the urban areas of the state; however, the uninsured rate in expansion states (both urban and rural areas) is significantly lower than that of non-expansion states. We know that people without insurance still get sick, of course, but they very often are unable to get preventive treatment because it is not available. By advocating for health care access and coverage for everyone, which is a key goal of Catholic health care, we can help make rural health providers more financially stable while also ensuring that those who are most vulnerable are able to access needed health services.

Payer mix and underfunding often lead to numerous other problems. For example, rural communities face serious workforce shortages due in part to financial woes and in part to regulatory restrictions. Rural hospitals are not as likely to attract new medical or nursing school graduates as urban areas. As a result, hospitals must entice clinicians to practice at their hospital, but are prevented from providing certain incentives by rules against overpayment and anti-kickback laws. The Centers for Medicare and Medicaid Services (CMS) recently proposed changes and

Rural medical practices and hospitals need generalists in an era of medical specialty. They need greater leeway to use advanced practice providers, like physician assistants and nurse practitioners, for general medical services.

asked for stakeholder input to improve some of these rules (known as the Stark Law and Anti-Kickback Statute). Individuals and organizations across the country were given the opportunity to provide feedback to the federal government on ways to improve the existing laws and, therefore, the overall health system. Regulatory comment opportunities like this are an excellent way to use public policy for the greater good.

Payment isn't the only barrier to a sufficient workforce, of course. Rural medical practices and

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hospitals need generalists in an era of medical specialty. They need greater leeway to use advanced practice providers, like physician assistants and nurse practitioners, for general medical services. Hospitals and clinics must have increased flexibility when hiring foreign medical graduates, both in terms of the number of visas allowed and the bureaucratic paperwork nightmare that comes when trying to hire these individuals. The federal government could utilize greater student loan paybacks to entice clinicians to rural areas. Loosening some of the regulatory burden around workforce would help reverse the trend of physicians opting for urban over rural practices.

This is where public policy continues to make a difference. Just last year, CMS finally ended rules that required a greater level of supervision for outpatient therapies than was required in the rural emergency room. This year, the federal government is seeking input on ways federal scope of practice laws prevent advanced practice providers from practicing at the top of their license and training. While these rules apply to far more than rural facilities, their positive impact on rural hospitals is disproportionately significant.

The challenges facing rural health care are discouraging, but as leaders in Catholic health care it

is our privilege and responsibility to work toward a better health care system for everyone. By advocating with and for our rural brothers and sisters, we can use public policy to bring about positive change.

RACHEL C. TANNER is the system vice president of regulatory affairs and state relations for CommonSpirit Health. She is based in Denver.

NOTES

1. Janie Boschma, "Record Number of Rural Hospitals Closed in 2019," Politico Pro Datapoint. See also Alya Ellison, "Rural Hospital Closures Hit Record High in 2019- Here's Why," Becker's Hospital CFO Report, Dec. 5, 2019.
2. Eli Saslow, "Traveling the Loneliest Road," *The Washington Post*, Dec. 21, 2019, https://www.washingtonpost.com/national/traveling-the-loneliest-road/2019/12/21/f8ec26b2-21ca-11ea-bed5-880264cc91a9_story.html.
3. "Health Insurance Coverage in Small Towns and Rural America - The Role of Medicaid Expansion," Rural Health Policy Project, https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf.

CALL TO PRAYER

Leader: From the mid-19th century, Catholic health care has been a vital presence in America's rural communities, lovingly caring for women, men and children at every stage of life, binding up their wounds, healing their infirmities, comforting them in their sorrow. We recognize the sanctity of life of each individual, as well as the treasure that rural communities are to our American way of life. As we gather today in this land of plenty, let us pray for our sisters and brothers living and working in rural America.

Response from Psalm 37 NIV®

Recite Alternately

Trust in the Lord and do good;
dwell in the land and enjoy safe pasture.

Delight yourself in the Lord
and the Lord will give you the desires of your heart.

Commit your way to the Lord;
trust in him and he will do this:

He will make your righteousness shine like the dawn,
the justice of your cause like the noonday sun.

Be still before the Lord and wait patiently for him . . .
. . . the meek will inherit the land
and enjoy great peace.

Those the Lord blesses will inherit the land,
but those he curses will be cut off.

For the Lord loves the just
and will not forsake his faithful ones.

They will be protected forever . . .

The righteous will inherit the land
and dwell in it forever.

PRAYERS OF PETITION

Leader: That we in Catholic health care may learn from our rural sisters and brothers that we are a community called to care for one another, let us pray to the Lord.

All: Gracious God, hear our prayer.

Leader: For the rural sick, that they may have access to the excellent tending they need and deserve, let us pray to the Lord.

All: Gracious God, hear our prayer.

Leader: For migrant workers who toil in the fields throughout our country, that they may receive the justice that is their due as children of our loving God and co-laborers with each of us, let us pray to the Lord.

All: Gracious God, hear our prayer.

Leader: That we in Catholic health care may show our respect for the earth through responsible use of our resources and respectful practices that diminish our carbon footprints upon the land, let us pray to the Lord.

All: Gracious God, hear our prayer.

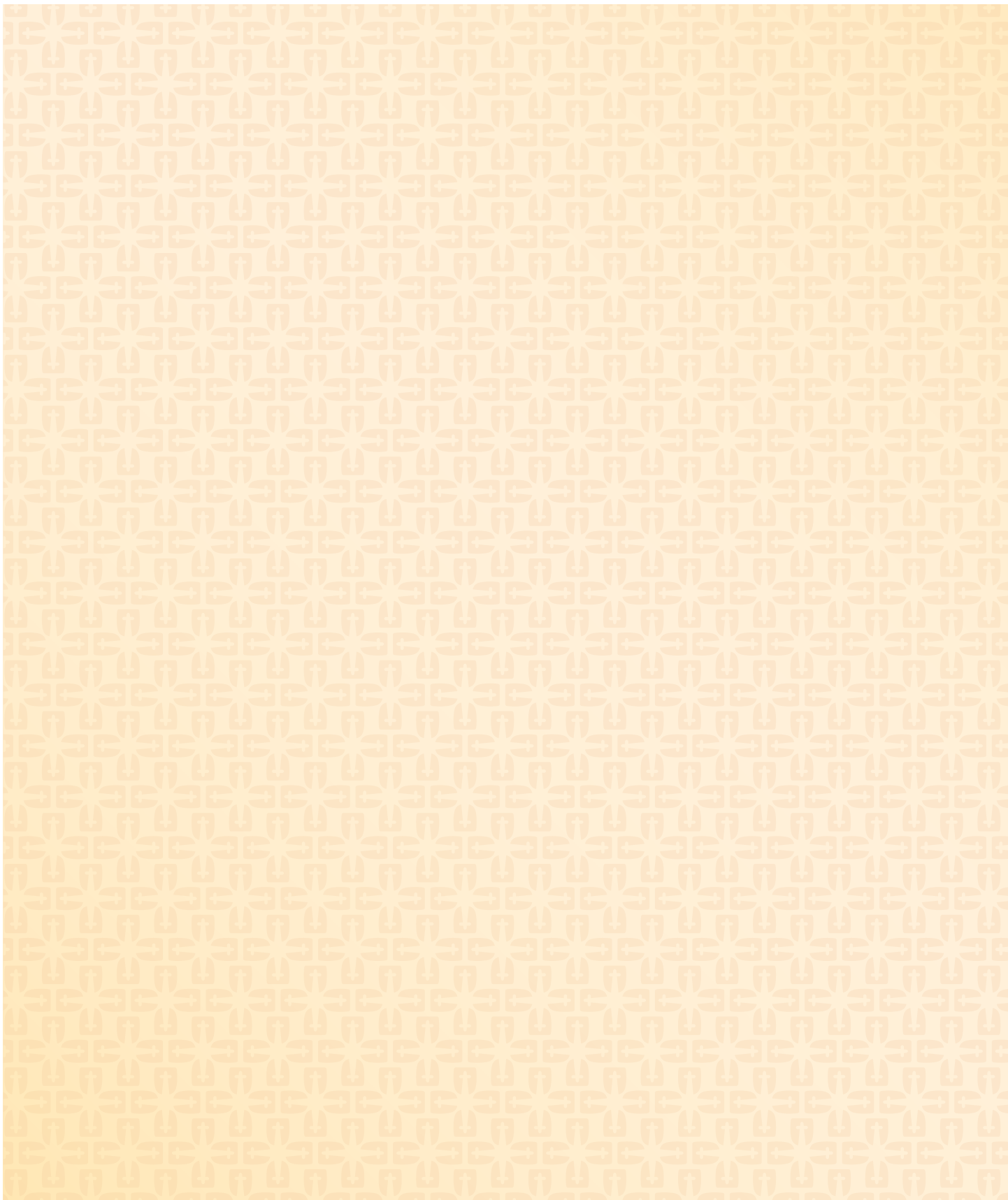
Leader: That we in Catholic health care may learn from our rural sisters and brothers that all that we have is a gift from our beneficent God, let us pray to the Lord.

All: Gracious God, hear our prayer.

CLOSING PRAYER

Leader: Lord God, deepen within each of us the realization that we are sisters and brothers, your loving daughters and sons. Help us to understand our interdependence with all persons but especially with those living in rural communities. Teach us to value the gifts that they give us and to learn from their lifestyle that we, too, depend upon the earth and upon you as our loving Creator. Bless them; bless the land you have given us. We ask this through Christ, our Lord.

All: Amen.



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