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Access to Affordable, High Quality Health Insurance for Rural Residents and its Impact on their health and on Rural Hospitals

Access to rural health care continues to be very challenging for those living in America's countryside. In particular, many rural hospitals have closed over the past two decades. This issue brief highlights the major challenges in rural health care and specifies financial and delivery policy options that can strengthen rural health care.

Of greatest importance, states that chose not to expand Medicaid coverage have suffered a significantly increased numbers of hospital closures. On the other hand, states that expanded benefits saw their rate of closures decline. Researchers recently published a study in the journal *Health Affairs* documenting that hospitals in Medicaid expansion states were 84 percent less likely to shutter than facilities in non-expansion states. Rural hospitals were particularly vulnerable to closure, but kept their doors open in places that extended coverage to more patients. The study found that rural hospitals, which are particularly vulnerable to closure, kept their doors open in places that extended coverage to more patients. The GOP-sponsored Graham-Cassidy bill, which would end Medicaid coverage for childless adults to replace it with a block grant formula, remains in play this year. While its prospects are unclear, the Trump administration has signaled its willingness to grant states Medicaid waivers that would require beneficiaries to hold jobs and pay premiums, measures likely to pare enrollments.

Other important aspects of the ACA for rural health generally and for the large number of individuals with chronic health conditions include the following:

• Requiring that qualified health plans cover wellness and preventive services;

• Requiring that qualified health plans accept all applicants, regardless of preexisting and chronic conditions;

• Shifting health care payments from fee-for-service to value-based or population-based purchasing.

Unfortunately, the Trump administration has made efforts to diminish each of these critical parts of the ACA; each such reduction will have a significant impact on rural health. For example, insurance policies excluding pre-existing conditions, encouraged by the Trump administration, will have a negative impact on the health of individuals with chronic illnesses and on the health care facilities, including rural hospitals, caring for these individuals.

What is being done to address these issues:

1. Medicaid expansion continues at a state level with the state of Virginia the most recent state to expand Medicaid. Maine passed a voter initiative to expand Medicaid. Maine's governor Le Page has thus far refused to implement the will of the voters. Several additional ballot initiatives are on tap in several states that aim to force legislators in states such as Utah and Nebraska to participate in Medicaid expansion.
2. Telehealth can make a significant health impact. For example, Intermountain Healthcare has "installed a common technology platform in more than 1,200 patient rooms, intensive care units, emergency departments, neonatal care units, and outpatient clinics in rural Utah. Since the launch of the Critical Care TeleHealth program: Mortality rates have decreased by 33% in community hospitals; Length of hospital stay has decreased by 7% ; Higher acuity patients are now able to stay in their communities more often; Over 12,000 digital visits have been completed through Connect Care. Despite these impressive results, reimbursement for telehealth services continues to be a challenge."
3. To maintain access to care in communities where inpatient volume is declining, there is an interest in payment models focused on outpatient access rather than on maintaining inpatient services. For example, Vermont Blueprint for Health (Blueprint) is one state-led, public-private initiative that aims to improve the health of individuals and communities. Primary care practices and community health teams (CHTs) participating in Blueprint serve enrollees not only from Medicaid or Medicate but from ALL payers in the state. Locally designed multidisciplinary CHTs provide care coordination services and support to Blueprint primary care practices and enrollees. Such services extend beyond the medically complex patient population. CHTs connect Blueprint enrollees to a variety of community-based resources (e.g., helping determine transportation options, assisting with applications for affordable housing and insurance enrollment). They connect people to nonclinical specialists like dieticians and health coaches who help with weight loss or making dietary and lifestyle changes, and with behavioral health specialists who provide assessment and intervention services.
4. Alaska has pioneered using community health workers who work together with local rural health professionals to cover many aspects of health care delivery.
5. The Medicare Payment Advisory Commission (MedPAC) has recently recommended that the Congress should "allow isolated rural stand-alone emergency departments (more than 35 miles from another emergency department) to bill standard outpatient prospective payment system facility fees and provide such emergency departments with annual payments to assist with fixed costs."
6. In addition, MedPAC recommended additional payments for inpatient facilities such that a hospital with inpatient services that converts to an out-patient-only facility would see the following changes in its financing and delivery of care:
    - Isolated hospitals choosing to eliminate acute inpatient services and accept prospective payment or Diagnosis Related Group rates would qualify to receive an annual fixed base payment from Medicare. The inpatient volume would flow to neighboring hospitals, potentially improving the neighboring hospitals' financial viability.

- Given that the fixed payment would be directed to preserving emergency access, some hospitals could convert their hospital beds to skilled nursing facility (SNF) beds for which they would receive SNF PPS rates for the SNF services provided under the existing eligibility rules.
- Converting facilities would make it possible to prioritize emergency care.
- Outpatient clinics would continue to operate (e.g., Federally Qualified Health Centers and freestanding rural health clinics).
- The facilities would have greater flexibility to use telehealth consultations.
- Another consideration with regard to rural hospitals considering shifting to stand-alone Emergency Department status is the degree to which beneficiaries' cost-sharing obligations would decline when hospitals shifted from Critical Access Hospital (CAH) status to Prospective Payment System (PPS) rates.

Additional information can be found at :

1. https://cph.uiowa.edu/rupri/publications/policypapers/RUPRICareCoordination.pdf.
2. https://www-healthaffairs-org.ezproxy.library.tufts.edu/doi/pdf/10.1377/hlthaff.2017.0338.
3. https://www.acog.org/-/media/Position-Statements/Practice-Considerations-for-Rural-and-Low-Volume-Obstetric-Settings.pdf?dmc=1,
4. http://www.akchap.org/html/home-page.html,