

Rural hospitals in crosshairs of federal budget cutters

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The Budget Control Act of 2011 signed into law earlier this year calls for reductions of \$1.2 to \$1.5 trillion in federal expenditures over the next ten years. Congress has created a new “super committee” tasked with developing policies and proposals that will produce these reductions.

In a sane world, policymakers would be searching for both additional cuts in spending and additional revenue to meet these targets. However, politics appears to have taken new revenue off the table and sanity remains in short supply in Washington.

Most observers believe the super committee will be deadlocked by its Thanksgiving deadline, thus triggering automatic, across-the-board cuts in federal spending, including reductions in Medicare and Medicaid payments to hospitals and other medical providers. Whatever the super committee or Congress ultimately decide, it is abundantly clear that rural hospitals are in the crosshairs of national lawmakers and that rural communities stand to lose a great deal in the rancor and partisan divide that define our political times.

Nevada’s 15 rural hospitals provide a wide range of inpatient and outpatient medical services to nearly 300 thousand rural residents – a population scattered across a 95 thousand square mile region that makes up our state’s 14 rural and frontier counties.

Eleven of these facilities are Critical Access Hospitals or “CAHs” – a designation created by Congress in 1997 to prevent the closure of the nation’s smallest and most isolated rural hospitals. The average CAH in Nevada is 46 miles from the next town and 105 miles from the closest tertiary care hospital in Reno or Las Vegas.

During the 1980s and early 1990s, rural hospitals struggled to maintain financial stability under the urban-based Medicare Prospective Payment System due to their low patient volume and unpredictable patient mix. Indeed, that period was marked by the closure of 360 rural hospitals and disrupted access to health care for millions of rural Americans.

Unable to achieve the economies of scales typical of hospital in urban areas, CAH designation currently allows these hospitals to receive payment from the federal government for care delivered to Medicare patients on the basis of reasonable costs, rather than prospective payments modeled on urban utilization and staffing patterns. CAH designation also permits more flexible staffing options and the ability of rural hospitals to tailor services to the older and relatively poorer populations typical of rural areas.

Over the past decade, enhanced reimbursement from CAH designation has not only kept rural hospitals in Nevada from closing their doors, an improved bottom line has allowed rural hospitals to improve their scope of services, offer competitive wages and thus retain physicians and other health professionals in a highly competitive labor market, and make sorely needed capital improvements to aging facilities that, in some cases, were built half a century ago.

Many of these gains stand to be lost if the proposed changes to rural hospital reimbursement being kicked around in Washington come to fruition – particularly, the elimination of CAH designation for rural hospitals or automatic cuts to Medicare payments to providers being suggested by some lawmakers.

In addition to providing local access to 24/7 emergency medical services, inpatient care, and skilled nursing services, Nevada's rural hospitals are the primary medical home for a quarter-million rural residents and thus anchor the health care safety net in most areas of rural Nevada. Equally important is the critical role played by rural hospitals in local economic development.

Nevada's rural hospitals currently employ 2,200 individuals and generate a combined annual payroll of \$120 million. When the day-to-day economic activity of these hospitals and spending of hospital employees in the local community are taken into account, rural hospitals are responsible for an additional 1,100 jobs in their respective communities and another \$31.8 million in payroll in other rural businesses.

In Nevada, CAHs and other rural hospitals are typically the second or third largest employers in their community. Thus, the threat of federal cuts that may hit rural hospitals not only jeopardizes access to health care for thousands of rural Nevadans, such cuts hold the prospect of undermining the vital economic contributions rural hospitals provide to their communities in the form of jobs, income, and tax revenue.

Rural health expert Tim Size concludes that "Congress needs to stop the bomb throwing and to start the hard work of finding common ground for our country's problems. We need government that works with rural hospitals to serve America's older, poorer and less healthy communities." That work cannot happen fast enough.

Additional information on Nevada's rural and frontier hospitals and the communities they serve can be found at <http://www.medicine.nevada.edu/CEHSO/databk11.html>.

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