

After Hospital Closure: Pursuing High Performance Rural Health Systems without Inpatient Care

*Prepared by the
RUPRI Health Panel*

Keith J. Mueller, PhD

Charlie Alfero, MA

Andrew F. Coburn, PhD

Jennifer P. Lundblad, PhD, MBA

A. Clinton MacKinney, MD, MS

Timothy D. McBride, PhD

Paula Weigel, PhD – *Guest Author*

June 2017



Acknowledgements

This report was supported by the Rural Policy Research Institute through a cooperative agreement with the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), US Department of Health and Human Services (HHS) under grant #U18RH28545. The information, conclusions and opinions expressed in this report are those of the authors and no endorsement by FORHP, HRSA, HSS, is intended or should be inferred.

The Health Panel would like to thank Aaron Horsfield, MHA, MPH, for his contributions to the text in this document. We also thank Susan Nardie for her careful editing of this document.

Contents

Purpose	1
Background	1
Redesigning Rural Health Systems to Support High Performance Objectives	4
Community Health System Development Process	6
Identifying and Analyzing Alternatives to Inpatient Care	8
Implementation Considerations	13
Legislative and Regulatory Considerations	14
Conclusion	17

Purpose

This paper describes opportunities for rural communities to develop a high performance rural health system after hospital closure. Communities with hospitals that are vulnerable to closure may also find the approaches outlined here constructive when considering options for optimal care delivery.

Health services delivery options are synthesized in Tables 1 and 2. These tables describe *currently available options* under existing Federal and State laws governing health care structures and payments (Table 1), and new ideas that are *policy options under consideration* introduced by various policy stakeholders in response to the crisis that closures have created for many rural communities (Table 2). The policy options *would promote* delivery arrangements that require new laws and/or Federal and State regulations and payment arrangements.

Background

Between January 2005 and December 2016, 120 rural U.S. hospitals closed, with annual numbers of closures highest after 2012 (Figure 1).¹

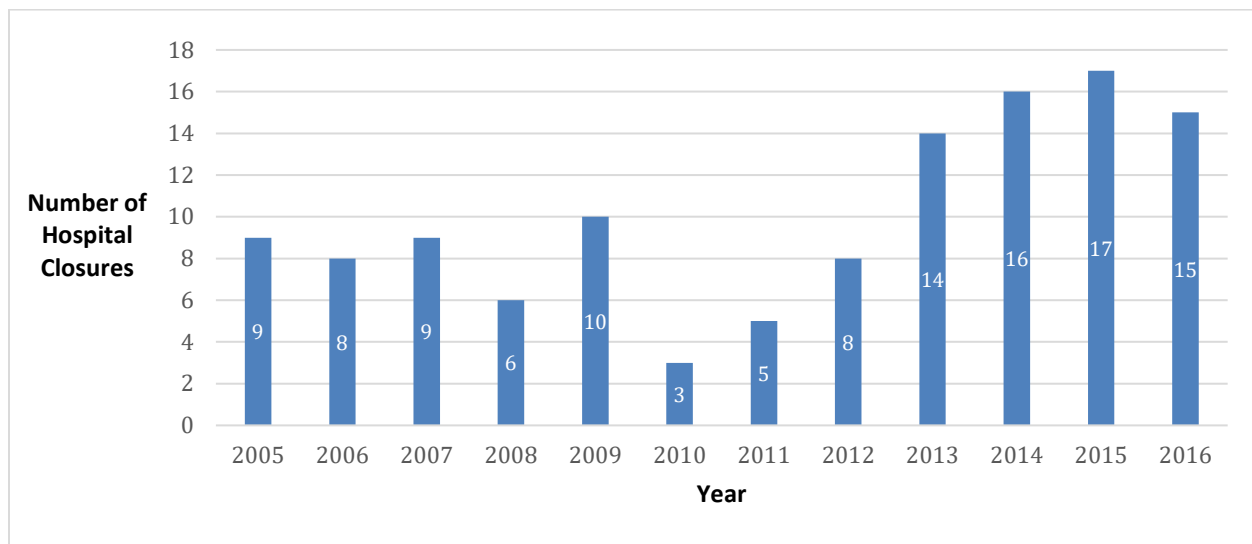


Figure 1. Number of Rural U.S. Hospital Closures, January 2005 through December 2016

¹ Pink GH, Thomas SR, Kaufman BG, Holmes, GM. Rural hospital closures and finance: some new research findings. Presentation at: AHA 30th Rural Health Care Leadership Conference; February 7, 2017; Phoenix, AZ. Modified based on posted list of closures: <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

Hospital closure is defined as ceasing inpatient care, but oftentimes it also results in the elimination of other services typically provided in a hospital, such as emergency care, laboratory, radiology, physical and occupational therapy, and skilled nursing or long-term care services.

Hospital closures can also affect the infrastructure of essential rural primary care, potentially creating serious access-to-care problems for all rural residents, especially those who have complex health care needs or transportation barriers. The health care infrastructure that develops after hospital closure is critical to both the health of rural people and the economic vitality of rural communities.

Many factors drive rural hospital closures, the proximate cause most often being insufficient revenue to sustain the cost structure of acute care hospitals. Contemporary market conditions and community characteristics, including declining population, contribute to rural hospital financial instability. Relative to hospitals in urban areas, rural hospital financial margins are typically lower.^{2,3} Challenging rural economic conditions and unfavorable demographics (e.g., aged, poor, uninsured, and underinsured populations) also contribute to hospital financial instability through poor payer mix (i.e., a high percentage of patient revenue from payers paying less than the total cost of providing care).^{4,5} Trends in health insurance and plan design, such as growing use of high deductible health plans and narrow provider networks, can increase a hospital's bad debt and charity care burden.⁶ Declining inpatient utilization due to shifts in how health care is delivered coupled with low patient volumes reduce rural hospitals' ability to generate revenue to cover fixed costs, let alone update infrastructure and invest in new services. All of these factors contribute to rural residents often bypassing their rural hospitals for more distant health centers with updated facilities and extensive service offerings,⁷ thereby exacerbating the financial distress experienced by local, rural hospitals.

² Freeman VA, Thompson K, Howard HA, Randolph R, Holmes GM. *The 21st Century Rural Hospital: A Chart Book*. Chapel Hill, NC: North Carolina Rural Health Research Program; March 2015. <http://www.shepscenter.unc.edu/wp-content/uploads/2015/02/21stCenturyRuralHospitalsChartBook.pdf>

³ Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: June 2016. <http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0>

⁴ Kaufman BG, Thomas SR, Randolph RK, et al. The rising rate of rural hospital closures. *J Rural Health*. 2016 Winter;32(1):35-43. doi: 10.1111/jrh. 12128. Epub 2015 Jul 14.

⁵ Wishner J, Solleveld P, Rudowitz R, Paradise J, Antonisse L. A look at rural hospital closures and implications for access to care: three case studies (Issue Brief). July 2016. Menlo Park: The Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation. <http://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care>. Accessed October 31, 2016.

⁶ Reiter KL, Noles M, Pink GH. Uncompensated care burden may mean financial vulnerability for rural hospitals in states that did not expand Medicaid. *Health Aff*. 2015 Oct;34(10):1721-9. doi: 10.1377/hlthaff.2014.1340.

⁷ Weigel P, Ullrich F, Finegan CN, Ward MM. Rural bypass for elective surgeries. *J Rural Health*. November 2015. doi: 10.1111/jrh.12163.

CASE STUDY: URGENT CARE SERVICES IN DOUGLAS, ARIZONA

Cochise Regional Hospital, located in the border city of Douglas, Arizona, was a rural 25-bed Critical Access Hospital (CAH) serving a community of nearly 17,000 people. After the hospital and emergency room closed in July 2015, the nearest medical services were 27 miles away in Bisbee, Arizona.

Shortly after Cochise Regional Hospital closed, Copper Queen Community Hospital from Bisbee opened the Douglas Medical Complex Quick Care facility, an “urgent care clinic on steroids.” The new facility is an extension of the existing Copper Queen clinic in Douglas, and is open from 8 a.m. to 8 p.m. daily. With the diagnostic capability of an emergency room but without the associated costs, the Douglas Medical Complex can treat a significant number of patients using fewer resources, and still provide transportation to Bisbee via ambulance for true emergencies. Furthermore, the Douglas Medical Complex has worked with the Douglas Fire Department to provide emergency responders for transportation within five minutes if a patient becomes seriously ill.

The Douglas Medical Complex has six patient rooms; a moderate complexity laboratory; an on-site surgery clinic; and a radiology department providing X-rays, ultrasound, and CT scan services. It also offers telemedicine capacity that can access specialists in cardiology, concussions, and pulmonology.

On April 4, 2017, Copper Queen Community Hospital opened the first rural free-standing Emergency Department in Douglas. Telemedicine capacity has been increased to include telestroke services provided in partnership with the Mayo Clinic.

Sources:

Cochise Regional Hospital Closes. Value Health Services Web site.

<http://valuehealthcareservices.com/education/cochise-regional-hospital-closes/>

Douglas Quickcare Now Open. Copper Queen Community Hospital Web site.

<http://cqch.org/douglas-quickcare-now-open/>

Copper Queen Medical Associates. Douglas Medical Complex. Copper Queen Community Hospital Web site. <http://cqch.org/cqma-clinics/copper-queen-medical-associates-douglas/>

Emergency Department opens in Douglas. Douglas Dispatch website.

http://www.douglasdispatch.com/features/emergency-department-opens-in-douglas/article_e692ff72-1953-11e7-b218-4f6fa403cfe0.html

Amidst the many challenges rural hospitals face, there are also opportunities to proactively reshape rural health services and delivery in a way that more effectively and efficiently meets rural communities' health needs.

This paper addresses a set of key questions rural communities and policymakers face after losing their community hospital:

- What kind of rural health system is possible in places that cannot support a full-service hospital?
- How does a rural community navigate the transition from hospital-centric care toward new, high performance models?
- If services must be reconfigured, what are the options?
- What implementation support will be needed?

Redesigning Rural Health Systems to Support High Performance Objectives

Hospital closure can be traumatic for a community. Rural hospitals are frequently the single largest local employer, and contribute to a community's identity of value, worth, and significance. Rural hospitals make accessing hospital-based services for local residents convenient, reducing the burdens of travel time and cost associated with more distant facilities. Rural hospitals give local citizens a sense of safety and security, especially through quickly accessible emergency care. Having a definable system of comprehensive care in a community is a key consideration in economic development decisions or for growing a retirement community.

The RUPRI Health Panel has articulated a vision for a high performing rural health system with primary and emergency care as its foundation and with a focus on delivering high quality, coordinated care and services that improve community health.⁸ Although rural hospital closures can threaten key elements of the rural health system, they can also provide communities the opportunity to examine alternative health care delivery arrangements built upon a robust primary care base that integrates medical care, dental care, behavioral health, human services, community health, and other services affecting rural quality of life.⁹ A rural health system with primary care at its core and strong community connections to other services is essential for good population health.

⁸ RUPRI Health Panel. *The High Performance Rural Health Care System of the Future*. Iowa City, IA: University of Iowa; September 2011. <http://www.rupri.org/wp-content/uploads/2014/09/The-High-Performance-Rural-Health-Care-System-of-the-Future.pdf>

⁹ RUPRI Health Panel. *Advancing the Transition to a High Performance Rural Health System*. Iowa City, IA: University of Iowa; November 2014. <http://www.rupri.org/wp-content/uploads/2014/11/Advancing-the-Transition-Health-Panel-Paper.pdf>

CASE STUDY: 24-HOUR EMERGENCY & OUTPATIENT SERVICES CENTER IN CHEBOYGAN, MICHIGAN

Cheboygan Memorial Hospital (CMH) in Cheboygan, Michigan, closed on April 3, 2012, leaving 403 employees without jobs and approximately 5,000 residents without access to hospital-based health care services. The hospital provided emergency, inpatient, and nursing home care to the residents of the area.

To prevent closure, CMH was attempting a sale to McLaren Health Care; however, licensing and recertification issues led to a delay. Fortunately, the Centers for Medicare & Medicaid Services (CMS) and McLaren came to an agreement in May of 2012 allowing the facility to provide services again. The new facility, known as McLaren-Northern Michigan, Cheboygan Campus, now operates a 24/7 emergency room and other expanded services. The expanded services include adult and pediatric primary care, imaging, laboratory services, a sleep center, rehabilitation services, and an outpatient surgery clinic performing minor procedures such as colonoscopies and cataract surgeries. Specialty services are also available.

The sale and reopening of the health care facility allowed for employment of about 150 of the former 403 employees.

Sources:

Slimmed-down Cheboygan Hospital to Reopen Monday. CBS Detroit Web site. May 13, 2012.

<http://detroit.cbslocal.com/2012/05/13/slimmed-down-cheboygan-hospital-to-reopen-monday/>

Cheboygan Memorial Hospital Undergoes Name Change. Petoskey News Web site. May 4, 2012. http://articles.petoskeynews.com/2012-05-04/emergency-services_31577169

New Details: Cheboygan Memorial Hospital Closing Today. 9 & 10 News Web site.

<http://www.9and10news.com/story/17318229/breaking-cheboygan-memorial-hospital-closing-today>

McLaren Northern Michigan – Cheboygan Campus. Cheboygan Area Chamber of Commerce Web site. <http://cheboygan.com/cheboygan/cheboygan-hospital/>

There is no single model for reconfiguring the rural health system after hospital closure; local assets, affiliations and partnerships, and financial and delivery flexibility and capacities must be critically assessed to determine the community's options and strategies.

For example, remote communities may need to develop clinic-based services, telehealth capability, emergency medical services (EMS), and nonemergency transportation to ensure access to essential primary care and specialty services. Determining which services should be delivered locally versus delivered at a distant site requires balancing affordability and quality, while remaining attentive to the importance of patient-centered care.

Community Health System Development Process

The experiences of rural communities that have lost their hospital demonstrate the importance of broad community engagement to develop and implement strategies for ensuring local availability and access to essential primary care, emergency, and other services.

The engagement of community stakeholders from not only the health care sector but also local government, economic development, and other sectors is vital to assessing and marshalling the necessary leadership and resources to effectively identify, evaluate, and implement a community health system development strategy. In many cases, communities already have community assessments to draw on in this process. For example, nonprofit hospitals regularly conduct triennial community health needs assessments (CHNAs) that can inform the development of a health system development strategy. Local health departments also can be a source of community analysis, including CHNAs completed by those departments.

The community health system development and planning process needs to be informed by a number of important considerations. First, there should be an assessment of available hospital and community assets that indicate system capacity. Types of assets include *financial* (retained earnings or endowments); *facilities* (hospital, clinic, other spaces appropriate for repurposing); *equipment* (imaging, laboratory, health information technology); *people* (clinical providers, local health care leaders, interested community members); *local organizations* (public health department, private physician practices, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), human service agencies); and *non-local organizations* (State health department and economic development agencies, regional health systems, foundations).

Second, the planning process should identify resource development opportunities. As mentioned earlier, CHNAs and other similar documents from nonprofit hospitals and local health departments can inform where the opportunities are to close gaps in community needs. State public health and economic development agencies, public and private development grants, and consulting and technical assistance resources all have the potential to contribute to the transformation of rural community health systems.

Third, stakeholders that determine service development strategies and deploy health care resources must be identified. These include the county or municipal public health authority, independent provider organizations, regional health systems, and even absentee owners or creditors.

Fourth, the community engagement process needs to identify and understand the impact of existing financing resources and liabilities. Financing resources may include private foundation grants, community organization/business/or individual donations, Federal or State grants (e.g., Bureau of Primary Health Care, Federal Office of Rural Health Policy), low-interest loans and/or bonds, loan guarantees (i.e., U.S. Department of Agriculture), favorable payment models in Medicare and Medicaid, and tax millage. Debt associated with existing health-related infrastructure is a liability that also must be considered and understood.

Finally, the community planning and development process should identify and prioritize health system reorganization or affiliation opportunities (“affiliation” represents a broad continuum from ownership to nonbinding agreements). Affiliations may be with local organizations or regional (both within and outside of geographic proximity).

Identifying and Analyzing Alternatives to Inpatient Care

Assessing the local health care landscape can help a community identify and analyze alternatives to inpatient care that build health system capacity that is locally appropriate and supports the goal of ensuring continued local access to essential, high-quality health services.

In the short term, alternative options and strategies will focus on existing policy and programs. With the future of many rural hospitals in doubt, however, new policies and programs are being suggested and debated to help communities make the transition to an effective and sustainable rural health system.

Table 1 outlines *currently available* delivery options for communities facing hospital closure. These options focus on provider and payment models explicitly designed for underserved rural communities. The provider models include independent provider practices, federally designated practices (e.g., RHCs and FQHCs), and urgent/emergency care alternatives. Some of these options, such as RHCs and FQHCs have special Medicare and Medicaid payment arrangements (commercial payer policies differ), require minimal legislative or regulatory changes, and are viable and sustainable health care delivery models in many rural places. All of the models presented in Table 1 can include implementation of telehealth to supplement access to specialized services located at a distance from the rural locus of care. In fact, Medicare payment policy is favorable toward telehealth services originating in rural areas.¹⁰

Table 1. Currently Available Options for Communities without Inpatient Care

Current Options	Care Delivery Features	Medicare Payment
Independent Practice Clinic	- Provides primary care-focused outpatient services - Clinic providers often own the practice - May be a part of an Independent Practice Association - Not required to provide 24/7 services, emergency services, or inpatient hospital services	- Fee-for-service payment, including the Medicare Physician Fee Schedule - Primary care practice demonstrations and models (e.g., Comprehensive Primary Care Plus demonstration currently underway in selected states¹¹)
Hospital-Owned Primary Care Practice	- Provides primary care-focused outpatient services - Owned by a rural hospital	Fee-for-service payment, including the Medicare Physician Fee Schedule

¹⁰ Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in either a county outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA) located in a rural census tract. Centers for Medicare & Medicaid Services. Telehealth Services. Medicare Learning Network. Rural Health Series. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctshsht.pdf>.

¹¹ Comprehensive Primary Care Plus. Centers for Medicare & Medicaid Services. <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>.

Current Options	Care Delivery Features	Medicare Payment
	Limited daily hours and services	
Provider-Based RHC	- Provides outpatient primary care-focused services located in rural areas - Must operate in a rural area and a Health Professional Shortage Area - Owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program (most provider-based RHCs are hospital-owned) - Not required to provide 24/7 services, emergency services, or inpatient hospital services	- Cost-based payment system with cap - Payment includes all services on day of service - Bills both professional and technical Medicare fee components - Medicare is billed using Part A forms, but payment is made from the Part B trust fund
Independent RHC	- As with Provider-Based RHC, but not as a hospital department - Owned by a provider or a provider entity - More than half of independent RHCs are owned by clinicians	As with Provider-Based RHC, but Medicare technical component is billed under Part B
FQHC and Community Health Centers (CHC) <i>(grant-funded by section 300 of the Public Health Services Act)</i>	- Provides expanded community-based services that include primary care, dental care, and behavioral health care - A Medicare Certification category of Community Health Center that receives Federal funding through section 330 of the Public Health Service Act - Majority of governing board of directors composed of FQHC patients - Serves a Medically Underserved Area/Population - Not required to provide 24/7 services, emergency services, or inpatient hospital services (FQHC regulations require having referral arrangements with local inpatient facilities and emergency medical services) - Must accept Medicare and Medicaid patients and provide discounted fees based on income below 200% of poverty	- Prospective payment system for individual health care services - Payments may include grant funding, such as from the Health Center Program (Section 330 of the Public Health Service Act provides up to \$650,000 per year) - Must offer a sliding fee schedule
FQHC Look-Alikes <i>(Primary care providers that meet FQHC and Sec. 330 CHC requirements but do not receive grant funds from that source)</i>	- Health centers that have been certified as meeting all the Health Center Program requirements under section 330 of the Public Health Service Act, but do not receive funding under the Health Center Program - Must accept Medicare and Medicaid patients	As for FQHC, but no Section 330 grant funding

Current Options	Care Delivery Features	Medicare Payment
Urgent Care Clinic	- Provides urgent care, not typical primary care or chronic care services - Not required to provide 24/7 services, emergency services, or inpatient hospital services	Fee-for-service payment, including the Medicare Physician Fee Schedule
Off-Campus Emergency Department	- Provides emergency care, not typical primary or chronic care services - Operates as a remote hospital department - Hours of operation may be 24/7 or more limited - Licensing and operating regulations differ by state	- Fee-for-service payment, including the Medicare Physician Fee Schedule and the Outpatient Prospective Payment System - To be provider-based, and thus eligible for Medicare payment, must meet all standard emergency department and hospital requirements
Freestanding Emergency Department	- Provides emergency care, not typical primary or chronic care services - Not a provider-based facility since not affiliated with a hospital - Hours of operation may be 24/7 or more limited - Licensing and operating regulations differ by state	Currently cannot bill under Medicare (and Medicaid) since not provider-based

Rural health stakeholders, State and Federal policymakers, and others have also proposed new models and strategies for addressing the needs of rural communities facing hospital closure. The options presented here have been proposed legislatively and/or by advocacy organizations. These proposals require significant policy and regulatory changes, which suggests a medium- to longer-term horizon for implementation. Table 2 summarizes *options under proposal* for reconfiguring services and ensuring health care access post hospital closure. Options include emergency care stabilization, clinic expansion to include emergency and observation care, new rural hospital designation that supports emergency care and transportation services, and expanded hours of operation in a Primary Health Center model.

Table 2. Policy Proposals for Inpatient Care Alternatives

Options	Care Delivery Features	Medicare Payment	Sources
24/7 Emergency Department (Option 1) <i>Proposed by MedPAC</i>	• Fee-for-service payment, including the Medicare Physician Fee Schedule and the Outpatient Prospective Payment System • Inpatient space may be converted to Skilled Nursing Facility • Fixed payment may allow greater flexibility to use telehealth services • Existing outpatient clinic(s) would continue to operate	• Fee-for-service payment, including the Medicare Physician Fee Schedule and the Outpatient Prospective Payment System • Fixed annual payment added to partially cover standby costs and overhead • Fixed payment would not increase with increased volume	“Improving efficiency and preserving access to emergency care in rural areas” http://www.medpac.gov/docs/default-source/reports/chapter-7-improving-efficiency-and-preserving-access-to-emergency-care-in-rural-areas-june-2016-repo.pdf?sfvrsn=0
Clinic and Ambulance (Option 2) <i>Proposed by MedPAC</i>	• Outpatient clinic – independent, RHC, or FQHC • Affiliated 24/7 ambulance service	• Prospective payment for primary care and ambulance services (like FQHC) • Fixed annual payment added to partially cover standby costs and overhead • Possible requirement for local matching funds	“Improving efficiency and preserving access to emergency care in rural areas” http://www.medpac.gov/docs/default-source/reports/chapter-7-improving-efficiency-and-preserving-access-to-emergency-care-in-rural-areas-june-2016-repo.pdf?sfvrsn=0
Frontier Extended Stay Clinic (FESC) <i>Demonstration under CMS authority</i>	• Outpatient clinic with expanded hours of operation and emergency care capacity • Minimal inpatient capacity (up to 48 hours) for observation services and stabilization prior to transfer • Comprehensive primary medical, dental, mental	• Prospective payment for primary care and ambulance services (like FQHC) • Special time-based fee-for-service payment for extended FESC stays	Frontier Extended Stay Clinic Demonstration https://innovation.cms.gov/initiatives/Frontier-Extended-Stay-Clinic/ “Evaluation of the Medicare Extended Stay Clinic Demonstration,” Report to Congress

Options	Care Delivery Features	Medicare Payment	Sources
	health and other services offered		https://innovation.cms.gov/Files/reports/MFESCD-RTC.pdf
Rural Emergency Hospital <i>Proposed by Senators Grassley (IA), Klobuchar (MN), and Gardner (CO)</i>	• CAHs and Prospective Payment System hospitals with 50 or fewer beds may convert to Rural Emergency Hospitals • Emergency care services, but no inpatient care • Existing or expanded outpatient clinic(s) would continue to operate	• Cost-based reimbursement at 110% of cost for emergency services and ambulance transport services	"Grassley, Klobuchar, Gardner Introduce Legislation to Help Rural Hospitals Stay Open, Focus on Emergency Room Care, Outpatient Services" https://www.grassley.senate.gov/news/news-releases/grassley-klobuchar-gardner-introduce-legislation-help-rural-hospitals-stay-open
12-Hour Primary Health Center <i>Proposed by the Kansas Hospital Association, Rural Health Visioning Technical Advisory Group</i>	• Provides care like an FQHC • Open 12 hours/day, 365 days/year • Supported by a robust EMS plan • Supported by a formal relationship with a larger partner organization to assist with operational and clinical aspects of delivering services • Communities retain local governance, but also affiliate with a strong partner in a regional system	• The payment system has not yet been determined • Goal is to incentivize participation by an integrated health system at the local level rather than the current CAH payment method that carves out, and consequently discourages, integration or continuous care	"Sustaining Rural Health Care in Kansas: The Development of Alternative Models" http://www.khanet.org/CriticalIssues/RuralIssues/
24-Hour Primary Health Center <i>Same as above</i>	• As above, but open 24 hours a day, 365 days a year	• As above	As above

Implementation Considerations

Essential local service delivery may require a blend of financing sources: current fee-for-service payments, special payments to support fixed costs, local tax support, area business support, and private/public grant support. For essential services not delivered locally, rural communities must consider alternative means of care delivery. For example, office-based specialist care may require building expanded telehealth capacity, and transportation services may need to be expanded to meet emergent and non-emergent needs. Absent a local hospital, remaining health care professionals may require support from distant health care organizations through tele-education, group practice administrative services, and professional collegiality.

Rural communities facing hospital closure need financial and technical assistance support that enables them to effectively strategize how to configure and deliver future services. Communities in which a hospital closed, or in which a hospital is at risk of closing, should proactively plan which essential services should be offered and how to deliver them locally. For example, the proposed Primary Health Center model outlined in Table 2 was developed by the Kansas Hospital Association in response to increasing vulnerability of rural hospitals in Kansas (see text box).¹² Planning discussions should include how to partner with a broader network of health care providers and community-based organizations to ensure delivery of the full continuum of care.

The Primary Health Center model proposed by the Kansas Hospital Association describes an integrated health system at the local level that provides essential services, supported by a formal relationship with a larger partner organization to assist with operational and clinical aspects of delivering services. Community health needs assessments, a key component of this model, are used to identify community health priorities. As such, they can serve as the starting point to guide discussions about how to configure care delivery that balances the objectives of accessibility, quality, patient-centeredness, and community health.

While each hospital closure has its own local hospital and community context, the processes and resources needed to address ongoing community needs tend to be similar. As in any public health emergency, community leaders need assistance to guide them in responding to the immediate crisis and planning for the transition to a reconfigured local health system. Although

¹² Kansas Hospital Association Rural Health Visioning Technical Advisory Group. *Sustaining Rural Health Care in Kansas: The Development of Alternative Models*. Topeka, KS: Kansas Hospital Association; March 2015. http://www.kha-net.org/FurtherInformation/DownloadsRuralIssuesCriticalIssues/Sustaining-Rural-Health-Care-in-Kansas_129577.aspx

there is no playbook designed for rural community organizations, there are resources available from State Offices of Rural Health, the National Rural Health Association, and the American Hospital Association. Their expertise and existing documents could be catalysts for a planning and action document specifically tailored to community organizations (including but not limited to local hospitals).¹³

Legislative and Regulatory Considerations

Rural communities that wish to proactively develop new delivery configurations before or following hospital closure should evaluate a variety of Federal and State policies. Medicare and Medicaid payment policies are critical considerations since Medicare and Medicaid represent a significant proportion of rural health care payments.

Current health care payment and regulatory systems that focus on the delivery of services for individual patients may be inconsistent with addressing broader rural health system development needs resulting from hospital closures. For example:

- A treating facility (including a CAH) must meet the definitional standard of a “hospital” to receive Medicare payment for emergency care or overnight observation care.
- Current payment systems reward volume increases, but do not cover fixed, standby costs associated with maintaining a fully functional emergency department (ED) and other services.
- Payment policies and State professional licensure restrictions limit opportunities to develop and deploy telehealth capacity.
- Payment policies are not adequate to support increasingly important health-related services, such as non-emergent transportation to access nonlocal health care.

Among *currently available options* for communities without inpatient care (Table 1), the primary policy considerations will involve (1) implications of hospital certification and licensure loss, (2) steps necessary to comply with new Conditions of Participation (CoP) and/or State licensure requirements, and (3) adequacy of new payments to sustain the new provider configuration. For example, hospitals that close their inpatient units will no longer meet Joint Commission hospital accreditation requirements or categorical certification under Title 18 of the Social Security Act, thus potentially disallowing Medicare/Medicaid billing for services delivered. Hospitals that close their inpatient units and convert to an RHC must meet Federal certification and State requirements for independent RHC designation to receive all-inclusive

¹³ Existing documents include: 1) National Organization of State Offices of Rural Health (October, 2016) “State Office of rural Health Roadmap for Working with Vulnerable Hospitals,” <https://nosorh.org/wp-content/uploads/2016/11/SORH-Roadmap.pdf>; and 2) American Hospital Association (November, 2016) “Task Force on Ensuring Access in Vulnerable Communities. <http://www.aha.org/content/16/ensuring-access-taskforce-report.pdf>

rate reimbursement. If a hospital transitions to a free-standing ED in a state that does not license free-standing EDs, then the hospital must explore partnership or joint venture opportunities with another hospital to meet CoPs for hospital-based, off-campus EDs. If a hospital closes inpatient services and converts space to an urgent care clinic that includes ancillary services, it may have to meet new accreditation and/or certification standards set by organizations such as the Joint Commission and State agencies. New delivery configurations must consider Federal and State licensure and certification laws. Another consideration will be implications for payment should a local healthcare organizations seek to finance a new operation by affiliating with a hospital providing inpatient care. New site-neutral payment policies (ending hospital payment under outpatient prospective payment for certain off-campus departments) may make such options more challenging financially.

CASE STUDY: FREESTANDING EMERGENCY CENTER IN STREATOR, ILLINOIS

St. Mary's Hospital of Streator, Illinois, closed its inpatient and ED in January 2016. A traditional 94-bed hospital founded in 1887, St. Mary's Hospital served more than 13,700 residents of Streator and surrounding communities.

During a transition of ownership to OSF HealthCare of Peoria, 24-hour urgent care services continued to be provided at the hospital facility. However, because the nearest emergency care provider was 16 miles away, OSF HealthCare and the community of Streator felt a critical need for emergency services to be provided locally.

OSF HealthCare lobbied the Illinois General Assembly for an exception to the State law prohibiting the establishment of freestanding EDs in rural areas, and in August 2016, OSF Center for Health-Streator became the state's first rural free-standing emergency center. In addition to providing emergency care access, OSF Center for Health-Streator provides an array of outpatient services (including medication and blood infusions, vaccinations, and wound care), cardiac services, health education classes, rehabilitation services, and diagnostic imaging and screening services such as mammography and bone density.

Sources:

St. Mary's closing; OSF to provide outpatient services. *The Pantagraph*. September 9, 2015. http://www.pantagraph.com/news/local/st-mary-s-closing-osf-to-provide-outpatient-services/article_6ed881df-3d0b-5365-b83e-7d2074f0802b.html

St. Mary's hospital to close; OSF plans new outpatient center. *The Times*. September 8, 2015. http://www.mywebtimes.com/news/local/st-mary-s-hospital-to-close-osf-plans-new-outpatient/article_a789887d-0f35-5347-8f2b-ac6651aa3c49.html

Creating a Healthier Streator. OSF Health Care Web site. <https://www.osfhealthcare.org/streator/>

Lukens J. Freestanding emergency departments: an alternative model for rural communities. *The Rural Monitor*. November 30, 2016. https://www.ruralhealthinfo.org/rural-monitor/freestanding-emergency-departments/?utm_source=racupdate&utm_medium=email&utm_campaign=update113016

Among *options under proposal* for communities without inpatient care (Table 2), Federal and State legislative and regulatory hurdles may be significant. The primary barrier to implementation is that there are currently no Federal or State designations for many integrated (private) or partial (ED only) service models, and consequently no payment methodologies to promote and sustain their use. For CMS payment, Congressional action may be necessary to define new provider categories and designations, and states will likely need to develop new licensure categories and certification processes. New payment methodologies should consider the low-volume environments in which these models will operate, and provide cost subsidies where necessary so services remain affordable. Therefore, when designing rural-appropriate health care systems that deliver essential health care services outside a conventional rural hospital, rural leaders must concurrently advocate for health care payment and regulatory policy changes that recognize the rural reality that local hospitals may no longer be the locus of health care.

Conclusion

The financial pressures leading to rural hospital closures will likely continue. Hospital closures can reduce local health care infrastructure, and thus reduce access to locally available services. This trend disproportionately affects rural residents, who are on average older, poorer, and sicker than urban and suburban residents. Therefore, not only ingenuity but also creative investment and financing are required to design and sustain an appropriate menu of local health care services. Rural places can be innovators of new health care delivery models when supported by committed local leadership, strong community backing, creative program design, and innovative payment policies.

About the Authors

The RUPRI Health Panel is led by Keith J. Mueller, PhD. He can be contacted at (319) 384-1503, keith-mueller@uiowa.edu.

Charles Alfero, MA, is the executive director of the Center for Health Innovation, Hidalgo Medical Services (HMS) based in Silver City, NM. He has over 36 years of experience in rural health policy, systems, and program development. The Center for Health Innovation is a research and development organization supporting innovative programming for frontier and underserved population health.

Andrew F. Coburn, PhD, is a professor of public health and directs the Population Health and Health Policy Program in the Muskie School of Public at the University of Southern Maine. He is also a senior investigator in the Maine Rural Health Research Center.

Jennifer P. Lundblad, PhD, MBA, is president and CEO of Stratis Health, an independent nonprofit quality improvement organization based in Bloomington, Minnesota, that leads collaboration and innovation in healthcare quality and patient safety. Dr. Lundblad has an extensive background in leadership, organization development, and program management in both nonprofit and education settings.

A. Clinton MacKinney, MD, MS, is a clinical associate professor in the Department of Health Management and Policy, College of Public Health, University of Iowa. He is also a board-certified family physician delivering emergency medicine services in rural Minnesota. He is the deputy director, RUPRI Center for Rural Health Policy Analysis.

Timothy D. McBride, PhD, is a professor at the Brown School, at Washington University in St. Louis. He also serves as one of the principal analysts in the RUPRI Center for Rural Health Policy Analysis, and serves in many state and federal roles, including serving as chair of the state of Missouri's MOHealthNET Oversight Committee, which oversees the state's Medicaid program.

Keith J. Mueller, PhD, is the Rural Health Panel chair. Dr. Mueller is the Interim Dean, University of Iowa College of Public Health, where he is also the Gerhard Hartman Professor, Department of Health Management and Policy and the director of the RUPRI Center for Rural Health Policy Analysis.

About the Rural Policy Research Institute

The Rural Policy Research Institute (RUPRI) provides unbiased analysis and information on the challenges, needs, and opportunities facing rural America. RUPRI's aim is to spur public dialogue and help policymakers understand the rural impacts of public policies and programs. RUPRI is housed within the College of Public Health at the University of Iowa. RUPRI's reach is national and international and is one of the world's preeminent sources of expertise and perspective on policies impacting rural places and people. Read more at www.rupri.org.