HEALTH

Rural Health Care and COVID-19

POLICY SNAPSHOT

Though early surges in COVID-19 cases have predominantly affected urban areas, the COVID-19 public health crisis may have a disproportionate effect on rural communities—potentially exacerbating existing rural health disparities. For example, rural Americans tend to be older and sicker compared to their urban counterparts—leaving them more susceptible to COVID-19. Additionally, 128 rural hospitals closed or ceased inpatient services between 2010 and June 30 of this year. Other health facilities, such as community health centers, are also feeling the financial pressure of the pandemic. During the COVID-19 crisis, however, access to care remains critical—and states can pursue various policy strategies to enhance the rural health delivery system and increase access to care in rural communities.

This policy snapshot includes more immediate and long-term state policy options for bolstering rural health care throughout and beyond the COVID-19 pandemic, as well as relevant state examples, federal action and additional resources.

State Policy Options

State legislators may consider the following policy options to mitigate the effects of COVID-19 on rural health care systems and prepare for future surges or pandemics, or both:

- Support Rural Health Care Facilities.
  - Evaluate the financial effects of COVID-19 on rural hospitals and health care facilities.
  - Provide sustainable investment and emergency funding opportunities for rural health care facilities and providers.
  - Consider greater regulatory flexibility for rural health care facilities by evaluating certificate of need (CON) laws.
  - Pursue alternative payment models, which generally incentivize the value of health services over volume, to potentially provide a more predictable funding source for rural hospitals in the long term.
- Increase Access to Health Care for Rural Patients.
  - Assess policies enhancing the availability of telehealth, including bolstering health insurance coverage for telehealth.
  - Strengthen private insurance coverage and affordability for rural Americans.

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

JULY | 2020

POLICY OPTIONS	STATE EXAMPLES
Support Rural Health Care Facilities: Many rural hospitals and health facilities were already facing financial difficulties prior to the pandemic. Limits on elective surgeries and drops in routine care have only compounded these pressures. State legislators can support rural health care facilities through the following policy options.	
Evaluate the financial effects of COVID-19 on rural hospitals and health care facilities.	**Pennsylvania** SB 841 requires the Pennsylvania Cost Containment Council to prepare a report on the various ways COVID-19 has affected hospitals and health facilities—such as evaluating the cost of staff training and recruitment and studying revenue losses due to limiting non-emergent services.
Provide sustainable investment and emergency funding opportunities for rural health care facilities and providers.	**North Carolina** HB 1043 provides $65 million in grant funding to establish the COVID-19 Rural Hospital Relief Fund. Funds will be allocated to designated critical access hospitals to offset the financial effects of COVID-19, including financial losses due to enhancing infection control protocols and triage, limiting non-emergent services and increasing the number of available beds for surge capacity scenarios.
Consider greater regulatory flexibility for rural health care facilities by evaluating CON laws.	**At least 23 states** have temporarily waived or provided an expedited review process for CON approval in response to COVID-19, according to NCSL research. Fourteen states have suspended requirements for multiple health care projects typically necessitating CON approval, while nine states have focused on specific CON requirements—often increasing a facility's bed capacity.
Pursue alternative payment models to potentially provide a more predictable funding source for rural hospitals amid the pandemic—and once the pandemic abates.	**Utah** HB 2 directs the Utah Department of Health to work with rural hospitals on developing new reimbursement methodologies for inpatient billing in order to curb health care expenditures to the state.
Increase Access to Health Care for Rural Patients: Several barriers impede access to health care for rural Americans, including living far from the nearest hospital or lacking quality health coverage. Many states have quickly adopted changes to their telehealth policies to increase access to care and limit in-person contact during the pandemic. Additionally, while several states have expanded Medicaid eligibility to enhance access to health services, states can also pursue policy options aiming to improve private insurance affordability in the long term for rural residents.	
Assess policies enhancing the availability of telehealth, such as ensuring payment parity and extending the types of covered services delivered via telehealth.	**All 50 states** have modified their telehealth policies in some capacity in response to COVID-19, with most state actions lasting for the duration of the pandemic. For example, **Vermont** HB 742 extends private insurance coverage to include teledentistry, requires coverage for store-and-forward modalities, and requires private health insurance plans to provide the same reimbursement for telehealth services as the insurer would for in-person services (i.e., payment parity).
Bolster private insurance coverage and affordability for rural Americans through policy options aiming to stabilize the individual insurance marketplace, such as reinsurance programs.	**Twelve states** have received federal approval and funding to operate a state-based reinsurance program through a Section 1332 waiver. **Colorado** SB 215 creates a special fee for certain health insurance carriers and hospitals to fund the state's reinsurance program for an additional five years and provide insurance subsidies for certain individuals. The reinsurance program helped lower premiums for 2020 individual health plans, especially in rural and remote areas.

Federal Action

To ensure the U.S. health system has the capacity to respond to COVID-19, federal lawmakers appropriated funds through the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund to support hospitals and other health facilities delivering vital services during the pandemic. The U.S. Department of Health and Human Services is in the process of distributing $175 billion in grants to hospitals and health care providers across the country, with $10 billion specifically targeted to rural providers. Hospitals and other providers can use federal dollars for treating COVID-19 patients and offsetting lost revenue due to the pandemic. Rural health clinics received just under $50,000 per clinic to support COVID-19 testing efforts.

Additionally, the Health Resources and Services Administration has distributed federal dollars supporting health care facilities responding to COVID-19. This includes nearly $165 million in CARES Act funding to 1,779 rural hospitals and 14 telehealth resource centers, $1.3 billion to health centers, and more than $21 million to look-alike health centers and health center controlled networks.

The CARES Act also authorized the Centers for Medicare and Medicaid Services to temporarily waive certain telehealth requirements for services delivered to Medicare enrollees. The guidance removes rural and site limitations so telehealth services can be delivered regardless of where the enrollee is located geographically.

Additional Resources

- Improving Rural Health: State Policy Options for Increasing Access to Care (NCSL, June 2020)
- States Support Rural Hospital While COVID-19 Highlights Challenges (ASTHO, June 2020)
- Sustaining Rural Hospitals After COVID-19: The Case for Global Budgets (JAMA, June 2020)
- The COVID-19 Pandemic and Rural Hospitals—Adding Insult to Injury (Health Affairs, May 2020)

Please note that NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UD3OA22893, National Organizations for State and Local Officials. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. government

NCSL Contact:

Kelly Hughes
Program Director, Health Access, Costs and Coverage
303-856-1367
kelly.hughes@ncsl.org

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

Tim Storey, Executive Director

7700 East First Place, Denver, Colorado 80230, 303-364-7700 | 444 North Capitol Street, N.W., Suite 515, Washington, D.C. 20001, 202-624-5400

www.ncsl.org