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Critical Access Hospitals' Initial Response to the COVID-19 Pandemic: Use of Federal Funding and Regulatory Flexibilities

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KEY FINDINGS

- A survey of Critical Access Hospital (CAH) CEOs in eight states revealed that most participating CAHs were supported in their initial response to the COVID-19 pandemic with federal funding from multiple sources including CARES Act Provider Relief Funds, the $10 billion rural hospital allocation, and the Paycheck Protection Program.
- The vast majority of respondents (70%) also used three or more regulatory waivers or flexibilities, such as reuse of face masks, relief from the 96-hour length of stay limit for CAHs, and reduced administrative and paperwork requirements.
- The majority of participating CAHs utilized the expansion of telehealth services and described it as being the most useful type of waiver, suggesting that ongoing attention to telehealth policy and infrastructure is key for the CAH response to COVID-19.

PURPOSE

The COVID-19 pandemic has heightened the financial and operational pressures on small rural hospitals such as Critical Access Hospitals (CAHs), which have 25 or fewer beds.[1,2] Many of these hospitals were under financial stress prior to the advent of COVID-19, with 181 rural hospitals (including 65 CAHs) closing between 2005 and July 2021 in the U.S., and roughly one quarter of rural hospitals at high or mid-high risk of financial distress in 2019.[3,4] In the first few months of the pandemic, the federal government passed a number of funding bills to respond to the COVID-19 crisis as well as regulatory flexibilities in an attempt to ease the burden on hospitals. This policy brief describes how CAHs have used these federal funds and waivers, using data collected through a survey of CAH CEOs in eight states with high COVID-19 prevalence rates in rural counties.

BACKGROUND

During the COVID-19 pandemic, many hospitals have received financial support through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the $10 billion allocation for rural hospitals and other rural providers distributed in April 2020, the Paycheck Protection Program, and the Accelerated/Advanced Payment Program.[5–8] In addition, several federal waivers and regulatory flexibilities were implemented to address COVID-19 patient care demands on hospitals and other health care providers during the public health emergency. These included permitting the reuse of personal protective equipment (PPE), increasing the types of services that can be covered by telehealth, expanding the types of practitioners that can provide and bill Medi-

care for telehealth services, easing patient transfers, and reducing administrative reporting requirements.[9] The Centers for Medicare & Medicaid Services (CMS) also created flexibility specifically for CAHs, including waiving the limits on the number of patient beds and the average length of hospital stays allowed, allowing off-site alternative treatment settings, and permitting on-call physicians to provide remote consultation.[9]

APPROACH

Data for this analysis come from a survey of CEOs in 216 CAHs across eight states. The survey was fielded between September 8, 2020 and October 30, 2020, and took respondents approximately 15 minutes to complete. Participants answered questions about their hospital's response during the initial months of the COVID-19 pandemic from February through August 2020.

Eight states were selected based on the prevalence of COVID-19 cases in rural counties. The 2013 Office of Management and Budget's core-based statistical areas were used to designate non-metropolitan micropolitan and non-core counties as rural.[10] Using COVID-19 case counts from USA Facts as of July 27, 2020,[11] the rural prevalence in every state with at least 10 CAHs was assessed. The two states with highest rural prevalence in each of the four U.S. Census regions (West, South, Midwest, and Northeast) were then selected. As a result, the sample included CAHs in Arizona, Florida, Indiana, Iowa, Louisiana, New York, Pennsylvania, and Utah. At the time the data were accessed, rural prevalence of COVID-19 in these states ranged from approximately 225 cases per 100,000 in Pennsylvania to 2,743 cases per 100,000 in Arizona.

Participating CAHs completed a survey that included questions on several topics: finance, federal policies, capacity for treatment, workforce, and partnerships. Feedback on the survey was received from an expert panel and a pilot test prior to finalizing the instrument. A multi-mode approach was used to conduct the survey electronically on the Qualtrics platform and via phone. In the initial email and over the phone, CEOs were also given the option to designate a different member of their staff who was knowledgeable about the CAH's COVID-19 response to participate in the survey. A response rate of 73% was achieved, with 108 surveys completed electronically and 50 surveys completed via phone.

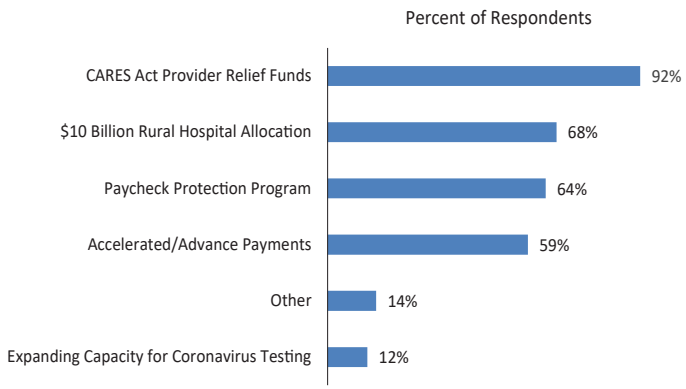
Response rates and basic frequencies were calculated using STATA software. Qualitative data from the survey's open-ended questions were coded by two members of the research team using conventional inductive content analysis to identify key themes, and a third team member collaborated to reach consensus.[12]

RESULTS

Finance

Almost all CAHs received support from at least one of the federal COVID-19 funding bills during the period of February through August 2020. Figure 1 shows the percent of respondents that reported receiving different types of federal funds for COVID-19 relief. CAHs were most likely (92%) to receive federal support from the CARES Act Provider Relief Fund, which provided financial support to hospitals and health care providers on the front lines of the COVID-19 response.

FIGURE 1: Sources of Federal Funding received by CAHs (February to August 2020)



Note: Respondents could select as many answers as applied

The majority of CAHs also reported receiving funds from the $10 billion rural hospital allocation (68%) used to cover increased health care related expenses and lost revenues attributable to COVID-19; the Pay-

check Protection Program from the Small Business Administration (64%) to help businesses keep their workforce employed during the COVID-19 emergency; and the Accelerated/Advance Payment Program (59%), which provided funds when there was a disruption in claims submission and/or claims processing due to the COVID-19 pandemic.

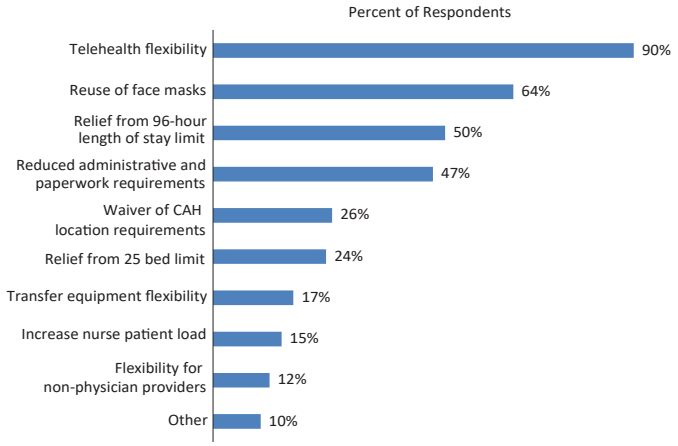
Overall, almost three fourths (73%) of CAHs benefited from support from three or more federal sources. When asked to select one category where they spent most of their federal funding, CAHs reported using this support to cover general operating costs (41%) and to prevent employee furloughs (29%). A large portion of respondents reported that federal funding was either very helpful (49%) in covering revenue losses and additional expenses during the period February through August 2020 or critical to the CAH remaining open (38%).

When asked about how their CAH was positioned financially for the future, more than half (56%) of CAHs responded that their financial status would be about the same compared to prior to the COVID-19 pandemic. Fourteen percent responded that their financial status would be significantly or somewhat better, while more than twice as many (30%) indicated their financial status would be significantly or somewhat worse.

Federal Waivers and Regulatory Flexibilities

In addition to receiving federal funding support, CAHs also took advantage of a range of federal waivers and regulatory flexibilities due to the COVID-19 public health emergency during the period of February through August 2020. The most frequently used waiver or regulatory change was related to telehealth flexibility, used by 90% of CAHs (Figure 2) and, when asked, was viewed as the single most beneficial waiver or regulatory flexibility by almost 60% of CAHs. Other frequently used waivers and regulatory flexibilities included the reuse of face masks, relief from the 96-hour length of stay limit for CAHs, and the reduction of administrative paperwork requirements (e.g. for audit and quality reporting, completion of medical records within 30 days of hospital discharge). Overall, 70% of CAHs reported using three or more federal waivers and regulatory flexibilities.

FIGURE 2: Use of Federal Waivers and Regulatory Flexibilities (February to August 2020)



Note: Respondents could select as many answers as applied

DISCUSSION

The results of the study of CAHs' responses to the initial seven months of the COVID-19 crisis have several important policy implications, including the short-term benefits of federal COVID-19 funding support and waivers and the value of telehealth expansion.

Federal Support

The short-term benefits of federal COVID-19 funding support and the use of federal waivers and regulatory flexibilities were apparent during the first seven months of the COVID-19 pandemic. Almost all (97.5%) of the survey respondents received support from at least one federal funding source and 90% of respondents used at least two federal waivers or regulatory flexibilities. This support was essential during a period of significantly reduced use of CAH services for non-COVID-19 patients. More than one third of CAHs reported that federal support was critical to avoid closure of their facility. While about two thirds of CAHs responded that their hospital's financial position for the future was about the same or better than prior to the COVID-19 pandemic, this is likely

in part due to the federal funding they received for COVID-19 relief. In open-ended responses, respondents noted that this financial support allowed them to minimize or avoid furloughing or laying off staff. Some respondents also raised concerns about the total amount and distribution plan for federal funds with issues related to provider eligibility, appropriate use of funds, regulatory requirements, and repayment requirements.

Due to the critical importance of these funds noted by many hospitals that participated in this survey, it is imperative to continue federal financial and regulatory support for CAHs during the remaining course of the COVID-19 pandemic similar to those Congress and federal agencies have already provided. Several helpful new federal initiatives have been passed since the time this survey was fielded. The American Rescue Plan Act of 2021 will provide $8.5 billion to reimburse providers who care for rural patients and also enables the Department of Agriculture to award $500 million in grants to eligible entities, including some rural hospitals.[13] An additional $17 billion will be distributed to eligible providers via the Provider Relief Fund.[14] Some CAHs have received additional funding for COVID-19 testing and mitigation through the Small Rural Hospital Improvement Program and the Rural Health Clinic COVID-19 Testing and Mitigation (RHCCTM) Program.[15,16]

Telehealth Expansion

The potential value of telehealth expansion was evidenced by almost all CAHs taking advantage of regulatory relief from the federal government as well as the expansion of Medicare reimbursement for telehealth services. The majority of CAHs found the flexibility in the use of telehealth services to be the most helpful federal waiver or policy change implemented in response to the COVID-19 pandemic. One component of these waivers was the allowance of audio-only telehealth for certain services, which may have been particularly useful for CAHs that did not have existing telehealth infrastructure in place prior to the COVID-19 pandemic.

Assessing the feasibility of long-term continuation (beyond the COVID-19 pandemic) of regulatory relief and reimbursement support for telehealth services is crucial. A new model of rural health care delivery (e.g., a hybrid model with support for both in-person and virtual care) may be on the horizon and could be embraced by patients and providers in a value-based health care environment. Extension of some of the telehealth provisions in the CARES Act would support this model.

Limitations

Despite having a high survey response rate a few limitations of the study should be noted. First, the use of two modes (online and phone) for data collection could potentially lead to response bias by survey participants. Second, some CAHs used multiple staff to answer specific questions, which could lead to response differences compared to CAHs whose CEOs answered all questions by themselves. Third, the survey was completed by CEOs in eight states with high COVID-19 prevalence rates in rural counties. The results are not necessarily generalizable to the more than 1,300 CAHs across the U.S.

CONCLUSIONS

The study results suggest that during the first seven months of the COVID-19 pandemic in the U.S., most of the CAHs in eight states with high COVID-19 prevalence in rural counties benefitted from the additional supports they received through federal funding sources and regulatory waivers. The COVID-19 pandemic has now spread to more rural communities, and CAHs have likely experienced one or multiple peaks of COVID-19 cases since this survey was fielded. New, more contagious variants of the virus are driving high transmission in many areas,[17] and the challenges described in this study, in addition to other challenges, remain relevant for CAHs. An appropriate response from CAHs will depend on several factors, including the continuation of federal fiscal support, waivers, and regulatory flexibilities that allow for effective operation of CAHs (including the expansion of telehealth services). Policymakers must understand and focus

on CAH-specific needs in providing ongoing support during the COVID-19 crisis.

REFERENCES

1. Bai G, Anderson GF. COVID-19 and the financial viability of U.S. rural hospitals. Health Aff. October 2020. https://www.healthaffairs.org/do/10.1377/hblog20200630.208205/full/.
2. Diaz A, Chhabra KR, Scott JW. The COVID-19 pandemic and rural hospitals—adding insult to injury. Heal Aff Blog. November 2020. https://www.healthaffairs.org/do/10.1377/hblog20200429.583513/full/.
3. 179 Rural Hospital Closures: January 2005 – Present (135 since 2010). Cecil G Sheps Cent Heal Serv Res. February 2021. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
4. Thomas SR, Pink GH, Reiter K. Trends in Risk of Financial Distress among Rural Hospitals from 2015 to 2019.; 2019. www.shepscenter.unc.edu/download/12744/. Accessed October 21, 2021.
5. U.S. Department of Health and Human Services. CARES Act Provider Relief Fund: General information. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html. Published October 30, 2021.
6. U.S. Department of Health and Human Services. HHS Awards Nearly $165 Million to Combat the COVID-19 Pandemic in Rural Communities. https://www.hhs.gov/about/news/2020/04/22/hhs-awards-nearly-165-million-to-combat-covid19-pandemic-in-rural-communities.html. Published February 19, 2020.
7. McCollum B. H.R.266 - Paycheck Protection Program and Health Care Enhancement Act. 116th Congress (2019-2020); 2020. https://www.congress.gov/bill/116th-congress/house-bill/266.
8. U.S. Centers for Medicare and Medicaid Services. Fact Sheet: Repayment Terms for Accelerated and Advance Payments Issued to Providers and Suppliers during COVID-19 Emergency. https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf. Published 2020.
9. U.S. Centers for Medicare and Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.
10. Cromartie J. Urban Influence Codes - Documentation. USDA Econ Res Serv Website. November 2019. https://www.ers.usda.gov/data-products/urban-influence-codes/documentation.aspx.
11. Detailed Methodology and Sources: COVID-19 Data. USAFacts. February 2021. https://usafacts.org/articles/detailed-methodology-covid-19-data/.
12. Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs. 2008;62(1):107-115. doi:10.1111/j.1365-2648.2007.04569.x
13. American Hospital Association. Summary of American Rescue Plan Act of 2021 and Provisions Affecting Hospitals and Health Systems. American Hospital Association. https://www.aha.org/advisory/2021-03-17-summary-american-rescue-plan-act-2021-and-provisions-affecting-hospitals-and. Published 2021. Accessed May 7, 2021.
14. U.S. Department of Health and Human Services. HHS Announces the Availability of $25.5 Billion in COVID-19 Provider Funding. https://www.hhs.gov/about/news/2021/09/10/hhs-announces-the-availability-of-25-point-5-billion-in-covid-19-provider-funding.html. Published 2021. Accessed September 13, 2021.
15. U.S. Department of Health and Human Services. HHS Provides $398 Million to Small Rural Hospitals for COVID-19 Testing and Mitigation. https://www.hhs.gov/about/news/2021/07/13/hhs-provides-398-million-to-small-rural-hospitals-for-covid-testing.html. Published 2021. Accessed September 13, 2021.
16. Health Resources & Services Administration. Rural Health Clinic COVID-19 Testing and Mitigation (RHCCTM) Program. https://www.hrsa.gov/coronavirus/rural-health-clinics/testing. Published 2021. Accessed October 21, 2021.
17. Centers for Disease Control and Prevention. Delta Variant: What We Know About the Science. https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html. Accessed September 13, 2021.

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