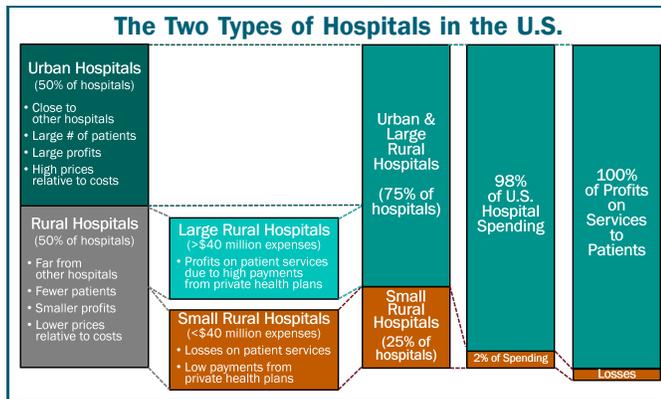


Saving Rural Hospitals and Strengthening Rural Healthcare

The Importance of Rural Hospitals

There are two very different types of hospitals in the U.S: (1) small rural hospitals, and (2) urban and large rural hospitals. There are over 1,000 small rural hospitals¹, representing more than one-fourth of all the short-term general hospitals in the country, but they receive only 2% of total national hospital spending.



Small rural hospitals provide most or all of the healthcare services in the small communities they serve. Small rural hospitals deliver not only traditional hospital services such as emergency care, inpatient care, and laboratory testing, but most of them also deliver primary care and inpatient rehabilitation services. The majority of the communities they serve are at least a half-hour drive from the nearest alternative hospital, and many communities have no alternate sources of health care.

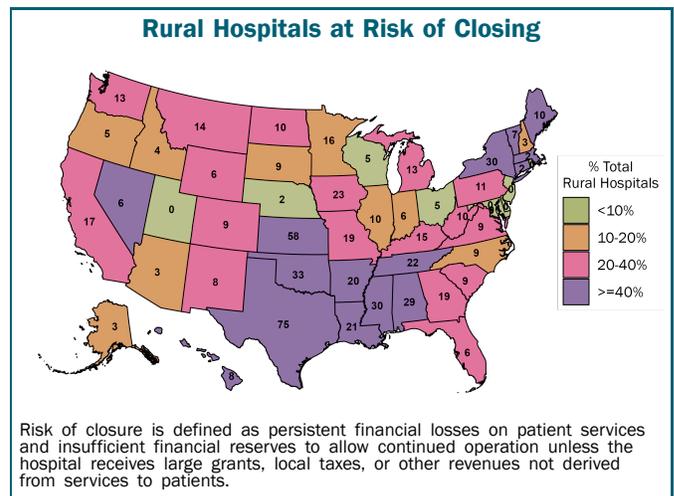
The services provided by small rural hospitals are also important for residents of urban areas. Most of the nation's food supply and energy production comes from rural communities. Farms, ranches, mines, drilling sites, wind farms, and solar energy facilities cannot function without an adequate, healthy workforce, and people will be less willing to live or work in rural communities that do not have an emergency department and other healthcare services. Many popular recreation, historical, and tourist sites are located in rural areas, and visitors to those sites need access to emergency services if they have an accident or medical emergency.

The Crisis Facing Rural Healthcare

Small rural hospitals are struggling to survive and rural communities are being harmed. The majority of small rural hospitals are losing money delivering patient services. More than 100 rural hospitals have closed in the past decade, and most of these were small rural hospitals. In most cases, the closure of the hospital resulted in the loss of both the emergency department and other outpatient services, and residents of the community must now travel much farther when they have an emergency or need other healthcare services. This increases the risk of death or disability when accidents or serious medical conditions occur, but it also increases the risk of health

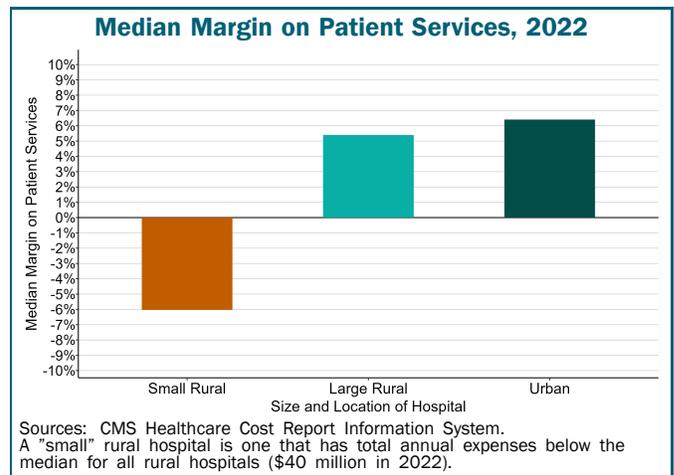
problems going undiagnosed or inadequately treated due to lack of access to care.

More than 600 rural hospitals – 30% of all rural hospitals in the country – are at risk of closing in the near future, and over 300 of these hospitals are at *immediate risk* of closing. Most of the at-risk hospitals are small rural hospitals located in isolated communities where loss of the hospital will severely limit access to health care services. Millions of people could be directly harmed if these hospitals close, and people in all parts of the country could be affected through the impacts on workers in agriculture and other industries.



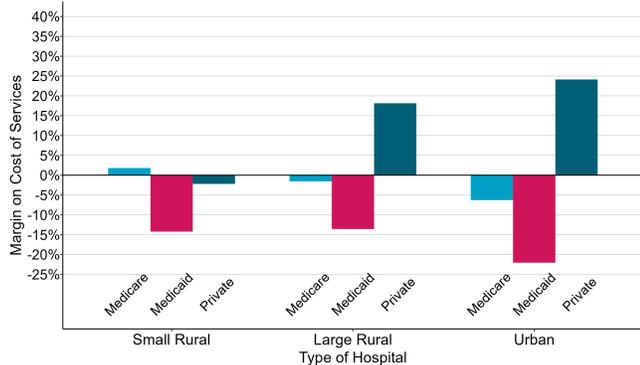
The Causes of the Financial Problems at Small Rural Hospitals

Small rural hospitals are being forced to close because they are not paid enough to cover the cost of delivering care to patients in rural areas. Most small rural hospitals lose money on the patient services they deliver, while most urban hospitals and larger rural hospitals make profits on patient services.



Small rural hospitals lose money on patient services because of inadequate payments from private insurance plans, whereas urban hospitals and larger rural hospitals make large profits on services to patients with private insurance. Most hospitals, regardless of their size, lose money on Medicaid and uninsured patients. However, while large hospitals can offset these losses with the profits they make on patients who have private insurance, small rural hospitals cannot.

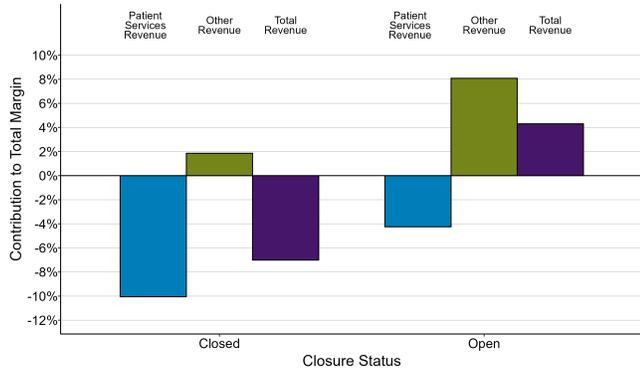
Margins in 2022 on Services to Patients with Medicare, Medicaid, and Private Insurance



Source: CMS Healthcare Cost Report Information System. A "small" rural hospital is one that has total annual expenses below the median for all rural hospitals.

Many small rural hospitals remain open only because they receive significant supplemental funding from state grants or local taxes. In some states, state governments provide grants that reduce or eliminate losses at small rural hospitals, while there is little or no such assistance in other states. Some small rural hospitals are organized as public hospital districts, and residents of these communities tax themselves to offset underpayments by private health plans and Medicaid. There is no guarantee that that these hospitals can continue receiving these large amounts of revenue in the future, and without them, the hospitals would likely be forced to close.

Sources of Total Margins at Small Rural Hospitals

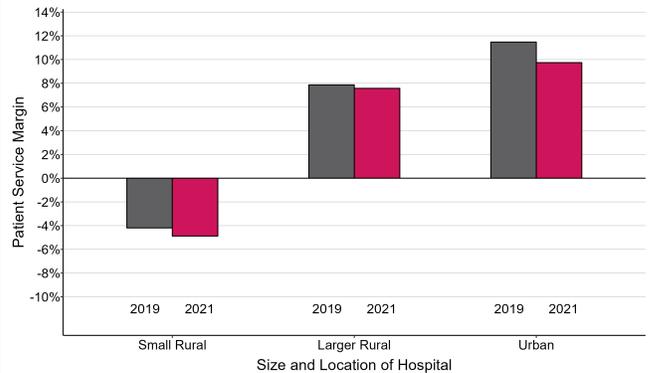


Each bar represents the median value for rural hospitals that (1) have closed since 2015 or (2) remained open in 2022. Only rural hospitals with total expenses less than the median for rural hospitals are included. The value for each hospital is the median for the three years prior to closure (for hospitals that had closed) or the median for the most recent three years available (for hospitals that were open in 2022) of (a) the dollar margin (i.e., profit or loss) earned on services to patients, (b) the amount of revenue received from sources other than patient services, or (c) the total hospital revenue, divided by the hospital's total expenses. This shows how much revenue from patient services and other sources of revenue contributed to the hospital's total margin.

The Impact of the Pandemic on Small Rural Hospitals

Small rural hospitals had greater losses on patient services during the pandemic. Most rural hospitals experienced lower margins on patient services during the pandemic. Since the majority of small rural hospitals were losing money on patient services prior to the pandemic, the reductions in margins during the pandemic pushed them even further into the red. In contrast, even though larger rural hospitals and urban hospitals also experienced lower margins, most of them continued to generate profits on patient services overall.

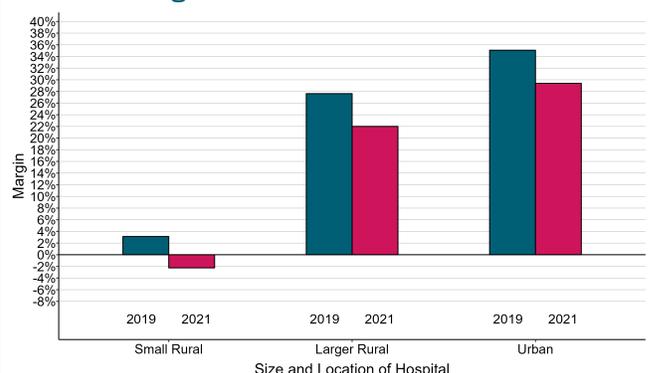
Change in Median Margins on Patient Services



"Small" rural hospitals are rural hospitals with total annual expenses less than the median for rural hospitals. 2020 is defined here as the hospital's fiscal year that included the March-June 2020 period. 2021 is the year that followed 2020, and 2019 is the year that preceded it.

The primary reason overall patient service margins at rural hospitals decreased during the pandemic was higher losses on patients insured by private health plans (including Medicare Advantage plans). The losses on patients insured by private health plans hurt the smallest rural hospitals the most because they were already receiving low payments from private payers prior to the pandemic. Although hospitals of all sizes experienced lower margins during the pandemic on services to patients with private health insurance, the reductions meant that most small rural hospitals lost money providing services to these patients.

Median Margin on Patients With Private Insurance



"Small" rural hospitals are rural hospitals with total annual expenses less than the median for rural hospitals. 2020 is defined here as the hospital's fiscal year that included the March-June 2020 period. 2021 is the year that followed 2020, and 2019 is the year that preceded it. The margin shown is the difference between the revenues received from private insurance plans (including Medicare Advantage plans) and the cost of the services delivered to the patients insured by those plans, divided by the cost.

Federal assistance enabled small rural hospitals to continue operating during the pandemic, but because that assistance has now ended, many hospitals could be forced to close. Despite the higher losses on patient services they experienced, a smaller number of rural hospitals closed in 2021 and 2022 than in 2020 because of the special federal funding that was available during the pandemic. Most rural hospitals received significant amounts of federal aid that enabled them to continue operating. However, this federal assistance was only temporary. The losses on patient services will likely continue or worsen because of the higher costs that rural hospitals are now facing, and without the extra federal assistance, many hospitals will be at risk of closing.

Problems With Current Payments

Standard payments for hospital services are not large enough to cover the higher cost of delivering services in small rural communities. The average cost of an emergency room visit, inpatient day, laboratory test, imaging study, or primary care visit is inherently higher in small rural hospitals and clinics than at larger hospitals because there is a minimum level of staffing and equipment required to deliver each of these services regardless of how many patients need to use them. For example, a hospital Emergency Department has to have at least one physician available around the clock in order to respond to injuries and medical emergencies quickly and effectively, regardless of how many patients actually visit the ED. A smaller community will have fewer ED visits, but the cost of staffing the ED will be the same, so the average cost per visit will be higher. Consequently, fees that are high enough to cover the average cost per service at larger hospitals will fail to cover the costs of the same services at small hospitals. Many private health plans pay small rural hospitals less than they pay larger hospitals for the same services, even though the cost per service at the smaller hospitals is inherently higher.

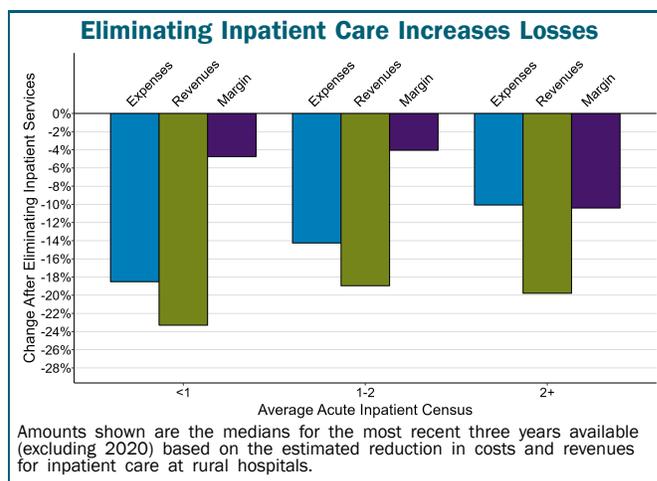
Critical Access Hospital status reduces a small rural hospital's losses only on services to Original Medicare beneficiaries. Most small rural hospitals are classified as Critical Access Hospitals, which enables them to receive cost-based payment for patients insured by Original Medicare and some state Medicaid programs. However, because of Congressional sequestration requirements, the payments are lower than the actual cost of delivering the services. The absence of any profit on payments for Medicare beneficiaries means the hospital has no way to cover its losses on uninsured patients or the losses on patients with other types of insurance, including patients with Medicare Advantage plans. In addition, Medicare rules require patients to pay higher cost-sharing amounts in order to receive services at Critical Access Hospitals than at other hospitals, so even though Critical Access Hospital status may help the hospital financially, it can have a negative financial impact on the hospital's patients.

Current methods of payment penalize hospitals for efforts to improve the health of rural residents. If community residents are healthier and need fewer ED visits and other services, the hospital's revenues will decrease, but the cost of maintaining the essential services will not change, thereby increasing financial losses at the hospital. The same problem occurs under Medicare's cost-based payment system for Critical Access Hospitals because Medicare's share of the hospital's costs decreases if Medicare beneficiaries need fewer services.

Problems With Proposed "Solutions"

Four policies commonly proposed to help rural hospitals are: (1) converting hospitals to "Rural Emergency Hospitals" by eliminating inpatient services; (2) creating a "global budget" for the hospital; (3) paying a hospital "shared savings" bonuses if it reduces total healthcare spending for its patients; and (4) expanding Medicaid eligibility. None of these proposals will solve the problems facing rural hospitals.

Requiring rural hospitals to eliminate inpatient services would increase their financial losses while reducing access to inpatient care for local residents. Beginning in 2023, hospitals with fewer than 50 beds are allowed to convert to "Rural Emergency Hospital" status if they eliminate their inpatient services. In most cases, the revenues generated by inpatient care at a small rural hospital exceed the direct costs of delivering that care, so even though eliminating the inpatient unit would reduce the hospital's costs, its revenues could decrease even more, making it worse off financially. In addition, if a Critical Access Hospital converts to a Rural Emergency Hospital, it would no longer be eligible for cost-based payments from Medicare for outpatient services, which could cause additional losses. Although the hospital would receive a supplemental annual payment of about \$3 million from Medicare, that may or may not be sufficient to offset these losses. Residents who have a medical condition that requires a short hospital admission could no longer be admitted to the hospital, so they would have to be transferred to another city, and that may not be possible if there are no beds available in other cities. Also, local residents who currently receive inpatient rehabilitation and/or long-term nursing care in the hospital's swing beds could no longer receive those services close to home.



Giving the hospital a global budget would increase losses when patients need more services or the hospital's costs increase. The goal of global budget programs has been to limit or reduce the amount health plans spend on hospital services, not to address shortfalls in payment or prevent closure of small rural hospitals. Although hospitals in communities that are experiencing significant population losses or that deliver unnecessary services could benefit from a global budget program in the short run, hospitals that experience higher costs or higher volumes of services due to circumstances beyond their control would likely be harmed, since their revenues could no longer increase to cover the additional costs.

- Although Maryland's global budget program has been cited

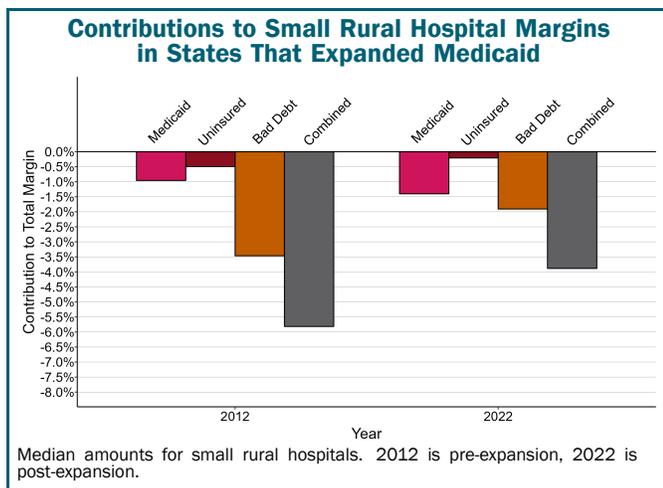
as an example of how rural hospitals can benefit from this approach, the smallest rural hospital in Maryland closed in 2020 despite operating under the global budget system.

- Under the Pennsylvania Rural Health Model that was created by CMS, hospitals receive global budgets that are based on the amount of revenues they received in the past, with no assurance the budgets will be adequate to support the higher cost of delivering essential services in the future.
- Under the Community Health Access and Rural Transformation (CHART) Model that was developed by the Center for Medicare and Medicaid Innovation, the “capitated payments” to rural hospitals would have been even lower than the inadequate amounts they had been receiving in order to reduce spending for Medicare and other payers.

Access to care for patients can be harmed if budgets are less than the cost of services, which has led many other countries to modify or replace their global budget systems.

Small rural hospitals are unlikely to benefit from “shared savings” programs, and most would be harmed by taking on downside risk for total healthcare spending. Most small rural hospitals are unlikely to benefit from forming an Accountable Care Organization (ACO) in order to participate in shared savings programs. It is difficult for small rural ACOs to qualify for shared savings bonuses because the minimum savings threshold is higher than for larger ACOs and because there are fewer opportunities to generate savings. “Downside risk” is especially problematic for small rural hospitals, because they do not deliver and cannot control many of the most expensive services their residents may need, and a requirement that the rural hospital pay penalties when community residents need expensive services at urban hospitals would worsen the rural hospitals’ financial problems.

Expansion of eligibility for Medicaid would reduce hospitals’ losses on uninsured patients and bad debt, but it will not reduce the losses on services due to low Medicaid payments. In states that have expanded Medicaid, losses on uninsured charity cases and bad debt decreased, but losses on services to Medicaid patients increased. While the net effect was a reduction in the combined loss from all three categories, the total loss remained high. Medicaid coverage is only of limited value if there is no hospital or primary care clinic in the community because Medicaid payments are too low to sustain local services.



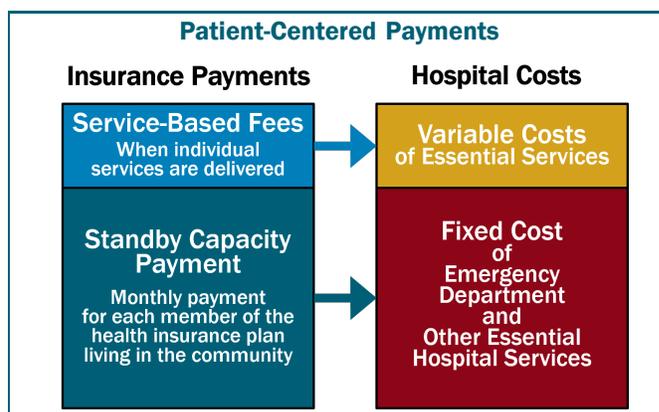
A Better Way to Pay Rural Hospitals

A good payment system must achieve three key goals:

1. Ensure availability of essential services in the community;
2. Enable safe and timely delivery of the services patients need at prices they can afford; and
3. Encourage better health and lower healthcare spending.

Patient-Centered Payment can achieve all three goals using the following four components:

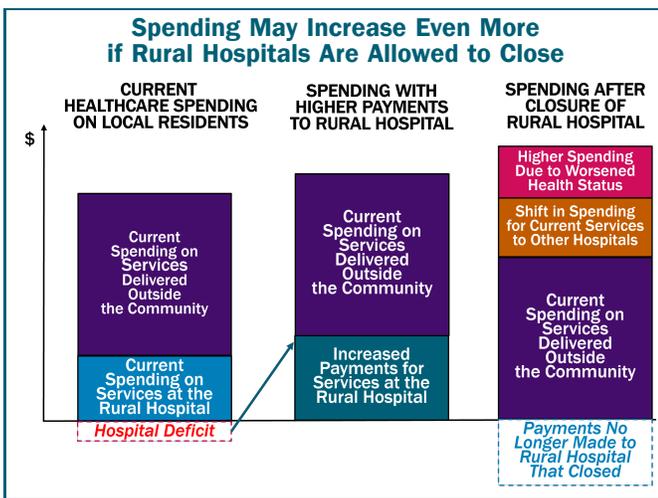
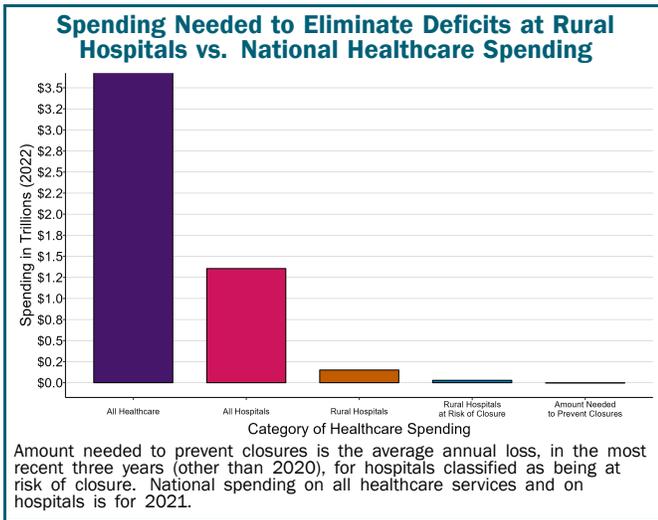
- **Standby Capacity Payments to support the fixed costs of essential services.** Each health plan (Medicare, Medicaid, Medicare Advantage, and commercial insurance) should pay a Standby Capacity Payment to the rural hospital based on the number of insured members who live in the community (regardless of the number of services the patients receive). This ensures the hospital has adequate revenues to support the minimum costs of essential services such as the emergency department, inpatient unit, and laboratory.
- **Service-Based Fees for diagnostic and treatment services based on the variable costs of each service.** Rural hospitals should continue to receive payments for delivering individual services, but under Patient-Centered Payment, the Service-Based Fees could be much lower than current payments. Since the hospital would receive Standby Capacity Payments to support the fixed costs of essential services, the Service-Based Fees would only need to cover the additional costs incurred when additional services are delivered. This means that if patients stay healthy and need fewer services, the hospital’s revenues and costs will decrease by similar amounts, so the hospital’s margin will not be harmed.
- **Accountability for quality and efficiency.** In return for receiving adequate payments to support essential services, rural hospitals should take accountability for delivering evidence-based services safely and efficiently.
- **Value-based cost-sharing for patients.** The amount a patient pays out of pocket to receive necessary services should be affordable for the patient, so patients are not prevented from obtaining the care needed to improve their health.



This is a *patient-centered* approach to payment because it is designed to support the services patients need, not to increase profits for hospitals or health insurance plans. Patient-Centered Payment would provide adequate funding to support services in rural communities without the problematic incentives to deliver unnecessary services or to stint on care that exist in current payment systems and “value-based” payments.

How to Save Rural Hospitals and Strengthen Rural Healthcare

It will cost about \$4 billion per year to prevent closures of the at-risk hospitals and preserve access to rural healthcare services, an amount equal to only 1/10 of 1% of total national healthcare spending. No payment system will sustain rural hospitals and clinics unless the amounts of payment are large enough to cover the cost of delivering high-quality care in small rural communities. Because current payments are below the costs of delivering services, an increase in spending by all payers will be needed to keep rural hospitals solvent, but \$4 billion is a tiny amount in comparison to the more than \$3.3 trillion currently spent on healthcare and the more than \$1.3 trillion spent on all urban and rural hospitals in the country. Moreover, most of the increase in spending will support primary care and emergency care, since these are the services at small rural hospitals where the biggest shortfalls in current payments exist.



Spending would likely increase even if the hospitals close. The reduced access to preventive care and delays in treatment resulting from a rural hospital closure will cause residents of the community to need even more services in the future. Paying more now to preserve local healthcare services is a better way to invest resources.

Citizens, businesses, local governments, state government, and the federal government must all take action to ensure that every payer provides adequate and appropriate payments for small rural hospitals and clinics:

- **Businesses, state and local governments, and rural residents must demand that private health insurance companies change the way they pay small rural hospitals.** The biggest cause of losses at most small rural hospitals is low payments from private insurance plans and Medicare Advantage plans. Private insurance companies are unlikely to increase or change their payments unless businesses, state and local governments, and residents choose health plans based on whether they pay the local hospital adequately and appropriately.
- **State Medicaid programs and managed care organizations need to pay small rural hospitals adequately and appropriately for their services.** Expanded eligibility for Medicaid will help more rural residents afford healthcare services, but small rural hospitals cannot deliver the services patients need if Medicaid payments are too low. CMS should authorize states to require Medicaid MCOs to use Patient-Centered Payments and to pay adequately for services at small rural hospitals.
- **Congress should create a Patient-Centered Payment program in Medicare for small rural hospitals.** Although Medicare is not the primary cause of deficits at small rural hospitals, Medicare needs to pay rural hospitals and clinics in a way that will better sustain services in the long run.

Rural hospitals need to be transparent about their costs, efficiency, and quality, and they should do what they can to control healthcare spending for local residents. In order to support higher and better payments for hospitals, purchasers and patients in rural communities need to have confidence that the hospitals will use the payments to deliver high-quality services at the lowest possible cost, and that the hospitals will proactively identify and pursue opportunities to control healthcare costs for community residents. Small rural hospitals should estimate the minimum feasible costs for delivering essential services using an objective methodology, they should proactively work to improve the efficiency of their services, and they should publicly report on the quality of their care.

Additional information about the causes of the problems facing small rural hospitals and how to address them is available at [RuralHospitals.org](https://www.ruralhospitals.org).

1. A “rural” hospital is a hospital located in an area that is classified as rural by the Health Resources and Services Administration. A “small” rural hospital is one that has total annual expenses below the median for all rural hospitals (\$40 million in 2022).

Data current as of January 2024