

SAVING RURAL HOSPITALS AND STRENGTHENING RURAL HEALTHCARE

The Crisis Facing Rural Healthcare in America

More than 800 rural hospitals – 40% of all rural hospitals in the country – are at risk of closing in the near future. Most of these are small rural hospitals that provide not only emergency care, inpatient care, and outpatient services, but also primary care, rehabilitation, and long-term care services for their communities. Moreover, most of the hospitals are located in isolated communities where loss of the hospital could severely limit access to health care services. More than 20 million 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.

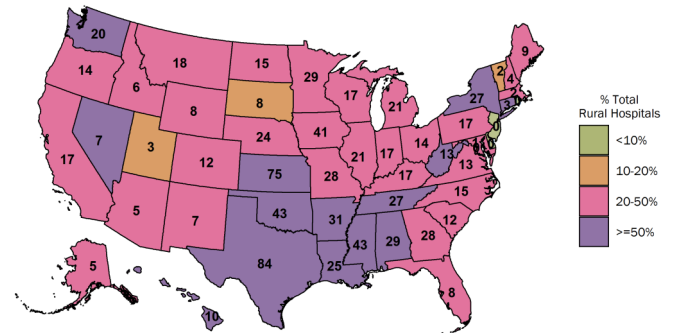
The Causes of the Financial Problems at Small Rural Hospitals

The smallest rural hospitals are facing closure because the payments they receive for services are less than the cost of delivering care to patients in rural communities. Most of the smallest rural hospitals (those with less than \$20 million in total hospital expenses) lose significant amounts of money delivering patient services, while the majority of larger rural hospitals make profits delivering services to patients.

Most of the smallest rural hospitals lose money delivering patient services in almost every state. In more than half the states, the majority of very small rural hospitals lose more than 5% on delivery of services to patients.

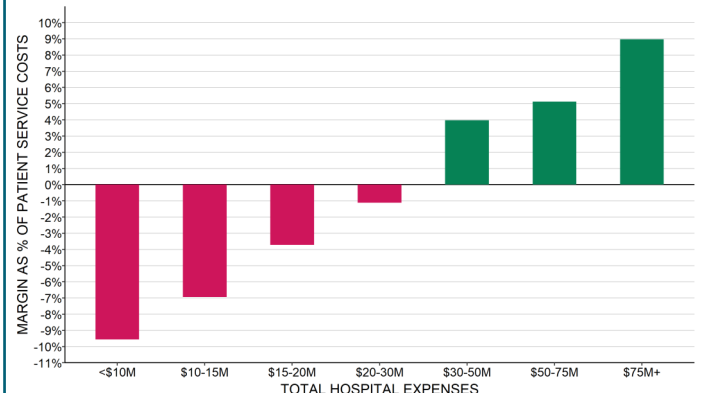
The largest causes of losses at the smallest rural hospitals are low payments by private health insurance plans and patient bad debt. Private insurance plans pay less than it costs to deliver essential services such as emergency care and primary care in very small rural communities, whereas payments from private plans are significantly higher than the costs of delivering services at most large hospitals. Although the majority of very small hospitals also lose money on Medicaid and charity care patients, losses or low payments on patients with private insurance (including Medicare Advantage) plans have a bigger impact on the hospitals' total margins because there are far more patients who have private insurance. The smallest rural hospitals also lose a significant amount on bad debt, i.e., insured patients who cannot pay required amounts of cost-sharing and patients who cannot afford insurance but do not qualify for charity care. Large hospitals can offset bad debt losses using margins from private-pay patients, but most small rural hospitals cannot do that because they don't make profits on private-pay patients. Medicare payments are not the biggest problem because most small rural hospitals are classified as Critical Access Hospitals and receive cost-based payments from Medicare.

Rural Hospitals at Immediate or High Risk of Closure



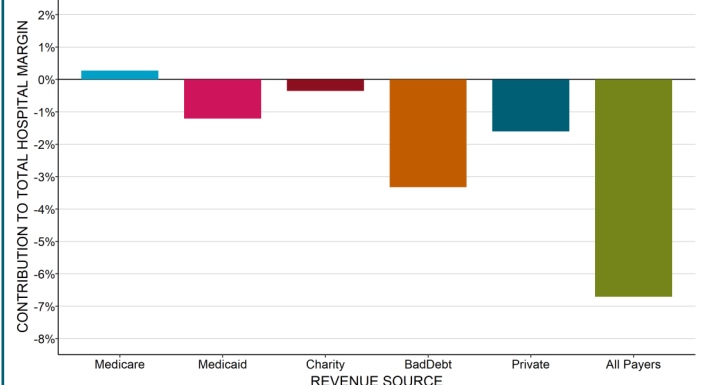
Risk of closure is based on persistent financial losses and low financial reserves, or high dependence on grants, local taxes or other revenues not derived from patient services. See the full report for details on the data and methodology.

Median Margins on Patient Services at Rural Hospitals by Size of Hospital



Amounts shown are medians for 2016-18. See the full report for details.

Payer Contributions to Margins at the Smallest Rural Hospitals



Amounts shown are medians for 2016-18 at rural hospitals with less than \$20 million in total annual expenses. See the full report for details on the data and methodology.

There is tremendous variation across the country in both the magnitude of losses and the causes of losses at very small rural hospitals. In many states, low payments from private insurance plans are the primary cause of financial problems in small rural hospitals, but in other states, low Medicaid payments and low rates of insurance coverage are the largest causes of losses.

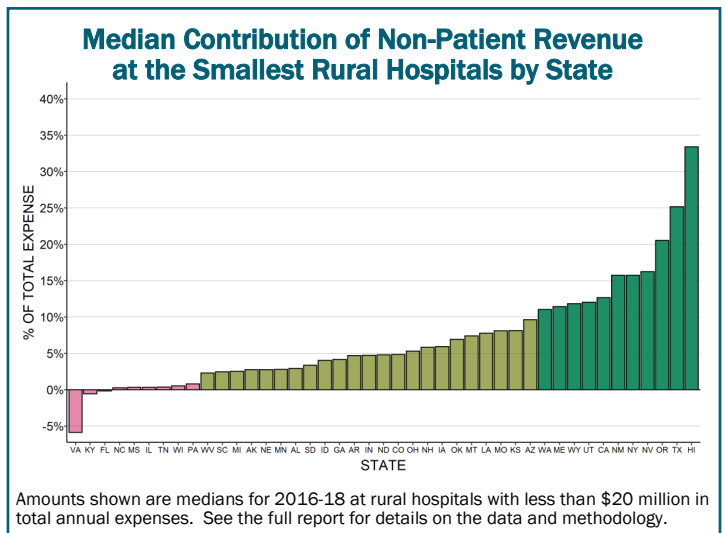
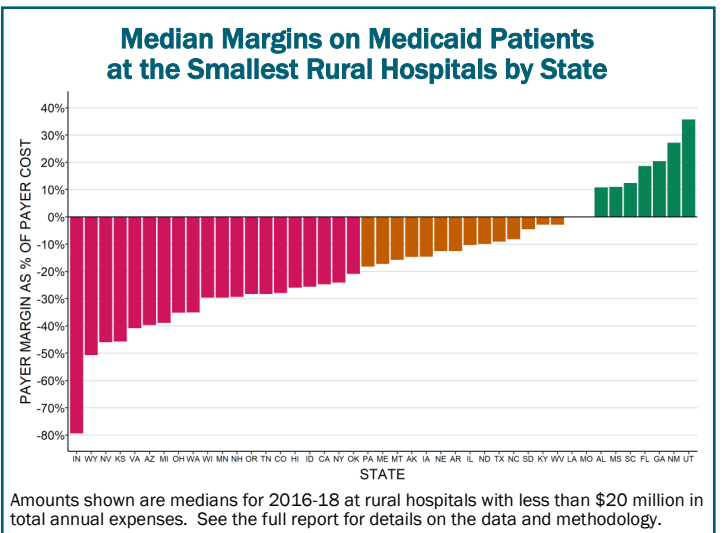
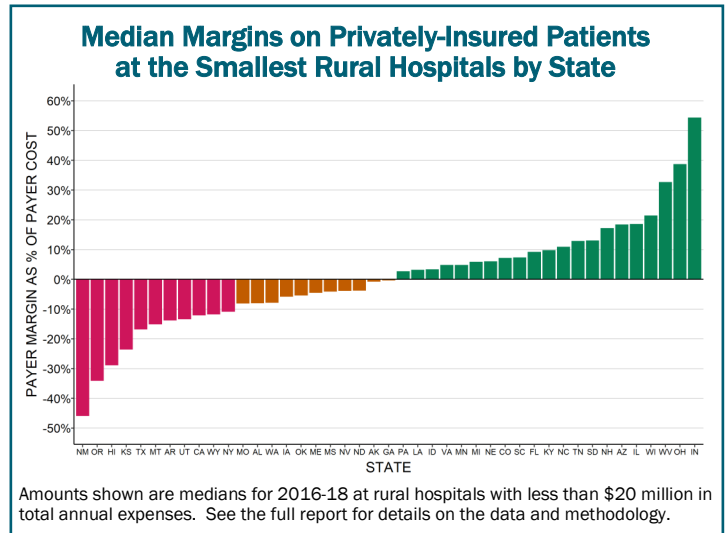
Many small rural hospitals remain open only because they receive significant supplemental funding from state grants or local taxes. In some states, state governments provide grants that reduce or eliminate losses at small rural hospitals, while there is little or no such assistance in other states. Small rural hospitals in some states are organized as public hospital districts, and residents of these communities tax themselves to offset underpayments by private health plans and Medicaid. It is not clear 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.

The Problems With Current Payment Methods

Standard fee for service payments are not large enough to cover the cost of delivering services in small rural communities. The average cost of an emergency room visit, inpatient day, laboratory test, imaging study, and 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 standby capacity cost of 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 the hospital's losses only on services to Original Medicare beneficiaries, and it makes services less affordable for the patients. Although the cost-based system for Critical Access Hospitals results in higher payments for patients with Original Medicare, it does nothing to reduce losses on uninsured patients and those with other types of insurance. Under Medicare rules, patients have to pay higher cost-sharing amounts in order to receive services at Critical Access Hospitals than at other hospitals.

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 fee-for-service 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 and Rural Health Clinics



The Serious Problems With Commonly Proposed Solutions

The four policies that are most commonly proposed to help rural hospitals are: (1) paying a rural hospital more if it eliminates 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.

Requiring rural hospitals to eliminate inpatient services would increase their financial losses while reducing access to inpatient care for local residents. 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 would decrease even more, making it worse off financially. Moreover, residents who have a medical condition that requires a short hospital admission would have to be transferred to another city, and 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.

Global budget programs would increase losses and reduce access to services for patients. Most global budget programs have been created in order to limit or reduce payments to hospitals, not to address shortfalls in payment or prevent closure of small rural hospitals. 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, but hospitals that experience higher costs or higher volumes of services due to circumstances beyond their control would likely be harmed, since their revenues would no longer increase to help cover the additional costs. Access to care for patients can be harmed if budgets are not large enough to support the costs of services, which has led many other countries to modify or replace their global budget systems.

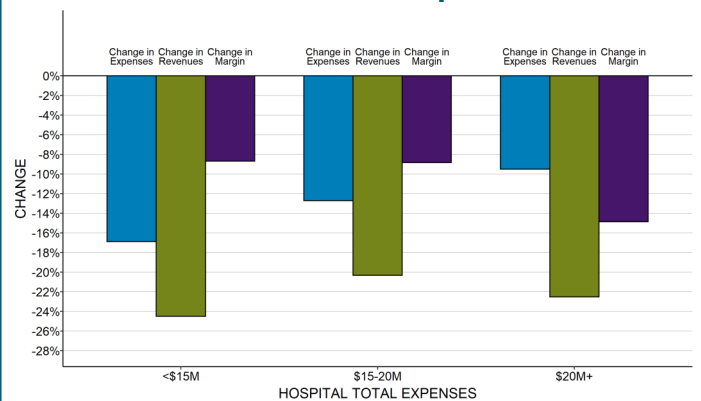
- Although Maryland’s global budget program has been cited as an example of how rural hospitals can benefit from this approach, the smallest rural hospital in Maryland closed in 2020 despite operating under the global budget system for over a decade.
- Under the Pennsylvania Rural Health Model that was 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 *current* cost of delivering essential services.
- Under the Community Health Access and Rural Transformation (CHART) Model announced by CMS in August 2020, the “capitated payments” to rural hospitals would be even lower than the inadequate amounts they currently receive.

Small rural hospitals would be unlikely to benefit from “shared savings” programs, and most would be harmed by taking on downside risk for total healthcare spending. The majority of Accountable Care Organizations (ACO) in the Medicare Shared Savings Program have been unable to qualify for shared savings bonuses, and it is particularly difficult for small rural ACOs to do so

because the minimum savings threshold is higher and 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.

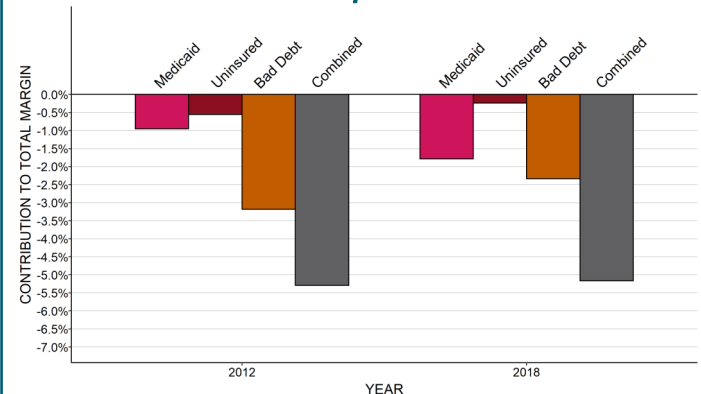
Expansion of eligibility for Medicaid reduces a portion of hospitals’ losses on uninsured patients and bad debt, but it does not eliminate all of those losses and it does not reduce the losses caused by the low amounts paid for services delivered to Medicaid patients in most states. In states that have expanded Medicaid, losses on uninsured charity cases and bad debt decreased, but losses on services to Medicaid patients nearly doubled, resulting in relatively little net benefit for the small hospitals.

Financial Impact of Eliminating Inpatient Services at Small Rural Hospitals



Amounts shown are medians for 2016-18 based on estimated reduction in costs and revenues for inpatient care. See the full report for details on the data and methodology.

Medicaid, Uninsured, and Bad Debt Contributions to Small Rural Hospital Margins in States That Expanded Medicaid



Amounts shown are medians for rural hospitals with <\$20 million total expenses in states that expanded Medicaid between 2012 and 2018. See the full report for details on the data and methodology.

A Better Way to Pay Rural Hospitals & Clinics

A good payment system for rural hospitals and clinics 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.

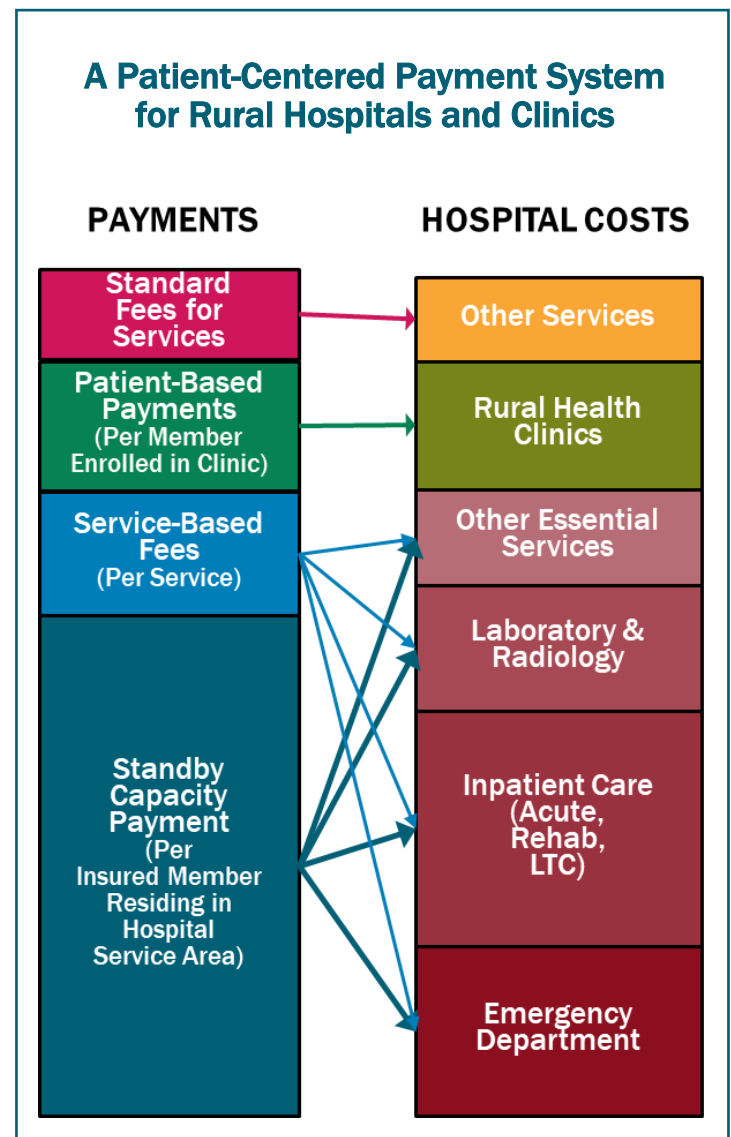
A **Patient-Centered Payment System** for rural hospitals and primary care clinics can achieve all three goals using the following five components:

- **Standby Capacity Payments to support the fixed costs of essential services.** Standby Capacity Payments would be paid to a rural hospital by each health insurance plan (Medicare, Medicaid, Medicare Advantage, and commercial insurance) based on the number of members of that plan who live in the community, not based on the number of services the patients receive. This ensures that the hospital has adequate revenues to support the minimum standby costs of essential services such as the emergency department, inpatient unit, and laboratory regardless of how many patients actually need services during any given month or year.
- **Service-Based Fees for diagnostic and treatment services based on marginal costs.** Under Patient-Centered Payment, hospitals would continue to receive fees for delivering individual services, but the Service-Based Fees will be much lower than current fees. Since the Standby Capacity Payments support the *fixed* costs of essential services, the Service-Based Fees only need to cover the small amount of *additional* costs incurred when additional services are delivered. This means that if patients stay healthy and need fewer services, revenues and costs will decrease by similar amounts, so the hospital's margin will not be harmed.
- **Patient-Based Payments for primary care management.** The Rural Health Clinic or primary care practice would receive a monthly Comprehensive Primary Care Management Payment from a health insurance plan for each insured member who enrolls with the clinic for ongoing primary care. This payment would give the clinic the flexibility to deliver services in ways that work most effectively for patients, rather than being restricted to delivering only in-person visits at the clinic. The payments would be higher for patients who have higher needs to ensure they can receive high-quality care.
- **Accountability for quality and spending.** In return for receiving adequate, predictable, flexible payments to support essential services, rural hospitals and primary care clinics would take accountability for delivering high-quality services and improving patient outcomes. Standards and measures of quality would be used that are appropriate for small rural hospitals and clinics.

- **Value-based cost-sharing for patients.** The high deductibles, copayments, and co-insurance used in most health insurance plans today cause many patients to delay or avoid receiving services they need. Rural hospitals and primary care clinics should have the flexibility to set lower cost-sharing rates for high-value services and to help pay for transportation or provide other assistance that would help patients to adhere to their care plans.

Rural hospitals that want to deliver desirable but non-essential services would need to support them using the standard fees for those services paid by Medicare and other payers.

A Patient-Centered Payment System would do a better job of matching payments to costs than either fee-for-service payments or global budgets, without problematic incentives to deliver unnecessary services or to stint on care.



How to Save Rural Hospitals and Strengthen Rural Healthcare

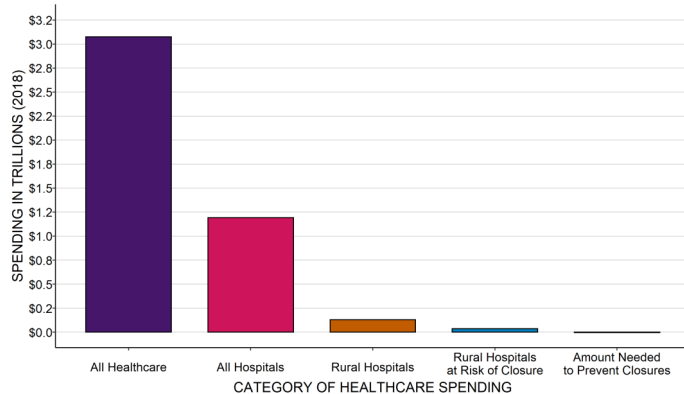
It will cost about \$3.7 billion per year to prevent closures of the at-risk hospitals and preserve access to rural healthcare services, an increase of only 1/10 of 1% in total national healthcare spending. No payment system will sustain rural hospitals and clinics unless the amounts of payment are large 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 will be needed to keep rural hospitals solvent, but \$3.7 billion is a tiny amount in comparison to the more than \$3 trillion currently spent on healthcare and the more than \$1 trillion spent on all hospital services nationally. Moreover, most of the increase in payments to small rural hospitals will support primary care and emergency care in rural communities, since these are the services where the biggest shortfalls in current payments exist.

Spending would likely increase even if the hospitals close. Reduced access to preventive care and prompt treatment will cause residents of the rural communities to experience additional and more serious health problems and increase their need for services and for more expensive 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:

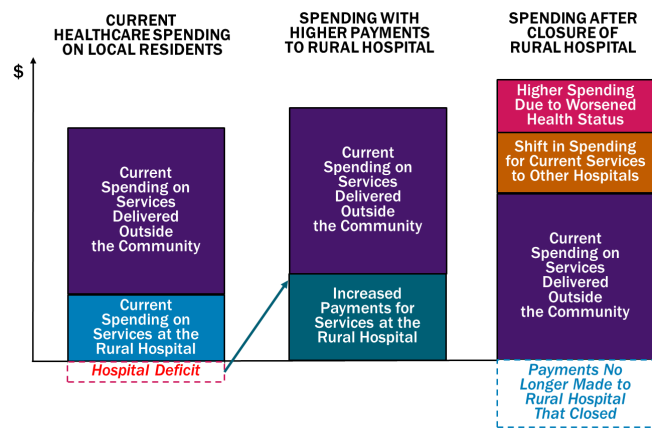
- Businesses, local governments, and rural residents must demand that private health insurance companies change the way they pay small rural hospitals.** The biggest cause of negative margins in most small rural hospitals in most states is low payments from private insurance plans and Medicare Advantage plans. Not only do the payments fail to cover the costs of services to the patients with insurance, the lack of any profit margin on the services makes it impossible for the hospitals to offset losses due to bad debt. Private insurance plans are unlikely to increase or change their payments unless businesses, local governments, and residents choose health plans based on whether they pay the local hospital adequately and appropriately. State insurance departments and state insurance exchanges can help by requiring health plans to disclose their payment methods and amounts for small rural hospitals and by encouraging the plans to use Patient-Centered Payments instead of traditional fees.
- 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 will benefit most from receiving higher Medicaid payments for their services. CMS should authorize states to require Medicaid MCOs to use Patient-Centered Payments and to pay adequately for services at small rural hospitals.

Increased Spending Needed to Eliminate Deficits at Small Rural Hospitals Compared to National Healthcare Spending



Amount needed to prevent closures is the average annual loss in the most recent three years for which data were available for hospitals classified as being at immediate or high risk of closure. See full report for details on methodology.

Spending May Increase Even More if Rural Hospitals Are Allowed to Close



- 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, creation of an appropriate Medicare payment system for rural hospitals and clinics could serve as a model for other payers. However, the “global budget” demonstration programs proposed to date are unlikely to help most rural hospitals and they could harm the smallest hospitals.

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, the purchasers and patients in rural communities need to have confidence that their local 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, they should proactively work to improve the efficiency of their services, and they should publicly report on the quality of their care.