

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 09-JUN-21

Subject: Addressing Payment and Delivery in Rural Hospitals

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

1 Despite legislative advances such as the Affordable Care Act (ACA) and Medicaid expansion
2 bringing insurance coverage and health care accessibility to millions of Americans, rural
3 Americans and the health care system intended to serve them continue to face a health care crisis.
4 By most measures, the health of the residents of rural areas is significantly worse than the health of
5 those in urban areas.¹ Though the American Medical Association (AMA) has policy on stabilizing
6 and strengthening rural health, it does not have policy specifically addressing changes to payment
7 and delivery for rural providers and hospitals to address the growing rural health crisis.

8
9 This report, initiated by the Council, provides background on the unique obstacles facing rural
10 hospitals including financial challenges, the rural hospital payer mix, the costs of delivering
11 services in the rural setting, and quality measurement and risk adjustment challenges. The report
12 also details relevant AMA policy and provides recommendations to improve the rural hospital
13 payment and delivery systems.

14 15 BACKGROUND

16
17 Sixty million Americans, almost one-fifth of the US population, live in a rural area. On average,
18 rural residents are older, sicker, and less likely to have health insurance. They stay uninsured for
19 longer and are less likely than their urban and suburban counterparts to seek preventive services.
20 Moreover, they are more likely than urban and suburban residents to encounter possibly
21 preventable deaths from heart disease, cancer, unintentional injuries, chronic lower respiratory
22 disease, and stroke. Disparities in health outcomes continue to increase for this population
23 compared to those living in urban and suburban areas. Rural residents tend to have higher rates of
24 smoking, hypertension, and obesity. They also report less physical activity and have higher rates of
25 poverty. Rural residents are also more likely to be Medicare or Medicaid beneficiaries. For
26 example, Medicare and Medicaid make up over half of rural hospitals' net revenue.^{2,3} Additionally,
27 45 percent of children in rural areas are enrolled in Medicaid or Children's Health Insurance
28 Program compared to 38 percent of children in urban areas.⁴

29
30 Those living in rural areas often must travel long distances to access the emergency department
31 (ED) and physician offices, a barrier to care that can lead to delayed or forgone care, which can
32 worsen their health status and increase the cost of care when they do receive it. They are more
33 likely than urban and suburban residents to say that access to good doctors is a major problem in
34 their community.⁵ Rural residents live an average of 10.5 miles from the nearest hospital compared
35 with 5.6 miles and 4.4 miles for those in suburban and urban areas respectively.

36
37 From 2018 to 2020, 50 rural hospitals closed, a more than 30 percent increase in the number of
38 closures compared to the 3 years prior.⁶ The closure of hospitals was generally preceded by

1 financial losses caused by a combination of decreasing rural population and inadequate payments
 2 from health insurers. There are more than 2,000 rural hospitals across the country, and more than
 3 800 (40 percent) of them are estimated to be at risk of closing. Most of the hospitals at risk of
 4 closing are small rural hospitals serving isolated rural communities.

5
 6 These hospitals are frequently the principal or sole source of health care in their communities,
 7 including primary care as well as hospital services. The closure of these rural hospitals could cause
 8 the vulnerable populations they serve to lose access to health care and worsen health disparities.⁷
 9 Rural hospitals also have more difficulty attracting physicians of varying specialties, which are
 10 essential to providing care to rural populations. Often, when a rural hospital closes, recruiting and
 11 retaining physicians in the local community becomes increasingly difficult, and the result is
 12 decreased access to care for the surrounding population.⁸ In addition, rural hospitals often serve as
 13 economic anchors in their communities, providing both direct and indirect employment
 14 opportunities and supporting the local economy.⁹ Rural hospitals are hubs of employment, public
 15 health, and community outreach initiatives.¹⁰ Their closure puts the already vulnerable populations
 16 they serve at increased risk of losing access to health care, worsening health disparities, and
 17 negatively impacting the economy of the local area.¹¹

18
 19 Meanwhile, the novel coronavirus (COVID-19) pandemic has highlighted the fragility of the rural
 20 health system and increased the financial threat to an unstable system. All hospitals experienced
 21 lower revenue due to canceled elective procedures and some routine care, while simultaneously
 22 facing higher expenses due to supplies, equipment, and staff to care for COVID-19 patients. Unlike
 23 large urban hospitals, small rural hospitals do not have financial reserves that they can use to cover
 24 these higher costs and revenue losses. Rural patients are also more likely to experience more severe
 25 impacts from COVID-19 because they are more likely to be obese and have chronic conditions
 26 such as diabetes and hypertension.¹² Temporary federal assistance during the pandemic helped
 27 many rural hospitals avoid closure during 2020, but the underlying financial problems may cause
 28 an increase in closures after the public health emergency ends. The financial impact of the
 29 pandemic on individuals living in rural areas has been significant, as many may have experienced
 30 unemployment or under employment on hourly jobs with limited benefits.

31 32 IMPACT OF PAYER MIX

33
 34 A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at
 35 urban hospitals.¹³ While having a high proportion of Medicare patients would be viewed as
 36 financially problematic at large hospitals, for many small rural hospitals, Medicare is their “best”
 37 payer because Medicare explicitly pays more to cover the higher costs of care in small rural
 38 hospitals.

39
 40 About 75 percent of rural hospitals are classified as Critical Access Hospitals (CAHs), which
 41 provides cost-based payment for services provided to Medicare beneficiaries. To be designated as a
 42 CAH, a hospital must meet a set of criteria including but not limited to being located either more
 43 than 35 miles from the nearest hospitals (or CAH) or more than 15 miles in areas with mountainous
 44 terrain; maintain no more than 25 inpatient beds; furnish 24-hour emergency care 7 days a week;
 45 and operate a psychiatric or rehabilitation unit of up to 10 beds.¹⁴ It is important to note, however,
 46 that CAH payments apply only to beneficiaries with traditional Medicare, not those with private
 47 Medicare Advantage (MA) plans.

48
 49 Most small rural hospitals lose money on Medicaid patients, but in some states, small rural
 50 hospitals also receive cost-based payments for Medicaid patients, and some states provide special
 51 subsidies to offset losses on Medicaid and uninsured patients.

1 For many small rural hospitals, the leading cause of negative margins is insufficient payment from
 2 private health insurance plans and MA plans. Many private health insurance plans pay less than the
 3 cost to deliver essential services in small rural hospitals, whereas private plan payments at most
 4 large hospitals are higher than the cost of delivering services.¹⁵ Although most hospitals lose
 5 money on Medicaid and care to the uninsured, larger hospitals can use profits on privately insured
 6 patients to cover those losses. In contrast, many small rural hospitals cannot cover losses on
 7 Medicaid and uninsured patients because the payments from private payers do not generate
 8 significant profits or may not even cover the costs of providing services to the privately insured
 9 patients.

10
 11 COST OF DELIVERING SERVICES IN RURAL HOSPITALS AND CLINICS

12
 13 Low patient volume represents a persistent challenge to the financial viability of rural hospitals.
 14 There is a minimum level of cost needed to maintain the staff and equipment required to provide a
 15 particular type of service, whether it be an ED, a laboratory, or a primary care clinic. As a result,
 16 the average cost per service will be higher at a hospital that has fewer patients. In addition, the
 17 hospital will need to incur a minimum level of overhead costs that include accounting and billing,
 18 human resources, medical records, information systems, and maintenance. These costs are
 19 allocated to each hospital service line, so the fewer services the hospital offers, the higher the cost
 20 for each service.¹⁶

21
 22 The mix of fixed costs paired with low volumes can result in instances where the current fee-for-
 23 service payments are often not large enough to cover the cost of delivering services in small rural
 24 communities. For example, a hospital ED must be staffed by at least one physician around the
 25 clock regardless of how many patients visit the ED. Generally, a small rural hospital will have
 26 fewer ED visits, but the standby capacity cost remains fixed, which means the average cost per
 27 visit will be higher. Therefore, a payment per visit that is high enough to cover the average cost per
 28 service at a larger hospital will fail to cover the costs of the same services at a smaller rural
 29 hospital. Exacerbating this issue is that some private plans pay small rural hospitals less than they
 30 pay larger hospitals for delivering the same services even though the cost per service at the rural
 31 hospital is intrinsically higher.¹⁷

32
 33 Due to the low population density in rural areas, it is impossible for many rural hospitals to have
 34 enough patients to use the full minimum capacity of services such as an ED. Medicare explicitly
 35 pays small rural hospitals more to compensate for the higher average costs, but most other payers
 36 do not, which is why small rural hospitals have greater financial problems.

37
 38 QUALITY MEASUREMENT CHALLENGES IN RURAL HOSPITALS

39
 40 Current quality measurement systems are problematic for small rural hospitals. Many commonly
 41 used quality measures cannot be used in small rural hospitals because there are too few patients to
 42 reliably measure performance, and some measures are not relevant at all for small rural hospitals
 43 because they do not deliver the services being measured.¹⁸

44
 45 Rural hospital volume varies significantly for several reasons including the population of the
 46 community, the age and health status of the population, the availability of other primary care
 47 options, and the accessibility of the hospital. Many currently used quality measures are not
 48 applicable to numerous types of patients and aspects of care, and many focus on a specific
 49 condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size
 50 because they do not have enough patients with that specific condition. Moreover, rural hospitals

1 often face challenges reporting quality measurement data due to limited staff, time, and
2 infrastructure.

3
4 The typical value-based payment system of bonuses and penalties often penalizes rural providers
5 and hospitals. Again, the small patient panels inherent in rural care mean that providers can easily
6 be penalized for random variation over which they have no control.¹⁹

7 8 RISK ADJUSTMENT CHALLENGES IN RURAL HOSPITALS

9
10 In addition to the reliability problems in measurement caused by small populations, the differences
11 between rural and urban populations with respect to age, health status, and ability to access services
12 makes risk adjustment of quality and spending measures essential. Random variation and outlier
13 patients make risk adjustment scores less accurate at small hospitals than at hospitals with large
14 patient populations.²⁰ The greater statistical variation at rural hospitals often leads to quality
15 incentive payments going to higher volume hospitals that can achieve lower standard deviations but
16 are not necessarily delivering higher quality care.

17
18 Moreover, risk adjustment is based on diagnosis codes recorded on claims forms. Since payments
19 to CAHs do not depend on what diagnoses a patient has, diagnosis codes tend to be underreported
20 by rural hospitals.²¹ Also, the use of diagnosis codes can fail to capture risk appropriately including
21 the lack of a comorbid condition diagnosis due to barriers to care such as distance from the health
22 care setting and lack of support services in the community. As a result, rural hospitals and clinics
23 can appear to have healthier patients or worse outcomes than they really do. Risk adjustment can
24 also make spending in rural communities appear higher than it is. For example, MA risk adjustment
25 scores fail to accurately measure the true differences in patient health because the hierarchical
26 condition category coding used in MA payments are retrospective based on past chronic
27 conditions, not acute or new chronic conditions. Therefore, there is no risk adjustment for patients
28 with injuries, acute conditions, or those newly diagnosed with cancer or diabetes, among other
29 conditions. Likewise, the higher barriers for rural patients to obtain preventive care can cause a
30 more severe presentation of diseases once finally diagnosed, requiring higher costs of care and
31 poorer absolute outcomes.

32 33 RELEVANT AMA POLICY

34
35 The AMA has significant policy on rural health. Policy H-465.994 supports the AMA's continued
36 and intensified efforts to develop and implement proposals for improving rural health care. AMA
37 policy specific to rural hospitals includes Policy H-165.888 stating that any national legislation for
38 health system reform should include sufficient and continuing financial support for rural hospitals.
39 Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals
40 to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach
41 toward certification of small, rural hospitals. Policy H-465.979 recognizes that economically viable
42 small rural hospitals are critical to preserving patient access to high-quality care and provider
43 sustainability in rural communities. Policy D-465.999 calls on the Centers for Medicare &
44 Medicaid Services to support individual states in their development of rural health networks;
45 oppose the elimination of the state-designated CAH "necessary provider" designation; and pursue
46 steps to require the federal government to fully fund its obligations under the Medicare Rural
47 Hospital Flexibility Program.

48
49 Policy H-385.913 discusses payment and delivery reform in the context of the shift away from
50 volume to value. The policy states that alternative payment models (APMs) must provide
51 flexibility to physicians to deliver the care their patients need. Policy H-385.913 also calls for

1 APMs to be feasible for physicians in every specialty and for practices of every size to participate
2 in. Importantly, Policy D-385.952 directs the AMA to continue encouraging the development and
3 implementation of APMs that provide services to improve the health of vulnerable and high-risk
4 populations, including those in rural areas.

5
6 Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid
7 payments. Policy H-290.976 advocates that Medicaid payments to medical providers be at least
8 100 percent of Medicare payment rates. Policy H-290.997 promotes greater equity in the
9 Medicaid program through adequate payment rates that assure broad access to care. Further,
10 Policy D-290.979 supports state efforts to expand Medicaid eligibility as authorized by the ACA.

11 DISCUSSION

12
13
14 Long-term solutions are needed to effectively address the health needs of the rural population.
15 Preventing the closure of rural hospitals that provide essential services is a first step. Rural
16 hospitals must be paid adequately to support the costs of delivering essential services, and they
17 should have the flexibility to tailor available services to the needs of their local populations.

18
19 To begin accomplishing its goal of providing adequate payment for rural hospital services, the
20 Council recommends reaffirming Policy D-290.979 directing our AMA to support state efforts to
21 expand Medicaid eligibility, and reaffirming Policy H-290.976 stating that Medicaid payments be
22 at least 100 percent of Medicare payment rates. Medicaid eligibility and enrollment are evidence-
23 based factors strengthening the viability of rural hospitals. Medicaid expansion, particularly if it is
24 accompanied by adequate payments, will improve hospital financial performance and
25 sustainability, and lower the likelihood of closure, especially in those rural markets with large
26 numbers of uninsured patients. For example, since 2010, of the eight states with the highest levels
27 of rural hospital closures, none are Medicaid expansion states. A key cause of financial losses at
28 most rural hospitals is the volume of care provided to uninsured patients, so a key component of
29 any strategy for sustaining rural health care services is increasing the number of insured residents.

30
31 The Council identified the need for better and more reliable payment for rural hospitals that support
32 their sustainability and recommends that a series of policies be adopted to ensure that payment to
33 rural hospitals is adequate and appropriate. Since small rural hospitals need to sustain essential
34 services even with low volumes of services, the Council recommends that health insurance plans
35 provide such hospitals with a capacity payment to support the minimum fixed costs of essential
36 services, including surge capacity, acknowledging that a small rural hospital requires a baseline of
37 staffing and expenses to remain open regardless of volume. It is also recommended that payers
38 provide adequate service-based payments to cover the costs of services delivered in small
39 communities. The Council also recommends that the capacity payment provide adequate support
40 for physician standby and on-call time to enable very small rural hospitals to deliver quality
41 services in a timely manner. Regarding quality measurement, the Council recommends only using
42 quality measures that are relevant for rural hospitals and setting minimum volume thresholds for
43 measures to ensure statistical reliability and avoiding financial penalties that might occur from
44 failing to have met specific quality metrics due to lower volumes. To help effect these changes, the
45 Council recommends encouraging employers and rural residents to choose health plans that
46 adequately and appropriately pay the rural hospitals.

47
48 The Council notes that taking these steps to ensure adequate and reliable payment for rural
49 hospitals is critical to addressing the barriers to procedural service lines. A small patient population
50 and declining revenue stifles the ability of rural hospitals to add new service lines that not only
51 attract needed specialists to underserved areas but also aid in the financial sustainability of a rural

1 hospital. The Council believes that addressing payment issues for rural hospitals will help give
2 those hospitals the flexibility to offer more complex services. In turn, those services will boost
3 financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately
4 increase patient access to care.

5
6 The Council also reiterates the need to address payment for primary care services at rural facilities.
7 The Council recommends voluntary monthly payments for primary care providers so that
8 physicians have the flexibility to deliver services in the most effective manner, particularly for
9 those patients for whom travel is a significant barrier to care. Importantly, such monthly payments
10 should include an allowance and expectation that some services would be provided via telehealth
11 or telephone.

12
13 Additionally, the Council recommends policy that encourages transparency among rural hospitals
14 regarding their costs and quality outcomes. It will be essential that rural hospitals publicly
15 demonstrate that higher payments are needed to support the cost of delivering high quality care.

16
17 The challenges facing the rural health system are varied and complex. Although many steps are
18 needed to ensure access to care and quality outcomes for the rural population, the Council offers
19 these recommendations as a pragmatic step forward to address the needs of rural populations.

20 21 RECOMMENDATIONS

22
23 The Council on Medical Service recommends that the following be adopted and that the remainder
24 of the report be filed:

- 25
26 1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our
27 AMA to support state efforts to expand Medicaid eligibility as authorized by the
28 Affordable Care Act. (Reaffirm HOD Policy)
- 29
30 2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical
31 providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)
- 32
33 3. That our AMA advocate that public and private payers take the following actions to ensure
34 payment to rural hospitals is adequate and appropriate:
 - 35
36 a. Create a capacity payment to support the minimum fixed costs of essential services,
37 including surge capacity, regardless of volume;
 - 38 b. Provide adequate service-based payments to cover the costs of services delivered in
39 small communities;
 - 40 c. Adequately compensate physicians for standby and on-call time to enable very small
41 rural hospitals to deliver quality services in a timely manner;
 - 42 d. Use only relevant quality measures for rural hospitals and set minimum volume
43 thresholds for measures to ensure statistical reliability;
 - 44 e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be
45 assessed due to low statistical reliability; and
 - 46 f. Create voluntary monthly payments for primary care that would give physicians the
47 flexibility to deliver services in the most effective manner with an expectation that
48 some services will be provided via telehealth or telephone. (New HOD Policy)
- 49
50 4. That our AMA encourages transparency among rural hospitals regarding their costs and
51 quality outcomes. (New HOD Policy)

- 1 5. That our AMA support better coordination of care between rural hospitals and networks of
2 providers where services are not able to be appropriately provided at a particular rural
3 hospital. (New HOD Policy)
4
- 5 6. That our AMA encourage employers and rural residents to choose health plans that
6 adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Ollove, M. Rural America's Health Crisis Seizes States' Attention. Pew Trusts. Available at: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/01/31/rural-americas-health-crisis-seizes-states-attention>
- ² Rural and Urban Health. Georgetown University Health Policy Institute. Available at: <https://hpi.georgetown.edu/rural/>
- ³ Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors. United States Government Accountability Office. Available at: <https://www.gao.gov/assets/700/694125.pdf>
- ⁴ Medicaid Works for People in Rural Communities. Center on Budget and Policy Priorities. Available at: <https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities>
- ⁵ Lam, O. et al. How Far Americans Live from the Closest Hospital Differs by Community Type. Pew Research Center. Available at: <https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/>
- ⁶ *Supra* note 3.
- ⁷ Barker, A. et al. Can the Market Deliver Affordable Health Insurance Options in Rural Areas? Health Affairs Blog. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20190104.599904/full/>
- ⁸ Wishner, J, et al. A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies. Kaiser Family Foundation. Available at: <https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/>
- ⁹ *Supra* note 7.
- ¹⁰ *Id.*
- ¹¹ Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care. American Hospital Association. Available at: <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>
- ¹² Thomas, S. et al. Alternatives to Hospital Closure: Findings from a National Survey of CAH Executives. North Carolina Rural Health Research Program. Available at: <https://www.shepscenter.unc.edu/download/22075/>
- ¹³ *Supra* note 10.
- ¹⁴ Critical Access Hospitals. Centers for Medicare & Medicaid Services. Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs>
- ¹⁵ Miller, H. Saving Rural Hospitals and Sustaining Rural Healthcare. Center for Healthcare Quality & Payment Reform. Available at: https://www.chqpr.org/downloads/Saving_Rural_Hospitals.pdf
- ¹⁶ *Id.*
- ¹⁷ *Id.*
- ¹⁸ *Id.*
- ¹⁹ *Id.*
- ²⁰ *Supra* note 7.
- ²¹ *Supra* note 14.