

Payment & Delivery in Rural Hospitals

Background

Despite legislative advances such as the Affordable Care Act (ACA) and Medicaid expansion bringing insurance coverage and health care access to millions of Americans, rural Americans and the health care system intended to serve them continue to face a health care crisis.

By most measures, the health of rural residents is significantly worse than the health of those in non-rural areas. Sixty million Americans, almost one-fifth of the US population, live in a rural area. On average, rural residents are older, sicker, more likely to experience a non-intentional injury, and less likely to have health insurance. They stay under or uninsured for longer and are less likely to seek preventive services. Moreover, they are more likely than urban and suburban residents to encounter preventable deaths from heart disease, cancer, and stroke. Rural residents tend to have higher rates of smoking, hypertension, and obesity, and disparities in health outcomes continue to increase for this population compared to urban and suburban residents.

Rural hospitals make up approximately a quarter of all American hospitals and often serve as one of the only sources of health care in their communities. These hospitals are vital to providing care and reducing rural health disparities, and many are struggling to remain financially viable. Nearly one third of all rural hospitals are at risk of complete closure and many more are at risk of needing to cut inpatient services to remain viable.

Impact of Payer Mix

A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at urban hospitals. Due to the lower reimbursement

rates, a high proportion of Medicare patients would often be viewed as financially problematic at large hospitals. However, for many small rural hospitals, Medicare is their “best” payer because Medicare explicitly pays more to cover the higher costs of care in rural hospitals classified as Critical Access Hospitals.

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

For many small rural hospitals, the leading cause of negative margins is insufficient payment from private health insurance plans and Medicare Advantage plans. Many private health insurance plans pay rural hospitals less than the cost to deliver essential services, whereas they pay large urban hospitals more than the cost of delivering services, even though the per service costs are intrinsically higher at rural hospitals.

Cost of Delivering Services

Low patient volume represents a persistent challenge to the financial viability of rural hospitals. There is a minimum level of cost needed to maintain the staff and equipment required to provide a service. As a result, the average cost per service will be higher at a hospital that has fewer patients. In addition, the hospital will need to incur a minimum level of overhead costs that include accounting and billing, human resources, medical records, information systems, and maintenance.

The mix of low fixed costs paired with low patient volumes can result in instances where payments are often not large enough to cover the cost of delivering services.

Quality Measurement Challenges

Current quality measurement systems are problematic for small rural hospitals. Many commonly used quality measures cannot be used in small rural hospitals because there are too few patients to reliably measure performance. Rural hospital volume varies significantly for several reasons including the population of the community, the age and health status of the population, the availability of other primary care options, and the accessibility of the hospital. Many currently used quality measures focus on a specific condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size because they do not have enough patients with that specific condition, and small patient panels mean that providers can be penalized for random variation over which they have no control. Moreover, rural hospitals often face challenges reporting quality measurement data due to limited staff, time, and infrastructure.

Risk Adjustment Challenges

In addition to the reliability problems in measurement caused by small populations, the differences between rural and urban populations with respect to age, health status, and ability to access services makes risk adjustment of quality and spending measures essential. Random variation and outlier patients make risk adjustment scores less accurate at small hospitals than at hospitals with large patient populations.

Moreover, risk adjustment is based on diagnosis codes recorded on claims forms. Since payments to Critical Access Hospitals do not depend on what diagnoses a patient has, diagnosis codes tend to be underreported by rural hospitals. Also, the use of diagnosis codes can fail to capture risk appropriately including the lack of a comorbid condition diagnosis due to barriers to care such as distance from the health care setting and lack of community support. As a result, rural hospitals can appear to have healthier patients or worse outcomes than they really do. Risk adjustment can also make spending in rural communities

appear higher than it is. Also, the higher barriers for rural patients to obtain preventive care can cause a more severe presentation of diseases once finally diagnosed, requiring higher costs of care and poorer absolute outcomes.

Strategies to Improve Rural Health and Hospital Viability

- Support the 41 states and districts that have expanded Medicaid eligibility under the Affordable Care Act.
- Encourage additional states efforts to expand Medicaid eligibility.
- Support Medicaid payments to medical providers be at least 100 percent of Medicare payment rates.
- Advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
 - Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
 - Provide adequate service-based payments to cover the costs of services delivered;
 - Adequately compensate physicians for standby and on-call time to enable rural hospitals to deliver quality services in a timely manner;
 - Use only relevant quality measures and set minimum volume thresholds to ensure statistical reliability;
 - Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
 - Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner including telehealth or telephone.
- Encourage transparency among rural hospitals regarding their costs and quality outcomes.
- Support efforts to ensure that care coordination is smooth and comprehensive when a service is not able to be provided by a rural hospital.
- Encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.