Saving Rural Hospitals
Will Changing Payment Methods Help?

Molly Firth, MPH

While rural hospitals are struggling financially, they continue to be essential in their local communities. What can states do to support them and the health care they provide?

Key Points

• Perverse reimbursement incentives create financial challenges for rural hospitals.

• States are exploring value-based payment models for rural hospitals to incentivize population health improvements – providing them with a stable revenue base to transform the way they serve their communities.

• Washington State should learn from Maryland’s experience, closely watch Pennsylvania and Vermont, and continue to pursue global budgets or other multi-payer alternative payment models for rural hospitals.

The Center for Health Innovation & Policy Science (CHIPS) is an interdisciplinary research center that works to improve health across communities and the lifespan—through innovation, evaluation, and training in health policy and health systems science.

Director: Michelle Garrison, PhD
Rural hospitals are struggling financially

One in five Americans lives in rural areas, but among the quarter of rural Americans traveling the longest to reach a hospital, the average travel time is 34 minutes by car. The distance is growing as rural hospitals are closing or reducing services across the country; over 110 rural hospitals have closed since 2010. A vast majority of closed rural hospitals are in states that did not expand Medicaid. A recent Navigant analysis finds one in five rural hospitals are at risk of closing unless their financial situations improve; 34 states have five or more rural hospitals at risk of closing. Some rural hospitals survive financial distress with the help of mergers or acquisitions, some close down services, and others convert to a different type of facility.

Washington State is not immune from the risk of hospital closures. The Navigant analysis found six rural Washington hospitals at risk of closing, two of which are considered “essential to the community” due to their trauma care status, service to vulnerable populations, geographic isolation, and economic impact. Public hospital districts across rural Washington have provided additional property tax revenue to support rural hospitals, but many still struggle.

Despite declining need for inpatient care, rural hospitals remain essential in their local communities. In 2014, the Washington State Hospital Association (WSHA) surveyed its ten smallest hospitals and found they only averaged 1.1 inpatients per day, but treat over 75 patients each day when their outpatient and community-based care programs are included. In order to strengthen rural health, the Washington State Health Care Authority (HCA), Department of Health, WSHA, and 13 rural hospitals have collaborated on the Washington Rural Health Access Preservation pilot, authorized by the Legislature in 2016. State funding in 2018 and 2019 is helping pilot hospitals build capacity for value-based payment and system transformations. Based on guidance from the Center for Medicare and Medicaid Innovation (CMMI), HCA is developing a multi-payer global budget model, or similar, available to all of the state’s approximately 52 rural hospitals. The model will include Medicaid, Medicare and commercial payers.
**Rural communities need access to care**

Rural communities experience more chronic conditions, higher mortality and lower life expectancies. These communities often fare worse than suburban and urban communities in social determinants of health due to geography and transportation challenges; less wealth, lower incomes, and more poverty; lower educational attainment; and less stable labor markets. Rural hospitals likely to be under financial distress serve communities with lower percentages of high school graduation, higher rates of unemployment, and worse health status.

**Table 1. Public Insurance Comprises Over Half of Rural Hospitals’ Net Revenue, but Hospitals Collectively Report Failures to be Adequately Compensated by Public Payers**

<table>
<thead>
<tr>
<th></th>
<th>Public Insurance</th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
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<tbody>
<tr>
<td>% Rural Hospital Net Revenue*</td>
<td>56%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Payment-to-Cost Ratio†</td>
<td>88%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Payer Share of Hospital Costs‡</td>
<td>19%</td>
<td>41%</td>
<td></td>
</tr>
</tbody>
</table>

† Other public insurance includes Medicare, Veterans Affairs and military.

**States are exploring value based payments to support rural hospitals**

Different payment reform models are being explored to transition rural hospitals from volume-based to value-based payments. Maryland and Pennsylvania have implemented global budgets for rural hospitals, and Vermont has implemented a comprehensive all payer Accountable Care Organization (ACO) model. Both models feature global budgets for hospitals, creating financial incentives for quality and outcomes.

These new payment methods bring benefits and challenges to rural hospitals (see Table 2).
Table 2. Benefits and Challenges to Paying Rural Hospitals for Value

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Creates income stability and predictability</td>
<td>Requires robust health information technology and care coordination infrastructure</td>
</tr>
<tr>
<td>Provides ability to spend on things that will</td>
<td>Fails to account for costly local or regional emergencies and events¹⁴</td>
</tr>
<tr>
<td>improve health, such as telehealth</td>
<td></td>
</tr>
<tr>
<td>Facilitates administrative simplicity</td>
<td>Lacking applicable quality or outcome metrics¹²</td>
</tr>
</tbody>
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Table 3. Population Comparison of Case Study States to Washington State and U.S.

<table>
<thead>
<tr>
<th></th>
<th>Maryland</th>
<th>Pennsylvania</th>
<th>Vermont</th>
<th>Washington State</th>
<th>U.S.</th>
</tr>
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<tbody>
<tr>
<td>Total Population¹</td>
<td>6,042,718</td>
<td>12,807,060</td>
<td>626,299</td>
<td>7,535,591</td>
<td>327,167,434</td>
</tr>
<tr>
<td>% Rural¹</td>
<td>13%</td>
<td>21%</td>
<td>61%</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>% Medicaid¹</td>
<td>12%</td>
<td>20%</td>
<td>28%</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>% Medicare¹</td>
<td>12%</td>
<td>16%</td>
<td>16%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>% Uninsured¹</td>
<td>6%</td>
<td>6%</td>
<td>4%</td>
<td>6%</td>
<td>9%</td>
</tr>
</tbody>
</table>

² U.S. Census Bureau. 2010 Census.

CASE STUDY

Maryland Has Nearly a Decade of Experience to Draw Upon

Maryland has the most experience with paying hospitals in new ways, piloting global budgets at select rural hospitals in 2010 before expanding to all hospitals in 2014 under CMMI’s authority. Maryland is somewhat unique; it has a long-standing rate-setting framework as a basis for their global budgets, and most physicians are not directly employed by hospitals.¹³ Performance measures for the statewide program included reductions in spending and reductions in hospital-acquired conditions and hospital readmissions. Critical to Maryland’s All Payer Model is the health information exchange, allowing hospitals to receive detailed real-time information on admissions and readmissions.¹⁴ Evaluation of the statewide global budget program found that Maryland achieved double the projected Medicare savings ($679 million vs. $331 million), largely driven by decreases in emergency department (ED) and other hospital outpatient department expenditures.¹⁵ One analysis of the rural hospital pilot found significant declines in hospital services, including a 12% decline in ED admission rates, 23% decline in direct admissions, 45% decline in ambulatory surgery center visits, and 40% decline in outpatient clinic visits and services.¹⁶

Overall, the transition to global payments in rural hospitals is perceived to have had a modest effect on care patterns due to scope and incentive structure.¹⁷ Yet Maryland’s rural hospitals have changed the way they do business, emphasizing care coordination, primary care follow-up, and community health partnerships.¹⁸ Grant funding from the state health department and the rate-setting commission has facilitated regional planning of collaborative programs to address preventable hospital admissions.¹⁴ Services provided outside of the hospital and spending by physicians were not included in the original model; a 2018 update includes both hospital and non-hospital services and expands hospital care coordination activities, becoming the Total Cost of Care All Payer Model.¹¹
CASE STUDY

Pennsylvania Recently Implemented Global Budgets for Rural Hospitals

In 2017, CMMI approved the Pennsylvania Rural Health Model, a six-performance-year multi-payer agreement to transition voluntary rural hospitals to global payments. A large state with a significant rural population, Pennsylvania implemented global budgets for five rural hospitals in 2019. Medicare and four other payers are reimbursing participating hospitals on a fixed monthly total budget based on historical net revenue, considering either the average of the past three years or the most recent fiscal year (whichever is higher). The state is exploring state levers to mandate participation by Medicaid managed care organizations and state employee plans.19 Each participating rural hospital’s global budget is expected to represent at least 75% of that hospital’s net revenue for inpatient and outpatient hospital-based services in 2019, increasing to 90% in 2020 and beyond. Hospitals must also complete care delivery transformation plans, approved by the state and CMMI, demonstrating how they will invest in quality and coordinate care, and tailor the services they provide to their community. Quality and performance measures are being established: financial incentives may be tied to increasing access to primary and specialty care, reducing rural health disparities through improved chronic disease management, and decreasing deaths from substance use; and participating hospitals are held accountable for a targeted set of quality measures.20

Accountable Care Organization (ACO): a network of doctors and hospitals sharing financial and medical responsibility for providing coordinated care to patients, with the goal of improved quality and care, and financial savings.

CASE STUDY

Vermont Takes Slightly Different Approach to Reduce Total Cost of Care

Vermont started with a Medicaid Accountable Care Organization (ACO), expanding to an All Payer ACO Model in 2018 with Medicare, Medicaid, and Blue Cross Blue Shield of Vermont as participating payers. Vermont builds upon the initial Maryland global budget model by including all hospital and non-hospital expenditures. Hospitals receive a fixed per-member per-month payment for each attributed patient, with additional payments going to the ACO, One Care, to fund primary care and community-based providers for prevention and population health management activities.11,21 Community-based providers include mental health agencies, home health agencies, and area agencies on aging, which offer care coordination and case management support to patients at high or rising risk based on a risk-prediction algorithm.22 In addition to savings targets, Vermont is required to meet patient outcome and quality of care targets in four priority areas: substance use disorder, suicides, chronic conditions, and access to care.11 Individual patients opt in to participate; enrollment growth has been slower than expected due to significant financial and operational readiness needed by the ACO, payers, and providers.23 OneCare built on Vermont’s pathway to health reform, including earlier efforts to constrain spending and its State Innovation Model grant, which created an integrated approach to complex care management.22
Policy Recommendations

Value-based payments, and global budgets in particular, for rural hospitals is an intriguing idea that warrants further exploration in Washington State. Maryland, Pennsylvania, and Vermont have policy experiences that may be instructive for Washington State. The following are recommendations for Washington State and other states considering rural hospital global budgets:

- **Global budgets should be implemented cautiously.** States should pay close attention to the incentives they create and how effects can be evaluated, while recognizing that the full effects are likely to appear over time.\(^{16}\) States will want to protect against unintended consequences, particularly for vulnerable populations, such as reduced access to care due to risk of high costs or poor outcomes.\(^{24}\) Strong pay for performance elements should be included to improve quality performance;\(^{11}\) the National Quality Forum is developing a core set of rural measures that may provide basis for tying rural health care provider quality performance to payment.\(^{12}\) Global budgets should incorporate goals, incentives and financing for improving the health and well-being of the total population.\(^{25}\) Global budgets should also be structured to include total cost of care, minimizing cost-shifting incentives.

- **States should ensure readiness prior to implementation;** information system infrastructure resources are key. Significant payment changes require alignment between payers, providers, and communities. Streamlining services and other steps towards integration take time. Vermont’s experience suggests that readiness is an essential building block in implementing statewide system transformation.\(^{26}\) Ensuring resources and technical assistance to bolster rural hospital IT infrastructure is key. Maryland ensures access to real-time information on hospital admissions and re-admissions.\(^{14}\) Vermont hospitals benefited from having access to the ACO’s analytic tools, which enable panel management, performance tracking, and care coordination.\(^{21}\) Washington’s Accountable Communities of Health (ACHs) are responsible for supporting providers in Medicaid value-based payment readiness and could play a key role here.

- **Multi-payer participation is critical.** Experience from other states suggests about 80% of hospital revenue should be included in a global budget model.\(^{27}\) Engagement of both Medicare and Medicaid is critical given their predominance in rural areas. States can start with a voluntary model, like Pennsylvania, but it may be harder to implement.\(^{11}\) Legislation may be needed to mandate hospital and payer participation over the long term.\(^{11}\) States should explore state levers to mandate participation, including from Medicaid managed care organizations and state employee plans.

- **Alignment between key players is critical to achieve population health outcomes.** Vermont’s OneCare differs from many other ACOs by engaging partners other than hospitals and physicians that are not at financial risk for results.\(^{22}\) States like Washington should depend on ACHs as regional conveners. Local health jurisdictions and public hospital districts both play important roles in rural communities and have taxing authority; close alignment may increase resources.

- **Hospital services should reflect the needs of the local area.** Value-based payment arrangements can help keep rural hospitals afloat, but hospitals cannot be expected to respond with a one-size-fits-all approach. Hospitals need to invest in different services and infrastructure to improve population health and meet the needs of their individual communities.\(^{12}\) Vermont OneCare’s approach is purposefully not directive: it assumes that given resources and opportunities to collaborate, communities will devise their own solutions.\(^{22}\)
Summary

Washington State is ahead of the curve and has already been working toward global budgets for rural hospitals, with buy-in from many stakeholders. Building support among stakeholders and building upon existing health reform infrastructure, such as the State Innovation Model, the Medicaid Transformation Waiver, and other critical investments, should help to ensure success on this path.

References


