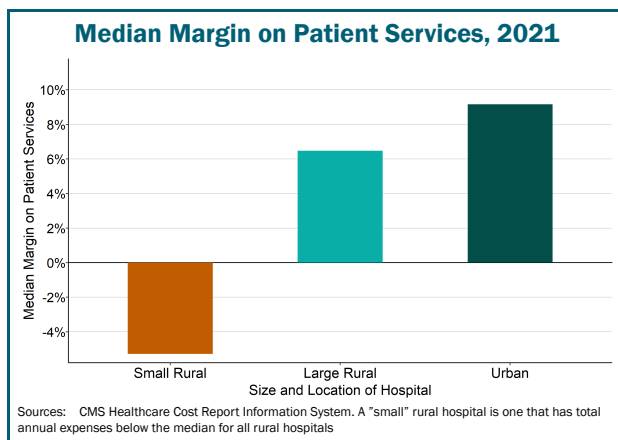


The Crisis Facing Rural Healthcare

There are over 1,000 small rural hospitals in the U.S., representing more than one-fourth of the short-term general hospitals in the country. 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. Most of the communities they serve are at least a half-hour drive from the nearest alternative hospital, and in many cases, there are no other sources of health care in their community.

More than 600 rural hospitals – nearly 30% of all rural hospitals in the country – are at risk of closing in the near future, and over 200 of these hospitals are at immediate risk of closure. Millions of people could be directly harmed if these hospitals close, and the rest of the country would also be affected through the impacts on workers in agriculture and other industries.

Small rural hospitals are being forced to close because they are paid less than what it costs to deliver care in rural areas. While most urban hospitals and larger rural hospitals make profits on patient services, most small rural hospitals lose money delivering services to patients. The biggest cause of these losses is inadequate payments from private insurance plans. Although large hospitals can offset losses on Medicaid and uninsured patients with the profits they make on patients with private insurance, small rural hospitals cannot.



The Cost of Delivering Essential Hospital Services

Understanding the problems with current payments requires understanding the differences between fixed costs, variable costs, and average costs in the delivery of healthcare services:

- **Fixed Costs.** Every hospital has to have a minimum level of personnel and equipment in order to ensure it can quickly deliver time-sensitive services to patients when needed. The most obvious example of this is the hospital Emergency Department (ED). Small hospitals need to have at least one

physician and nurse available on a 24/7 basis in order to promptly diagnose and treat patients when they come to the ED. Other hospital departments, such as the laboratory and radiology, also have to be available around the clock to perform basic tests and imaging studies for patients who come to the ED. The minimum number of physicians, nurses, and technicians need to be "standing by" to deliver services every hour, even if there are no patients at all during some of those hours. This "standby capacity" is a *fixed* cost for the hospital, i.e., it does not decrease if fewer patients come to the hospital over the course of the year.

- **Variable Costs.** The hospital will incur additional costs when a patient does come to the hospital for a service (e.g., the cost of supplies and drugs used for diagnosis and treatment), and it will also incur additional personnel costs if the number or types of patients needing services is more than what can be handled with the minimum level of staffing in the ED, laboratory, or inpatient unit. These are *variable* costs for the hospital, i.e., they increase or decrease based on the number of patients and the types of services delivered.
- **Total Cost.** The *total* cost of providing a particular type of service (e.g., Emergency Department visits or inpatient care) is the sum of the fixed costs and the variable costs. The total payments the hospital receives for the services must be greater than the total cost of delivering them. Since the variable costs depend on the number of services delivered, the total cost will be higher if the service is delivered more frequently, and so more revenue will also be needed.
- **Average Cost.** The *average* cost of a service is equal to the total cost incurred in delivering the service over a period of time (e.g., a year) divided by the number of services delivered during that period of time. Since the fixed costs do *not* depend on the number of services delivered, the average cost of a service will *increase* if fewer patients need the service, and vice versa. The average cost of an essential service is higher at a smaller rural hospital than at a larger hospital because the fixed cost is the same, even though the volume of services is lower.

The Problems Caused by Current Fee-for-Service Payments

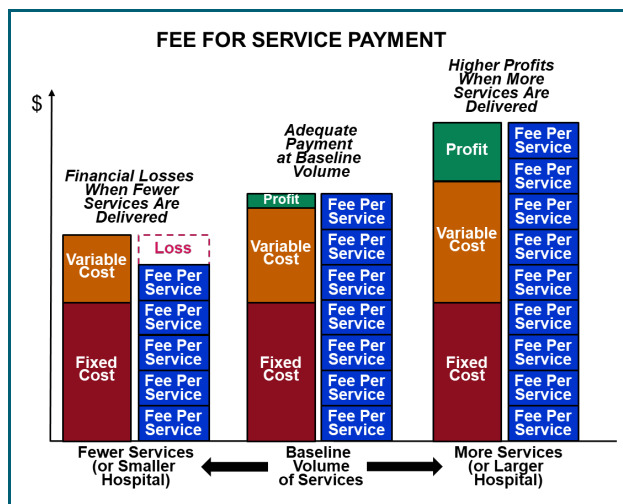
Under standard fee-for-service payment systems, a hospital is paid a fee each time it delivers a service to a patient (e.g., an Emergency Department visit, laboratory test, or imaging study). In theory, the fee should equal the average cost of delivering each service, so the hospital will receive just enough revenue to cover the total cost of delivering services during the year.

However, because of the high fixed cost of delivering essential services, the *average* cost depends on the number of patients who need the service. As a result, the average cost will almost always be higher or lower than a preset fee. This means:

- **Higher profits for the hospital if it delivers more services.** If the hospital delivers the service to more patients, the aver-

age cost of the service will decrease, and the revenue from the fees will be higher than the total cost.

- **Losses for the hospital if patients need fewer services.** Conversely, if the hospital does not need to deliver as many services, the average cost of delivering a service will *increase* because only the variable costs will decrease, not the fixed costs. If the fee for each service stays the same, total revenues will fall short of the total cost, causing a loss.



This also means that if small rural hospitals are paid the same fees for services as larger hospitals, the small rural hospitals will lose money. In fact, many insurance companies actually pay small rural hospitals less than they pay larger hospitals for the same services, even though the average cost of delivering the services at the small hospital will be higher.

Moreover, if a small hospital provides primary care and other services designed to help patients stay healthy, the number of ED visits and treatment services at the hospital is likely to decrease, which can increase financial losses for the hospital.

Small rural hospitals that are designated as Critical Access Hospitals are paid by Medicare based on the actual cost of their services instead of the standard fees paid to larger hospitals, so those payments will increase if fewer patients need services during the year. However, commercial health insurance plans, Medicare Advantage plans, and most Medicaid programs pay for services using standard fees, so the majority of revenues at Critical Access Hospital still come from fee-for-service payments. Moreover, under current federal sequestration rules, the “cost-based” payments from Medicare are only 99% of the average cost of services, so a Critical Access Hospital is forced to lose money even on services to Original Medicare patients.

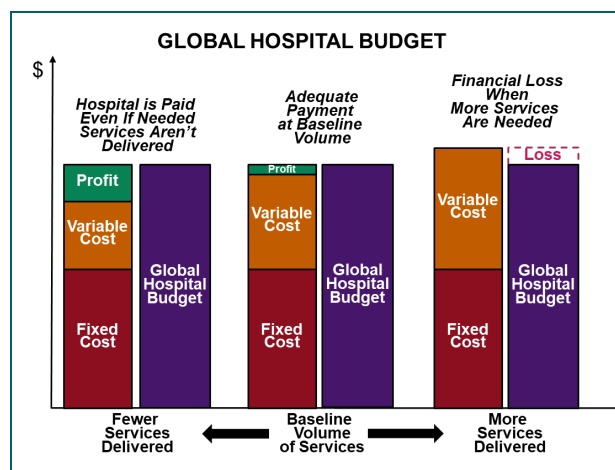
Since current payment systems do a poor job of supporting the delivery of high-quality healthcare in rural areas, a better method for paying small rural hospitals is needed. However, just because a payment system is *different* does not make it *better*. The weaknesses in current systems need to be corrected while also preserving their strengths.

Global Budgets Are Not a Solution

“Global hospital budgets” have been proposed as a way of helping small rural hospitals. In a global budget system, a government agency determines the total amount of revenue a hospital should receive. The hospital is not permitted to receive more or less than that amount, regardless of the number or types of services it delivers.

Most global budget programs have been created to control or reduce the amount payers spend on hospital services, not to address revenue shortfalls or prevent closure of small rural hospitals. Although Maryland’s global budget program is often 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 a global budget. Under a global budget demonstration program developed by Medicare (the CHART Model), a hospital would be required to accept a budget that is smaller than the revenue it received in the past, even if its past revenues were insufficient to cover the costs of its services.

Hospitals located in communities experiencing population losses and hospitals that want to eliminate specific types of services could benefit from a global budget, at least in the short run, because it would prevent the hospital’s revenues from decreasing when the volume of services decreases. However, hospitals that need to deliver more services to meet the needs of their community would likely be harmed, since their revenues could not increase to cover the costs of delivering additional services. During the initial months of the pandemic, a fixed global budget would have prevented hospitals from losing revenue when patients were not receiving elective services, but later, when COVID cases surged, a fixed budget would have prevented hospitals from delivering all of the services needed in their communities.



If the global budget is not large enough to enable the hospital to deliver an adequate number of services, access to care for patients will suffer. For example, after implementation of global budgets, Maryland had the longest emergency department wait times of any state in the country. In other countries where hospitals receive global budgets, many patients have to wait months to obtain the services they need. As a result, a number of countries have modified or replaced global budgets with “activity-based” payment systems that are similar to the fee-for-service payment system used in the U.S.

Patient-Centered Payments for Rural Hospitals

Goals for a Successful Payment System

A good payment system should achieve three key goals:

- 1. Ensure availability of essential services in the community.** A rural community needs to have assurance that the hospital's emergency department and basic diagnostic and treatment services will be available to deliver high-quality services at all times. There is a minimum cost involved in providing this capacity in a small community, and the hospital needs to have sufficient revenue to cover that cost, regardless of how many people actually have emergencies or illnesses requiring diagnosis and treatment. Payments based solely on the number of services delivered may not generate sufficient revenues to cover this cost, and an arbitrary global budget may also fail to do so.
- 2. Enable timely delivery of the services patients need.** When community residents have health problems, payments should enable the hospital to provide appropriate diagnostic and treatment services as quickly and efficiently as possible. The hospital should not be prevented from delivering services to all patients who need them by an arbitrary cap on its revenues, nor should it be paid the same amount even if it delivers fewer services than patients need, which is what would happen under a global budget. Moreover, insurance plans should not discourage or prevent patients from obtaining high-quality care by requiring high cost-sharing amounts or refusing to pay for services at the community hospital.
- 3. Support delivery of appropriate, high quality, affordable care.** Hospitals should be paid adequately to deliver services safely, efficiently, and in ways that evidence indicates will achieve good outcomes. The payment system should not reward hospitals for delivering unnecessary services or for charging prices that are higher than necessary, nor should it financially penalize hospitals for preventing complications and improving patient outcomes, as happens under the fee-for-service system. The payment system should also not reward a hospital for reducing access to services for patients or pay the hospital even when it delivers low-quality care, as a global budget would.

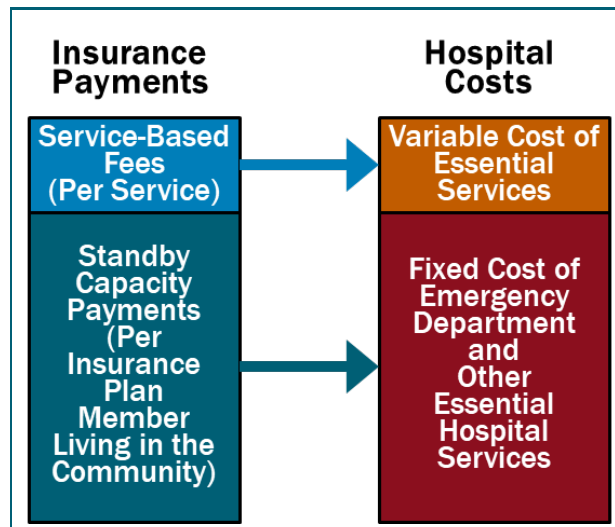
Components of a Successful Payment System

Achieving all three of these goals requires a payment system with four components:

- 1. Standby Capacity Payments to Support the Fixed Costs of Essential Services.** The hospital should receive a *Standby Capacity Payment* for each person living in the community served by the hospital, regardless of how many services those people actually receive. These payments would be designed to pay for the minimum fixed costs required to adequately staff an Emergency Department, inpatient unit, and other essential service lines.
- 2. Service-Based Fees for Diagnostic and Treatment Services Based on Variable Costs.** The hospital should also receive a *Service-Based Fee* when a patient receives a specific service. This payment would only need to cover the variable costs of the service, since the minimum fixed costs would be paid for by the Standby Capacity Payments. As a result,

the Service-Based Fees would be smaller than current fee-for-service payments.

- 3. Accountability for Quality and Efficiency.** In return for receiving adequate payments, hospitals should be expected to deliver evidence-based services safely and efficiently.
- 4. Value-Based Cost-Sharing for Patients.** The amount that a patient has to pay 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 that patients need, not to increase profits for either hospitals or health insurance plans.

More details on each of these components are provided below.

Standby Capacity Payments to Support the Fixed Costs of Essential Services

The fee-for-service payment system includes fees for thousands of individual healthcare services, but there is no fee at all for what residents of a rural community would likely view as the most important service of all – the *availability* of physicians, nurses, and equipment to diagnose and treat a serious health problem if the resident experiences an injury or illness.

Instead of being paid only for the patients who actually receive emergency, inpatient, or other services during the month, the hospital also needs to be paid for each *potential patient*, i.e., each community resident who does not happen to need the ED or inpatient care during a particular month, but who benefits from having those services available in case they do have such a need.

Communities do not force their fire department to support itself by charging high prices for extinguishing fires. Similarly, small rural hospitals should not be expected to pay for their emergency department by charging high prices for patients who need emergency care.

Standby capacity is an important healthcare service, because failure to provide it can result in worse outcomes and higher healthcare spending for residents of the community. Consequently, hospitals should receive **Standby Capacity Payments** from health insurance plans to pay for that capacity.

- **All health insurance plans (Medicare, Medicare Advantage, Medicaid, and commercial insurance) should pay a Standby Capacity Payment for each of their members who live in the community served by the hospital.** For each resident of the hospital's service area who has health insurance, their insurance plan would pay the Standby Capacity Payment to the hospital each month. This per-member payment would be paid by the insurance plan in addition to Service-Based Fees for any individual services the insurance plan member receives if they go to the hospital for care.
- **The hospital's total revenue from Standby Capacity Payments should cover the fixed cost of adequate standby capacity.** In aggregate, the Standby Capacity Payments from all payers should be sufficient to support the fixed costs of adequate staffing and equipment for the hospital's Emergency Department services, laboratory and radiology services, basic inpatient care, and other essential services, i.e., the cost that the hospital would have to incur even if only a small fraction of community residents actually need to use the services in any particular month.

A separate Standby Capacity Payment should be paid to a hospital if it delivers specific types of services (e.g., labor and delivery services or inpatient psychiatric services) to a broader service area. This enables the insurance plans for residents of other communities to pay to support the standby capacity needed for those specific services.

Conversely, a hospital should not expect to receive Standby Capacity Payments from health insurance plans for purely elective services, or if there are other providers already offering adequate access to a service in the same community.

Many rural communities currently use local taxes to cover the financial losses their hospitals incur delivering services to community residents. These local tax levies could be reduced if the hospital receives adequate Standby Capacity Payments from health insurance plans funded by the premiums local residents and businesses have already paid for health insurance.

Service-Based Fees for Diagnostic and Treatment Services Based on Variable Costs

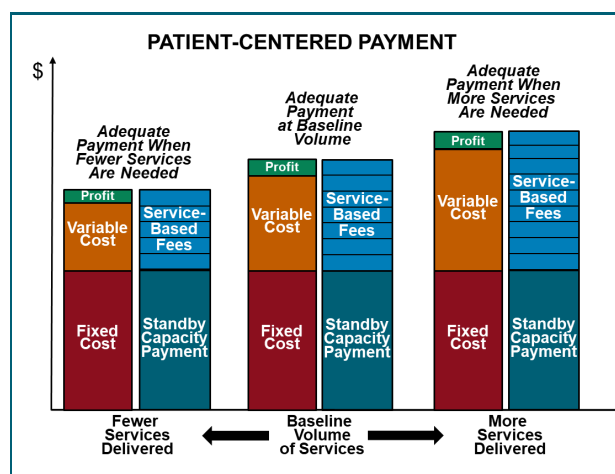
By design, the Standby Capacity Payments will only be sufficient to support the minimum fixed cost of operating a service line. Consequently, the hospital will still need to charge Service-Based Fees in order to cover the additional, variable costs incurred when it delivers services to patients. However, these Service-Based Fees can be lower than the fees charged today because they will no longer need to cover the fixed costs of the service line; the fixed costs will be paid for by the Standby Capacity Payments.

Using two different types of payments to support essential services – a Standby Capacity Payment based on fixed costs, and Service-Based Fees based on variable costs – will do a much better job of matching the hospital's revenues to its costs than either paying fees only when services are delivered or paying a single global budget regardless of how many services are delivered:

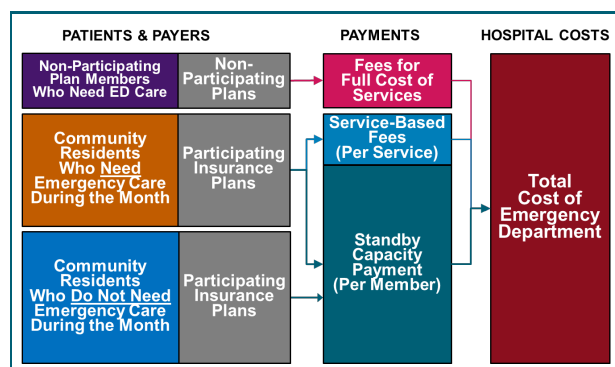
- If the amounts of Service-Based Fees are based on the variable cost of services, the hospital will not make significant profits by delivering more services nor will it incur significant losses when fewer services are delivered. Many hospitals charge high prices for all of their services and justify doing so

based on the need to pay for standby capacity, even though many of the services are not available on a 24/7 basis and even though the extra revenue generated through the higher charges may be far more than is needed to sustain the services that do need to be available on a round-the-clock basis. Paying directly to support standby capacity for essential services would enable more appropriate and affordable prices for individual hospital services.

- Using two different payments (the Standby Capacity Payment and the Service-Based Fee) is a more equitable way of charging patients (and their health insurance plans) for services than either traditional fees or global budgets, since patients who use more services will pay more but patients who need few services will still help to maintain the capacity required so they can receive services when they do need them.



If a health insurance plan is unwilling to pay Standby Capacity Payments for its members, it would be unfair for it to pay the same Service-Based Fees when its members receive services, since the plan would not be contributing to the fixed cost of the hospital's services. These health plans (and their members) would need to pay higher Service-Based Fees when essential services are delivered to their members. Similarly, if tourists or non-residents who work in the community receive emergency services in the hospital, they would need to pay a higher fee, particularly if the hospital has to maintain a higher ED capacity to meet the needs of both residents and non-residents.



Accountability for Quality and Efficiency

In return for receiving adequate payments to support the cost of services, rural hospitals should take accountability for delivering high-quality care to patients.

The “value-based payment” systems currently used by Medicare and other payers cannot and should not be used for small rural hospitals. Not only have these systems **failed to significantly improve quality** where they have been used, they are particularly problematic in rural communities because the quality measures do not produce statistically valid results for many types of rural residents and patients, and because rural hospitals cannot control the services that physicians and hospitals in other cities will order or deliver for those patients who need specialized care the rural hospital cannot provide.

Instead, in order to participate in the Patient-Centered Payment system, the hospital should agree that it will only bill for a service if the service has been delivered in accordance with evidence-based Clinical Practice Guidelines (CPGs). If the hospital has to deviate from evidence-based guidelines for patient-specific reasons (e.g., the patient was unwilling or unable to use the evidence-based treatment), the hospital would need to document those reasons in the patient’s clinical record in order to be paid for the services that were delivered.

In contrast to current pay-for-performance systems that are based on measures of average quality, this approach assures that each *individual* patient is receiving the most appropriate, high-quality care for their *specific* needs. It also eliminates the need for burdensome quality reporting systems that significantly increase administrative costs for both hospitals and payers. Moreover, since clinical practice guidelines define which services are *inappropriate* as well as which services are appropriate, they can reduce use of unnecessary services in a more patient-centered way than burdensome and problematic prior authorization processes operated by health plans.

Since the Standby Capacity Payments are designed to ensure that essential services are available when needed, in order to receive those payments, the hospital would need to document that the Emergency Department, laboratory, inpatient unit, and other standby services are staffed appropriately on a 24/7 basis.

Value-Based Cost-Sharing for Patients

Medicare and commercial health insurance plans require patients to pay a portion of the costs of most outpatient services they receive. Although cost-sharing is ostensibly intended to discourage unnecessary utilization of services by patients and to encourage them to seek out lower-cost services and providers, in many cases, cost-sharing merely shifts costs from insurers to patients and causes patients to delay or avoid receiving services they need.

Standard approaches to cost-sharing are particularly problematic in small rural communities. Because the cost of delivering essential services is higher in a small rural community, residents of the community who have high deductible insurance plans or who are required to pay high co-insurance amounts for services will have to pay more to receive essential services than patients in larger communities. Although Medicare pays Critical Access Hospitals more for services than it pays larger hospitals, it also **forces Original Medicare patients to pay**

higher cost-sharing amounts than if they had received the services from larger hospitals.

If a hospital is receiving Standby Capacity Payments, its Service-Based Fees will be much lower than the fees currently charged for services. This will limit the maximum amount that a patient with no insurance or a high deductible health plan would have to pay for a service, thereby reducing the financial burden for these patients as well as reducing bad debt for the hospital. Health plans will also need to modify co-payment and co-insurance amounts for individual services to ensure patients can access the services they need without encouraging unnecessary use of services. Patients should not be expected to pay cost-sharing on the Standby Capacity Payments.

An Example of How Patient-Centered Payment Would Work

The table below shows the costs of operating an Emergency Department (ED) at a hypothetical rural hospital located in a community with 15,000 residents. The ED has 5,000 visits per year, i.e., about one visit every two hours. The hospital has a physician and nurse in the ED around the clock, which requires the hospital to employ a total of 4 physicians and 5 nurses to cover all of the shifts. The cost of the staff and overhead for the ED represent a fixed cost for the hospital, i.e., it does not change even if the hospital has more or fewer visits during the year. At this hypothetical hospital, about 1/6 of the cost of the ED is assumed to be associated with supplies used during the visits, and those costs do increase or decrease with more or fewer visits. (The costs of other services, such as lab tests, x-rays, or drugs that are typically billed for separately are not included here.)

With 5,000 ED visits per year, the average cost per visit is \$645, which means the hospital would need to be paid an average of \$645 per visit in order to cover its costs. However, as shown in the table, if the hospital is paid a \$645 fee for each visit, but the number of visits decreases by 20%, the hospital would lose a significant amount of money (a 17% loss). Conversely, if the number of visits increases by 20%, the hospital would make a 16% profit on the ED. This creates an undesirable incentive for the hospital to encourage more ED visits.

\$645 is significantly more than what Medicare pays for an ED visit except at Critical Access Hospitals, and it is more than what Medicaid plans would typically pay, which means the hospital would have to charge even more for patients who have private insurance in an effort to make up the difference. This would make ED visits very expensive for patients who have high-deductible health plans or who have no insurance at all.

If the hospital were given a fixed global budget equal to the baseline cost of operating the ED (\$3.2 million), it would no longer lose money if the number of ED visits decreased. Instead, the hospital would lose money if the number of ED visits *increased*, e.g., during a flu outbreak or natural disaster, because the hospital would incur additional costs for treating patients but would receive no extra revenue to cover those costs.

Under the Patient-Centered Payment system, the hospital would need to receive a Standby Capacity Payment of \$182 per year for each resident in the community to support the fixed cost of operating the ED. (The hospital’s total Standby Capacity Payment would need to be higher than this to cover

the standby costs of other services, such as the laboratory, the radiology department, the inpatient unit, etc. For simplicity, only the costs and payments associated with the ED itself are shown here.) The hospital would then only need to charge a Service-Based Fee of \$100 for an individual ED visit. As shown

in the table, the hospital would neither lose money nor make excessive profits when the number of ED visits changes. Moreover, an ED visit would be much more affordable for individuals with high-deductible health plans or no insurance at all.

Costs, Revenues, and Margins for a Hypothetical Emergency Department

	Rate	Baseline	Fewer Visits	Change	More Visits	Change
Community Population		15,000	15,000	0%	15,000	0%
ED Visits		5,000	4,000	-20%	6,000	+20%
Annual Cost of ED						
Physicians		\$1,200,000	\$1,200,000	0%	\$1,200,000	0%
Nurses		\$450,000	\$450,000	0%	\$450,000	0%
Supplies	\$100 per visit	\$500,000	\$400,000	-20%	\$600,000	+20%
Overhead		\$1,075,000	\$1,075,000	0%	\$1,075,000	0%
Total		\$3,225,000	\$3,125,000	-3%	\$3,325,000	+3%
Under FFS Payment:						
Revenue	\$645 per visit	\$3,225,000	\$2,580,000	-20%	\$3,870,000	+20%
Profit/Loss		0%	-17%		+16%	
Under a Global Budget:						
Revenue		\$3,225,000	\$3,225,000	0%	\$3,225,000	0%
Profit/Loss		0%	+3%		-3%	
Under Patient Centered Payment:						
Standby Capacity Pmts	\$182 per resident	\$2,725,000	\$2,725,000	0%	\$2,725,000	0%
Service-Based Fees	\$100 per visit	\$500,000	\$400,000	-20%	\$600,000	+20%
Total Revenue		\$3,225,000	\$3,125,000	-3%	\$3,325,000	+3%
Profit/Loss		0%	0%		0%	

The Costs and Benefits of a Patient-Centered Payment System

Using Patient-Centered Payment to pay rural hospitals instead of traditional fees for services will not, in itself, increase or reduce healthcare spending. As shown in the example, the amounts for the Standby Capacity Payments and Service-Based Fees can be set in such a way that a hospital will receive exactly the same total revenue at its current volume of services as it does under the current payment system. Patient-Centered Payment would be a better *method* of payment for the hospital because its revenues will be more likely to match its costs when the volume of services changes. It would also be a better method of payment for payers, because it would make their spending on hospital services more predictable.

However, this also means that using Patient-Centered Payment will not prevent small rural hospitals from closing unless the Standby Capacity Payments and Service-Based Fees are adequate to cover the fixed and variable costs of delivering essential services in rural communities. Most small rural hospitals are losing money delivering patient services because the cur-

rent fees they are paid, particularly by commercial insurance and Medicare Advantage plans, are less than what it costs to deliver the services. **No matter what *method* is used to pay rural hospitals, the payments will need to be larger than they are today in order to be adequate.**

Although higher payments to small rural hospitals will increase spending for health insurance plans, the impact will be very small because the hospitals are so small. In aggregate, **payments to small rural hospitals in the U.S. need to increase by about \$4 billion to prevent closures of the hospitals that are most at risk.** This would represent an increase of only 1/10 of 1% in total national healthcare spending. Health plans are likely to spend as much or more than this if the hospitals are forced to close and rural residents can no longer receive timely treatment and preventive care.

Using Patient-Centered Payment to pay small rural hospitals, with adequate payment amounts, would not only prevent closures, but enable small rural hospitals to deliver the services needed by the residents of their communities in a high-quality way. That would be true “value-based payment” that supports high-quality rural health care at the most affordable cost.