

Rural Hospital Viability and Financial Performance

Keith J. Mueller, Ph.D.
Director,
RUPRI (Rural Policy Research Institute) Center for Rural
Health Policy Analysis
University of Nebraska Medical Center

June 3, 2002

Session in User Liaison Program Workshop
Rural Health Care:
Readiness to Function Effectively in Times of Fiscal Constraint
Denver, Colorado

Outline

- I. Characteristics of Rural Hospitals
- II. Federal Payment Policies
- III. The Rural Hospital Flexibility Program
- IV. The Future of the Flex Program
- V. Closing Comments

I. Rural Hospitals Come in Different Sizes and Shapes

Staffed Bed Size (1996)

- ❑ 6-49 beds: 47%
- ❑ 50-99 beds: 31%
- ❑ 100-199 beds: 18%
- ❑ 200+ beds: 4%

Source: Medicare Cost Report Data, used by the U of Minnesota Rural Health Research Center

Rural Hospitals Come in Different Sizes and Shapes (*continued*)

Services Provided (1996)

- Obstetric care: 63%
- Skilled Nursing: 41%
- Inpatient Psychiatric: 18%
- More than 10 surgeries per week: 60%

Source: American Hospital Association Annual Survey, used by the U of Minnesota Rural Health Research Center (U of MN RHRC)

Set in Different Types of Rural Communities

- ❑ Large trade centers
- ❑ Medium size communities with populous service areas
- ❑ Isolated medium size communities
- ❑ Small communities and populous service area
- ❑ Isolated small communities

These Differences Matter for Hospital Finance

- ❑ Strong regional centers of excellence in rural America
- ❑ Financially stable large tertiary centers, growing (Kearney, Nebraska)
- ❑ Potential for financial stability in medium size communities
- ❑ Building on strength to assist in problem areas
- ❑ Some places where direct assistance will be needed

The Financial Health of Rural Hospitals

Context:

In 1999, over 45% of rural hospital costs were from Medicare,

In 1996, Medicare accounted for 60% inpatient days in rural hospitals
data from Medicare Cost Reports

Barometer: Various margins, also remaining open regardless of operating margins

The Financial Health of Rural Hospitals (continued)

1999 Hospital Margins by Type of Hospital

<u>Type</u>	<u>Medicare Inpatient (Excl GME)</u>	<u>Medicare Outpatient (Excl GME)</u>	<u>Medicare (With GME)</u>
Urban	13.2%	-17.0%	6.1%
Rural referral	4.2	-14.9	-2.1
Sole Community	5.0	-15.4	-2.4
Small rural Med Dep.	6.6	-21.9	-3.0
Other rural <50 beds	2.5	-21.0	-5.4
Other rural >50 beds	1.6	-19.4	-5.1

Source: MedPAC March 2002 report to Congress

The Financial Health of Rural Hospitals (continued)

Total Margins in 1999 higher in most rural as compared to urban, but include all revenues
Lowest in most remote areas (not adjacent to Metro area without a town of 2,500)

from the June 2001 MedPAC report to Congress

OVERALL A PROBLEMATIC SITUATION

II. Federal Payment Policy Responses

The principle in Medicare is to pay for services delivered efficiently to beneficiaries

Excludes sources of inefficiency & costs of access for other populations

Includes access for beneficiaries

Federal Payment Policy Responses (continued)

Result is categories of hospitals that have special claim to higher than Prospective Payment System (PPS) rates:

Category

Sole community hospitals:

Criteria

distance from other hospitals

Rural referral centers:

look like urban
tertiary hospitals, pay like
them

Medicare-dependent hospitals:

60% or more Medicare

Critical Access Hospitals (CAHs): size and distance

Breaking a Downward Spiral

Direct Pressure on Payment

Pressure from Medicare

Medicaid programs struggling

Expenditure pressures on private
insurers

Breaking a Downward Spiral (continued)

Pressure To Retain Business

AHRQ-funded study published in 2000 (*Journal of Rural Health* 16(2)) people likely to “bypass” local rural hospitals in NY, NJ, PA, CT: young who are severely ill

AHRQ-funded study published in 2000 (*Medical Care* 38 (11)) people treated for Acute Myocardial Infarction (AMI) in low-volume rural hospitals more likely to receive thrombolytics little difference in aspirin use based on hospital volume and physician volume

policy and practice strategies needed

The Policy Levers in Medicare

The categories of payment allow for state designations

Thorough examination of revenue potential in PPS

inpatient: Diagnosis Related Groups (DRGs) favorable to small hospitals, reducing costs

outpatient: Ambulatory Payment Classifications (APCs) favorable to small hospitals, reducing costs

requires information systems and analysis

III. The Special Case of the Medicare Rural Hospital Flexibility Program

- ❑ Designation of and payment to Critical Access Hospitals (CAH): Financial relief
- ❑ Developing rural health networks
- ❑ Establishing programs of quality improvement
- ❑ Improving emergency medical services (EMS)
- ❑ Establishing States as leaders

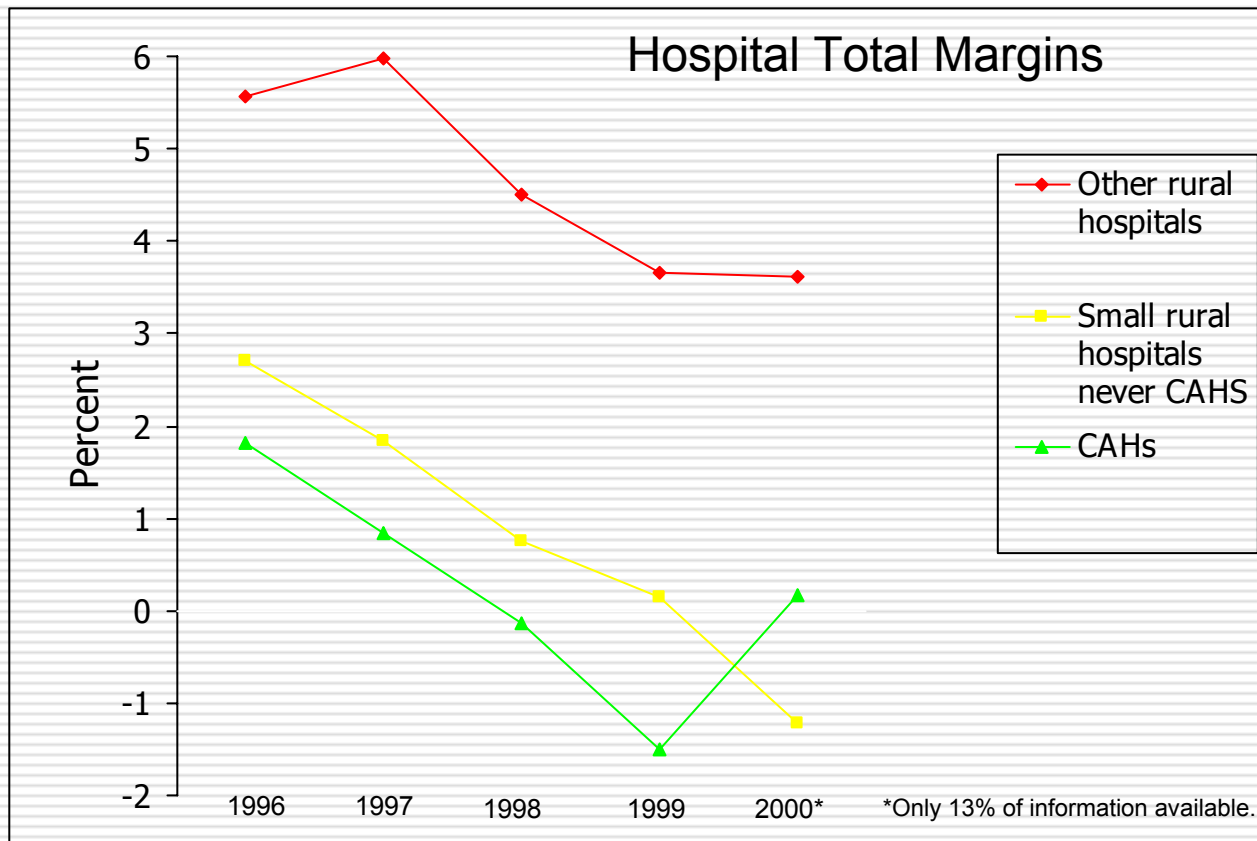
Scope of the CAH Effort

- 600 Certified CAHs
- 140 CAH certifications pending
- 831 still eligible

Source: data taken from www.rupri.org/rhfp-track, as of May 1, 2002

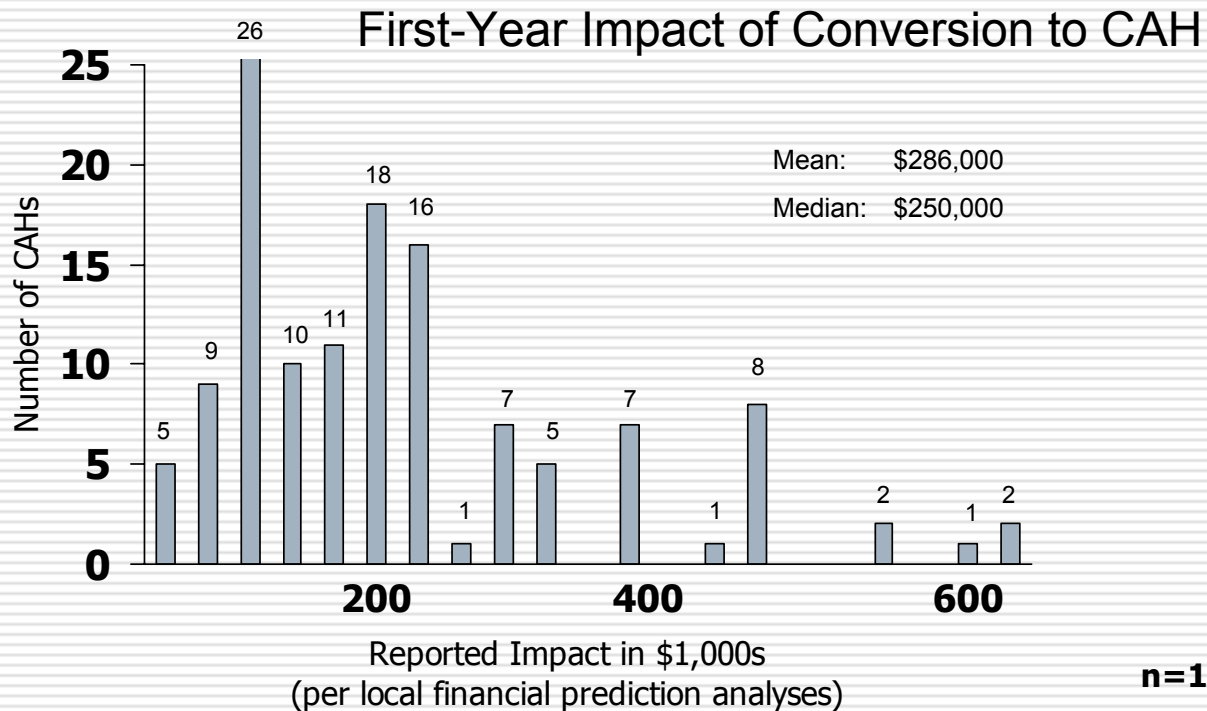
Strengthening Hospitals for the Long Term

Increases in total margins by Hospital type



Strengthening Hospitals for the Long Term

Reverse the decline in hospital revenues



Building Hospital Networks

- Majority of States require network formation for every CAH they certify

- Early activities of networks, descending order of mention in a survey:
 - Patient transfer agreements
 - Quality assurance or improvement activities
 - Referral arrangements
 - Specialty services
 - Administration

Rural Hospital Flexibility Program Tracking Team Recommendations to Further Strengthen Rural Health Systems

The following slides are taken from the document "Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field." *Findings from the Field 2* (5). February 8, 2002.
National Tracking Project.

IV. Expand Rural Network Development

- Encourage and support partnerships among rural hospitals and their partners, community organizations, and rural networks

- Expand training and networking opportunities for CAH administrators and other hospital staff (including medical director), including an understanding role of the hospital in the community health system

Developing Quality Improvement Projects

- “Unexpectedly, we found that CAHs and states reported substantial interest and involvement in quality assurance and quality improvement activities despite the short amount of time they have been involved in the program....” (p. 8)

- CAH linkages are valuable in quality improvement projects
 - Network hospital
 - State hospital association
 - Peer review organization (PRO), now quality improvement organization (QIO)

Expand Quality Improvement

- Encourage States, hospitals, and communities to include quality improvement initiatives as a core component in other activities (network development, EMS)

Strengthening Emergency Medical Services (EMS)

- Training initiatives
 - Clinical training for EMS personnel, including hospital personnel and medical directors
 - Management, billing, and data entry

- Needs assessments

- Encouraging local collaboration

- Enhancing data collection and reporting systems

Strengthen Rural EMS

- Encourage development of EMS as a critical component of hospital care through expanded partnerships of EMS provider organizations with other providers and inclusion of EMS in rural health network development

Creating The Statewide Vision

- As the third year of the Flex Program evolves, states are shifting attention and priorities to longer-term issues
 - Refining state priorities for the Program
 - Focusing on longer-term rural hospital and health systems performance issues
 - Quality improvement
 - Strategic planning

Creating The Statewide Vision

(continued)

- As the third year of the Flex Program evolves, states are shifting attention and priorities to longer-term issues
 - Increasing efforts to improve EMS
 - Meeting capital needs of rural hospitals

Rural Health Planning and Policy Development

- Continue to support role of the states in partnerships with others including state hospital associations, to monitor and update statewide planning and policy development
- Provide incentives and support for states to track and assess the status of vulnerable rural communities and hospitals

Importance of State and Local Efforts

States using Flex Program to create finance mechanisms

- helping make capitol available: renovation, new technology
- payment policies in Medicaid
- influence of state insurance plans on construction of preferred provider panels

local governments already a critical source of revenue: in 1992 rural local governments contributed \$10,8 billion

Source: Wellever and Radcliff, "The Contribution of Local Government Financing to Rural Hospitals and Health Systems" Working Paper #25, November, 1998, U of Minnesota Rural Health Research Center

Importance of State and Local Efforts (continued)

Facilitating new delivery modalities and networks

- communications infrastructure
- facilitating network development
- training programs

Networks in Our Future

Networks can improve fiscal viability of rural hospitals

findings of AHRQ-sponsored study of Oklahoma rural hospitals (Networks and the Fiscal Performance of Rural Hospitals in Oklahoma (1998) *Journal of Rural Health* 14(4), 327-337. Robert W. Broyles, Ph.D., Edward N. Brandt Jr., M.d., Ph.D., and Dianne Biard-Holmes, M.S.W.)

Could include other providers in the community, especially physicians

Networks

Provide the means of:

- learning from shared experience
- aggregating functions for efficiencies
- linkages for providing continuum of care from a rural base

Closing: Building for the Future by Meeting Demands for Change

Documenting and improving the records of rural hospitals in patient safety

Demonstrating and improving quality

Being accountable by demonstrating acceptable outcomes

Realizing fiscal efficiencies in service delivery

Being a part of the community – medical care, economic contribution, social institution: this will require a partnership with local and state government

For more information, see:

RUPRI Center for
Rural Health Policy Analysis

www.rupri.org/healthpolicy