

The Argument For The Rural Community Hospital Assistance Act

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative and Past President, National Rural Health Association presented on 2/14/03 in Washington D.C. in a briefing for staffers of Members of the U.S. Senate Rural Health Caucus and House Rural Health Coalition. This is an update of an editorial published by *Modern Healthcare*, (8/5/02), as “The way to pay for rural care: Cost-based payment would stabilize finances for a class of troubled hospitals.”

There are hundreds of small and rural hospitals across the country that are “too busy” to be eligible for the Critical Access Hospital (CAH) program but not “busy enough” for the fixed cost assumptions inherent in the Prospective Payment System (PPS). Many of these hospitals don’t have Medicare-Dependent Hospital or Sole Community Hospital status and of those that do, many don’t receive significant assistance. As a group, these hospitals are heavily Medicare dependent with massively negative Medicare margins and meager or nonexistent operating margins.

In 2002, The Rural Community Hospital Assistance Act was introduced to enhance the Critical Access Hospital (CAH) program and to create a new Medicare payment classification for rural hospitals with 50 or fewer acute care beds. This new classification would be called Rural Community Hospital (RCH). Reintroduction in 2003 in both the Senate and the House is expected. RCH protects the core infrastructure of rural health in America while not undermining the public policy inherent in the Medicare Prospective Payment System. For twenty years we have tried to adapt PPS for these hospitals; it is now time to admit that the theoretical model simply doesn’t fit this small minority of hospitals. **Acknowledging that PPS is inappropriate for hospitals which account for only about 2% of Medicare hospital payments is simply not a threat to, or contradiction of, the Prospective payment System.** (*ProPAC Report To The Congress*, 6/97)

In 1999, rural hospitals were paid 9.6% less than their reasonable costs (as defined by Medicare) for providing services to Medicare beneficiaries. Rural hospitals with under 50 beds not eligible for rural referral, sole community or Medicare dependent status were paid 14.2% less than their reasonable costs. (*MedPAC Report To The Congress*, 3/01) In 1999, 54.5% of these hospitals had a negative inpatient Medicare margin; almost all lost money on their outpatient services. (ibid.)

The arrival of CAHs doesn’t help those hospitals too busy to qualify unless they are willing to force significant numbers of Medicare beneficiaries to leave the community for care which could easily be done locally. Data collected by the State of Wisconsin for 2001, shows Total Medicare Margins of -21.9% for the then 32 rural hospitals with under 50 beds that were not CAHs. The margin drops further to -22.9% when seven hospitals who subsequently became CAHs are excluded. Hospitals with these losses cost shift to the private sector as long as they can, or close.

RCH is a cost based option for rural hospitals with 50 or fewer acute care beds that are not eligible to be a CAH. With the Rural Community Hospital Assistance Act, CAHs would receive an add-on payment for infrastructure and technology improvement, cost-based reimbursement for additional post acute care services, including skilled nursing, home health and geriatric psychiatric service (10 or fewer beds) and elimination of the 35-mile test to receive cost reimbursement for ambulance services. RCH would provide the following: cost-based reimbursement for inpatient and outpatient services plus a technology and infrastructure add-on; cost-based reimbursement for home health

services where the provider is isolated, cost-based reimbursement for ambulance services and the restoration of Medicare bad debt payments @ 100%.

Some have argued against this initiative based upon a Darwinian notion of the “survival of the fittest”—that any assistance to rural hospitals inappropriately saves the inefficient. While these same commentators seldom note other long standing urban based Medicare subsidies that dwarf what rural communities are asking, the question is a fair one and can be squarely answered.

- Inefficiency means not producing the effect intended, compared to similarly situated organizations. When a whole cohort of America’s hospitals, on average, are losing money serving Medicare beneficiaries, the problem is the payment system, not hospital efficiencies.
- The traditional Federal methodology for managing other reimbursement schemes based on reasonable costs allows them to administratively limit costs to rule out clearly inappropriate expenditures. Historically administrative pricing has been used to “hold the line” on spending by setting arbitrary limits on spending, which can be done by formula, a fee schedule, or policing “reasonable and allowable” controls.
- If a hospital receives cost based reimbursement from Medicare it still has to operate in a community where much of its revenue from other payers is NOT cost based. This provides an ongoing major external incentive to keep RCH hospitals mindful of costs.

Medicare beneficiaries, like everyone else with health insurance, benefit only when they can access services. To be useful, services which are covered as insured benefits must be accessible and to be accessible they must be available timely and conveniently to the beneficiary and their care-givers (family). Rural hospitals offer the essential services that Medicare beneficiaries need and how they need them, that is timely and conveniently. For benefits to be accessible, rural hospitals must be viable.

In most of America, health care for Medicare beneficiaries is paid for by the Federal government and the beneficiaries themselves. In rural America there is a third payer—the “hidden tax” of the cost shift to the private sector and their insurers. **The Medicare rural cost shift nationwide equates to about a 30% tax on private payers** (according to rural payment to cost ratios, MedPAC 6/01). **In an increasingly price competitive environment, this tax is not sustainable.** Rural counties across the country are facing the future of America today—the waning ability of the private sector to absorb the Medicare induced cost shift. The Medicare cost shift to private payers (workers) which currently holds the rural infrastructure together, is not sustainable—fewer workers per beneficiary are fueling a rapidly increasing price resistance in rural markets. The Congressional advisory body, MedPAC tells us we don’t have a problem as all payer rural hospital margins, financed by the cost shift, are adequate—they need to look more closely.

The estimated cost of the Rural Community Hospital Assistance Act is about \$500 million a year, less than a quarter of one percent of annual Medicare expenditures—a small adjustment to assure a stable core of health services for America’s rural communities.

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