Rural hospitals have their jobs cut out for them and so do policymakers who care about them.

Forty-eight rural hospitals have closed their doors since 2010, according to data recorded by the North Carolina Rural Health Research Program at the University of North Carolina, Chapel Hill.

The typical rural hospital has 25 to 50 beds. It is more dependent on Medicare and Medicaid, which generally pay less than other insurers, and it has lower patient volume than urban hospitals.

“The implication of lower volume is that the hospital is spreading fixed costs over less people and there is less certainty about the numbers of services that will be provided on any given day,” said Mark Holmes, director of the North Carolina Rural Health Research Program. “This uncertainty makes it hard to staff the hospital and hard to plan.”

A Long-Simmering Issue

Federal policymakers have focused on the sustainability of rural hospitals since the 1980s.

Medicare, the federal health care insurance for people 65 and older, changed the way it paid hospitals in
1983. Before then, Medicare asked a hospital for its total annual costs and paid the amount proportionate to their Medicare patient population, Holmes said. The new payment system instituted a standard payment for each procedure. Medicare used urban hospitals to set the reimbursement prices, Holmes said, which ignored the fact that rural hospitals have higher per patient costs.

By the late 1980s, a considerable number of rural hospitals closed, drawing the attention of Congress. The fix, Holmes said, was to create designations for rural hospitals that provided additional funding to the standard Medicare and Medicaid formulas. Facilities designated as sole community hospitals, rural referral centers and Medicare dependent hospitals received a bump in Medicare reimbursements.

In 1996, the federal government added the critical access hospital designation. The majority of rural hospitals—53.5 percent according to Holmes’ program—qualify as critical access hospitals. Such hospitals have fewer than 25 acute care beds, provide 24-hour emergency services and are located more than a 35-mile-drive from another hospital, or a 15-mile-drive in mountainous terrain.

“Critical access hospitals are a very different animal,” Holmes said. Their Medicare reimbursement formula amounts to 20 to 30 percent more than other payers provide.

LifePoint Hospitals, a national company that operates more than 60 facilities that are the sole hospitals in their communities, said maintaining the federal designations and additional funding are critical to keeping their hospitals open.

“It is important for policymakers to remember that, when rural hospitals struggle, their communities struggle, too,” said William F. Carpenter III, chairman and CEO of LifePoint Hospitals. “Once a rural hospital eliminates services or closes for financial reasons, these essential services rarely, if ever, return to the community. ... Also, when hospitals are forced to cutback needed services, it leads to loss of jobs and economic instability for the community.”

For the second year, the Obama administration has proposed cutting funding for critical access hospitals and eliminating the designation for several hospitals, a savings of $2.5 billion over the next decade. The president’s budget is considered dead on arrival by most observers.

Wyoming Emergency Funding

Wyoming, one of nation’s most rural states, approved $3 million in the 2015 legislative session to help its beleaguered hospitals. The state has 26 hospitals, 16 of which are designated critical access.

“We have five hospitals with less than 100 days cash-on-hand and one with just 19 days,” said state Rep. Elaine Harvey, chair of the Labor, Health and Social Services Committee. “When a hot water heater went out in that hospital, staff had to carry hot water from the acute care bed section to the nursing home side of the facility.”

Expanding Medicaid would have eased hospitals’ charity care burden, estimated at $200 million annually. Instead, the Senate approved $5 million direct aid for hospitals. After the House stripped out the $5 million, Harvey found an old hospital challenge grant program already in law and used it to provide $1 million to hospitals with less than 100 days of cash-on-hand.

A final compromise in the waning days of the session restored $2 million, along with Harvey’s $1 million, for hospitals. Two-thirds of the $2 million will go to critical access hospitals.
Harvey said her committee, along with the House Appropriations Committee, will undertake a study of the governance structure of the state’s hospitals and how to support rural health care as an economic driver in rural communities.

Georgia Rural Hospital Recommendations

Five rural hospitals have closed in Georgia since 2010. Gov. Nathan Deal put together a committee of legislators and state leaders in 2014 to identify the needs of the state’s rural hospitals and develop policy solutions.

The Rural Hospital Stabilization Committee recommended establishing a pilot program in four areas using a hub-and-spoke model. The hubs are four communities with nursing homes, home health, rural health clinics and a regional hospital. The spokes include critical access hospitals, WiFi and telemedicine equipped ambulances, school clinics with telemedicine, federally qualified health centers, public health departments and local physicians.

The goal of the pilot program is to ensure patients are treated in the most appropriate setting, often with the assistance of technology, to relieve some of the cost pressure on the smallest rural hospital emergency departments.

The $3 million cost of the pilot is in the adopted budget, according to Georgia Rep. Terry England, a committee co-chair.

“The hub hospitals will put in a small amount of cash as local buy-in,” he said. Additional cash will come from the state’s Medicaid managed care organizations and local providers.

“The goal of the hub-and-spoke model is to get the right patient to the right place at the right time,” England said. Technology will allow ambulances to access real-time bed and doctor inventories and take patients to the hospital best suited for a particular patient.

“If the model works as we hope, we are trying to help the small rural hospitals survive,” England said. “The goal is to maintain as many as we can. But I am probably kidding myself if I say that no rural hospitals will close.”

“Early in the committee's work, there was a quick search for a magic bullet—stand-alone emergency departments—but the financials didn’t work out,” said Gary Nelson, president of the Healthcare Georgia Foundation, whose mission is to advance the health of all Georgians.

Nelson hopes that as leaders consider a new model of rural health care for Georgia, they don’t become reliant on the state’s safety net programs—such as school clinics and federally qualified health centers—to replace community hospitals.

“What happens to mental health care where a hospital is lost?” Nelson said. “What about the golden hour following a stroke?”

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