

TRENDWATCH

The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform

Seventy-two million Americans live in rural areas¹ and depend upon the hospital serving their community as an important, and often only, source of care. The nation's nearly 2,000 rural community hospitals² frequently serve as an anchor for their region's health-related services, providing the structural and financial backbone for physician practice groups, health clinics and post-acute and long-term care services. In addition, these hospitals often provide essential, related services such as social work and other types of community outreach.³

Rural communities rely on their hospitals as critical components of the region's economic and social fabric. These hospitals are typically the largest or second largest employer in the community, and often stand alone in their ability to offer highly-skilled jobs.⁴ For every job in a rural community, between 0.32 and 0.77 more jobs are created in the local economy, spurred by the spending of either hospitals or

their employees.⁵ A strong health care network also adds to the attractiveness of a community as a place to settle, locate a business or retire.

Rural hospitals provide their patients with the highest quality of care while simultaneously tackling challenges due to their often remote geographic location, small size, limited workforce, and constrained financial resources. Rural hospitals' low-patient volumes make it difficult for these organizations to manage the high fixed costs associated with operating a hospital. This in turn makes them particularly vulnerable to policy and market changes, and to Medicare and Medicaid payment cuts. The recent economic downturn put additional pressure on rural hospitals as they already operate with modest balance sheets and have more difficulty than larger organizations accessing capital to invest in modern equipment or renovate aged facilities. Compounding these challenges, rural Americans are

more likely to be uninsured and to have lower incomes, and they are, on average, older and less healthy than Americans living in metropolitan areas.⁶

The Patient Protection and Affordable Care Act of 2010 (ACA) begins to address some of the urgent issues facing the nation's health care system, such as lack of access to health insurance coverage, and includes provisions that recognize rural hospitals' unique circumstances. However, limited financial and workforce resources present significant ACA implementation challenges for rural hospitals. As more rural Americans gain access to health coverage through Medicaid and the commercial markets, rural hospitals will experience greater patient demand that may strain already limited staff and capital resources. Furthermore, additional accommodations must be made so that rural hospitals can benefit fully from ACA programs, demonstrations and pilots.



from the field

"As we move forward with health care reform, it will be particularly important in rural areas that providers work together, perhaps in network arrangements, to address the scarcity of resources that rural providers often face, and to improve the overall efficiency of care throughout the health care continuum."⁷

Gerald Wages, executive vice president, North Mississippi Health Services, Inc., Tupelo, MS

The Characteristics of Rural America Challenge Rural Hospitals

Twenty-three percent of the U.S. population lives in rural areas.⁸ Rural residents tend to be older, have lower incomes and are more likely to be uninsured⁹ than residents of metropolitan areas.

Rural Americans also are more likely to suffer from chronic illnesses than their urban and suburban counterparts. Nearly half of rural residents report having at least one major chronic illness, and chronic diseases such as hypertension, cancer, and chronic bronchitis are

up to 1.4 times more prevalent in rural than in large urban areas.¹⁰

Rural America is experiencing an out-migration of younger Americans and some rural areas are seeing an in-migration of older Americans nearing or at retirement age.¹¹ At the same time, the rural health care workforce is aging, and nearer to retirement than the urban health care workforce.¹² These declines in working age residents, in concert with rising demand from aging baby boomers,

exacerbate the considerable workforce shortages rural hospitals face.

Compounding these demographic trends, residents of rural areas face barriers in accessing health care services. Patients often have to travel long distances to seek care, made more difficult by a lack of reliable transportation.¹³ These factors contribute to their tendency to delay seeking care, which aggravates health problems and leads to more expensive interventions upon receiving care.¹⁴

Rural populations are older and poorer than urban populations.

Chart 1: Percent of Population over Age 65, 2009

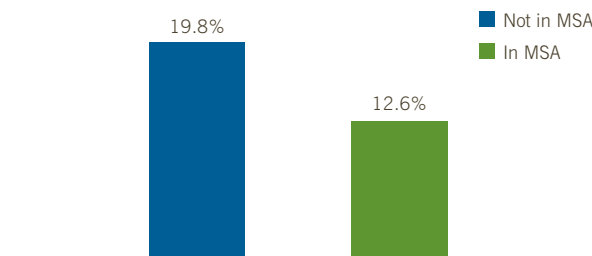
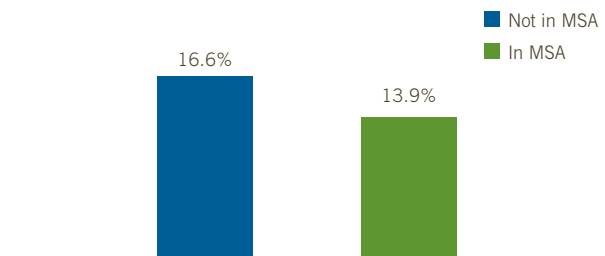


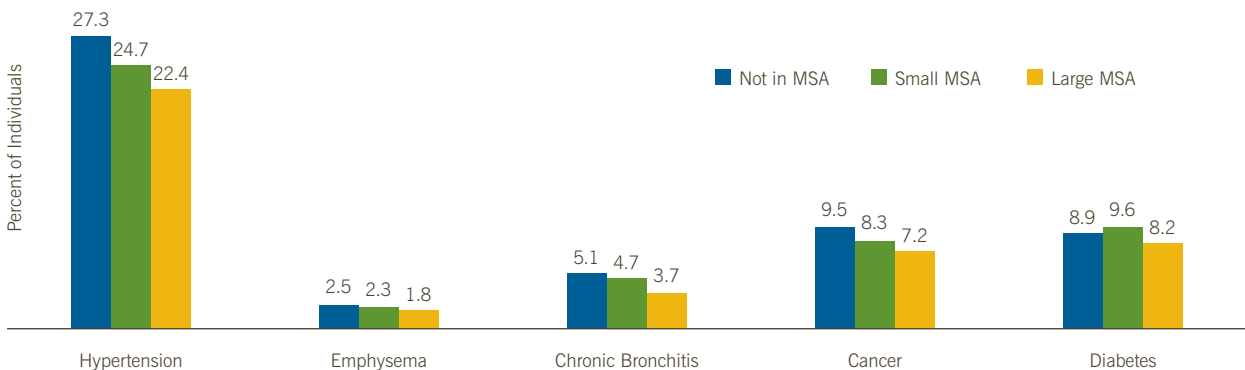
Chart 2: Percent of Population in Poverty,* 2009



Source: U.S. Census Bureau. American Community Survey Estimates and Current Population Survey Annual Social and Economic Supplement (CPS ASEC), 2009. Access at <http://www.census.gov/cps/>.
 * Poverty defined as <100% FPL.
 Note: MSA is metropolitan statistical area.

Chronic diseases are more common in rural areas.

Chart 3: Age-adjusted Percentage of Individuals with Select Chronic Conditions, 2009



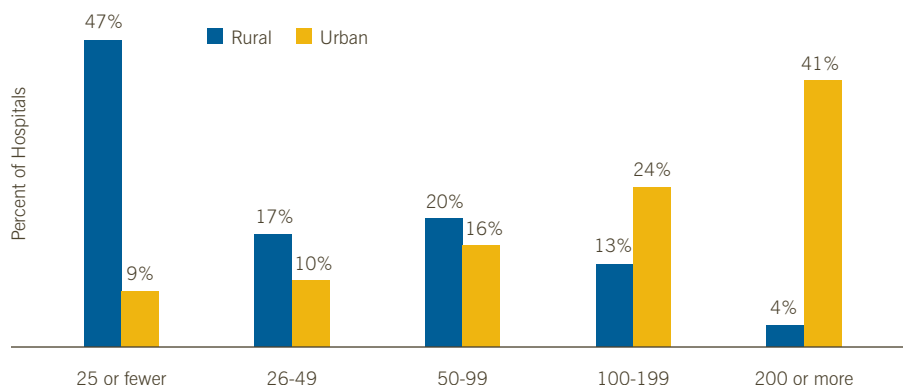
Source: Centers for Disease Control and Prevention. (2009). Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009. Access at http://www.cdc.gov/nchs/data/series/sr_10/sr10_249.pdf.
 Note: MSA is metropolitan statistical area. Large MSAs have a population of 1 million or more; small MSAs have a population of less than 1 million.

Smaller Size, Different Service and Patient Mix Create Financial Stress for Rural Hospitals

Rural hospitals typically are much smaller than their urban and suburban counterparts; nearly half have 25 or fewer beds. Although rural hospitals make up half of all hospitals, they only represent about 12 percent of spending on hospital care.¹⁵ Despite a smaller size and smaller base of patients to draw from, rural hospitals still have to maintain a broad range of basic services to meet the health care needs of their communities. But with fewer patients over which to spread fixed expenses, costs per case tend to be higher. Smaller size also translates into a financial position that is much less predictable, complicating long-range financial forecasting and contingency planning.

Rural hospitals tend to be smaller than their urban counterparts.

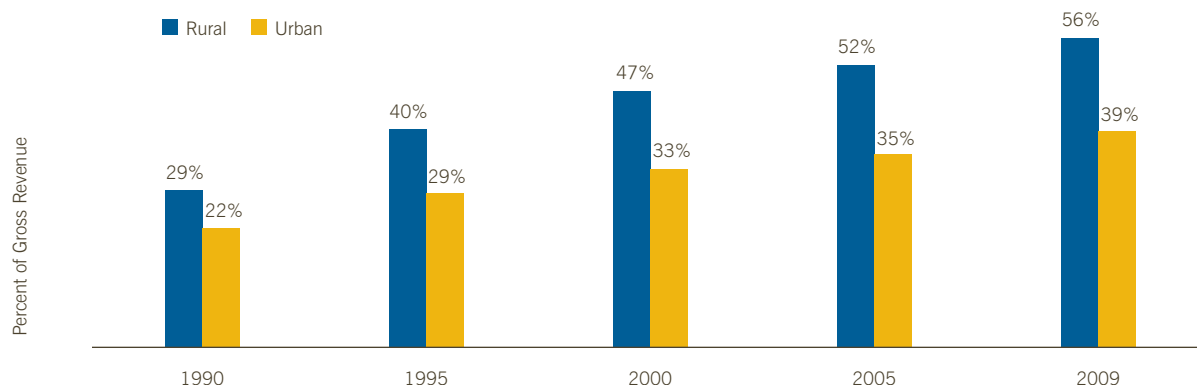
Chart 4: Percent of Hospitals by Bed Size, Urban vs. Rural, 2009



Source: AHA analysis of *Health Forum*, 2009. AHA Annual Survey of Hospitals.
 Note: Includes only beds in hospital units.

Rural hospitals have seen a more dramatic shift of care to the outpatient setting...

Chart 5: Outpatient as a Percent of Total Gross Revenue, Urban vs. Rural Hospitals, 1990 - 2009



Source: AHA analysis of *Health Forum*, 2009. AHA Annual Survey of Hospitals.

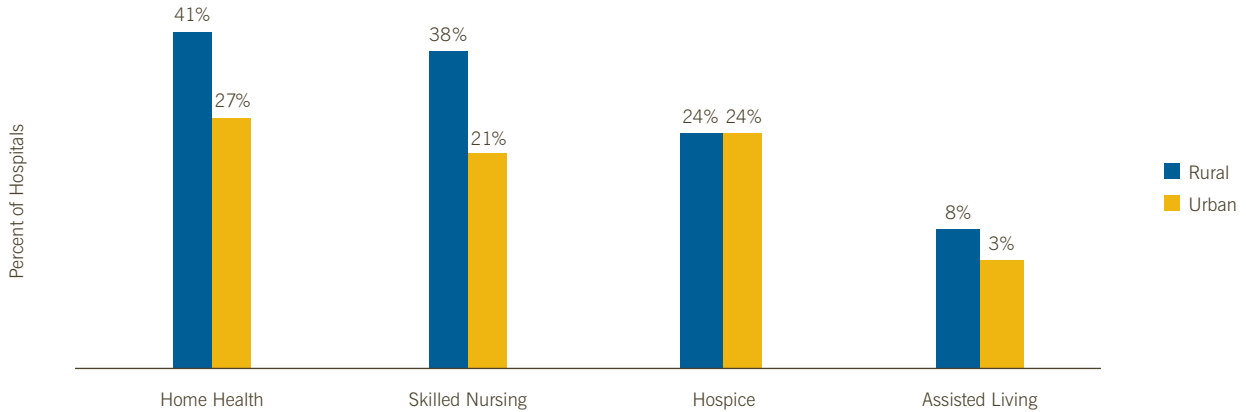
“ ”
from the field

“You don’t have the volumes. You still have to provide the same quality. You still have to buy the same equipment. You don’t have the economy of scale on the equipment, so your overhead is more and your reimbursements are less.”¹⁶

Dr. Wendell Smith, practicing physician at Virginia Regional Medical Center, Duluth, MN

...and are more likely to offer home health, skilled nursing and assisted living.

Chart 6: Percentage of Hospitals Offering “Non-hospital” Services, by Location, 2009



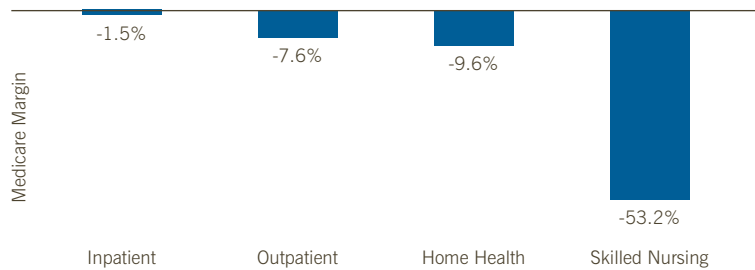
Source: Avalere Health analysis of *Health Forum*, 2009. AHA Annual Survey of Hospitals. Based on 4,086 community hospitals responding to these questions.

Rural hospitals have seen a dramatic shift from inpatient to outpatient care as technology and practice patterns have changed and specialized inpatient services have remained concentrated in urban areas. Since rural hospitals are often the sole site for patient care in the community, they also are more likely to offer additional services that otherwise would not be accessible to residents. For example, many rural hospitals provide hospice, home health services, skilled nursing, adult day care, and assisted living. Often, rural hospitals step in to offer these services out of a sense of community responsibility, as stand-alone providers may have trouble keeping their doors open in low-volume, isolated areas of the country. In the Medicare program, outpatient and post-acute care services have significantly lower margins adding to the financial challenges facing rural hospitals.

Many rural hospitals support broader social needs through subsidized programs such as meal delivery services and community health education. They also often enhance local health system

Medicare payment shortfalls are even greater for outpatient, home health and skilled nursing.

Chart 7: Medicare Margins by Service for Rural Hospitals Subject to Inpatient Prospective Payment, 2009



Source: Vaida Health Data Consultants analysis of Centers for Medicare and Medicaid Services, HCRIS Database, September 30, 2010 Update. Uses Medicare cost accounting rules to determine allowable costs. Full assignment of costs using generally accepted accounting principles would result in lower margins.

capacity by providing financial or other support to local primary care providers, rural health clinics, long-term care facilities, mental health services and emergency medical services.¹⁷

The older age mix of the population in combination with the greater poverty levels in rural areas make rural hospitals highly dependent on public programs.¹⁸ With nearly 60 percent of

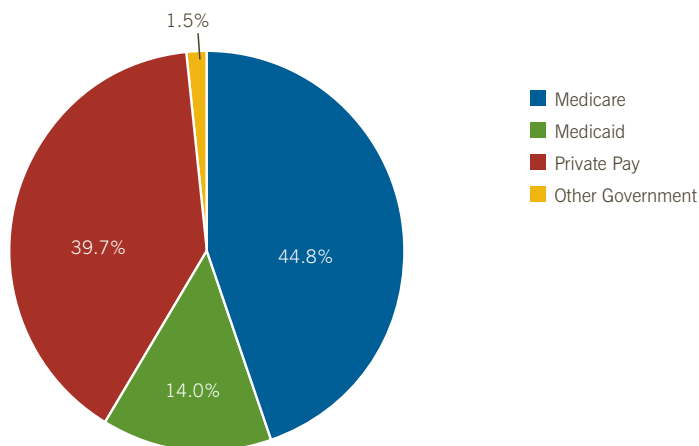
rural hospital gross revenues coming from Medicare and Medicaid, rural hospitals are particularly vulnerable to policy changes.¹⁹ Currently, Medicare and Medicaid fail to cover the cost of care and the shortfall has grown over the past decade. Insufficient Medicare and Medicaid reimbursement is compounded by the problem of the uninsured in rural communities. When

rural employers – many of them small or family businesses – do not provide health insurance, hospitals must absorb the costs of treating these patients. Many either make too much money to qualify for government assistance or are ineligible for government health care programs, often due to their undocumented status.

Together these challenges – small size, service mix, dependence on public programs and high numbers of uninsured – make small and rural hospitals less able to weather financial fluctuations. For example, the recent economic downturn hit rural hospitals particularly hard due to declining revenues and increased uncompensated care, leading some to cut services, slow hiring or even to lay off staff.

Nearly sixty percent of rural hospital revenues come from public programs...

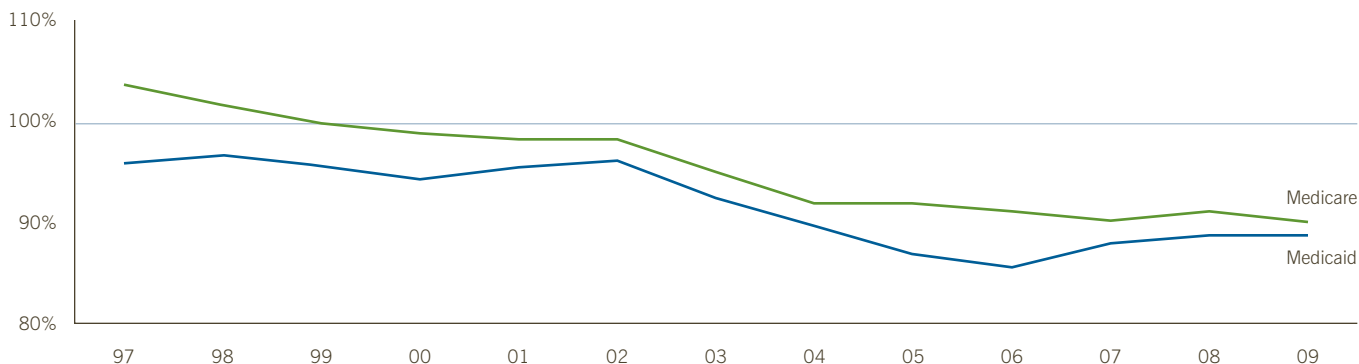
Chart 8: Percent of Gross Revenue by Payer Type for Rural Hospitals, 2009



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2009.

...whose payments fall short of costs.

Chart 9: Aggregate Hospital Payment-to-cost Ratios for Medicare and Medicaid, 1997 – 2009



Source: AHA analysis of American Hospital Association Annual Survey data, 1997-2009, for community hospitals.
 *Costs reflect a cap of 1.0 on the cost-to-charge ratio.



“Seventy-five percent of my patients are public, that is Medicare and Medicaid, another 5 percent are uninsured, I have nowhere to shift costs.”²⁰

Joann Anderson, President and CEO, Southeastern Regional Medical Center, Lumberton, NC

Special Medicare Programs and Payment Enhancements Have Helped to Stabilize Rural Hospitals

Recognizing the dependence on Medicare and other special challenges faced by rural hospitals, Congress created the Critical Access Hospital (CAH) program in 1997 to preserve access to health care for rural beneficiaries. Today, the CAH program allows the smallest rural hospitals to receive Medicare reimbursement at 101 percent of allowable costs, up from 100 percent of costs when the program was initiated. As of September 2010, more than half of all rural hospitals – 1,325 hospitals – had converted to CAH status.²¹ Other types of rural hospitals that receive an adjusted Medicare payment include sole community hospitals, Medicare-dependent hospitals and rural referral centers. The rest – about 13 percent of rural hospitals – have no special designation and are

paid under Medicare’s standard inpatient and outpatient prospective payment systems (PPS).

A recent study examined the financial performance of the special classes of rural hospitals compared to those receiving PPS payments and found that CAHs are under the most financial pressure.²² CAH status is sometimes perceived as being the ideal solution to help rural hospitals’ financial situations. However, the findings of this study suggest that while cost-based reimbursement does help hospitals increase revenue, it does not fully address all of the financial challenges rural hospitals face.

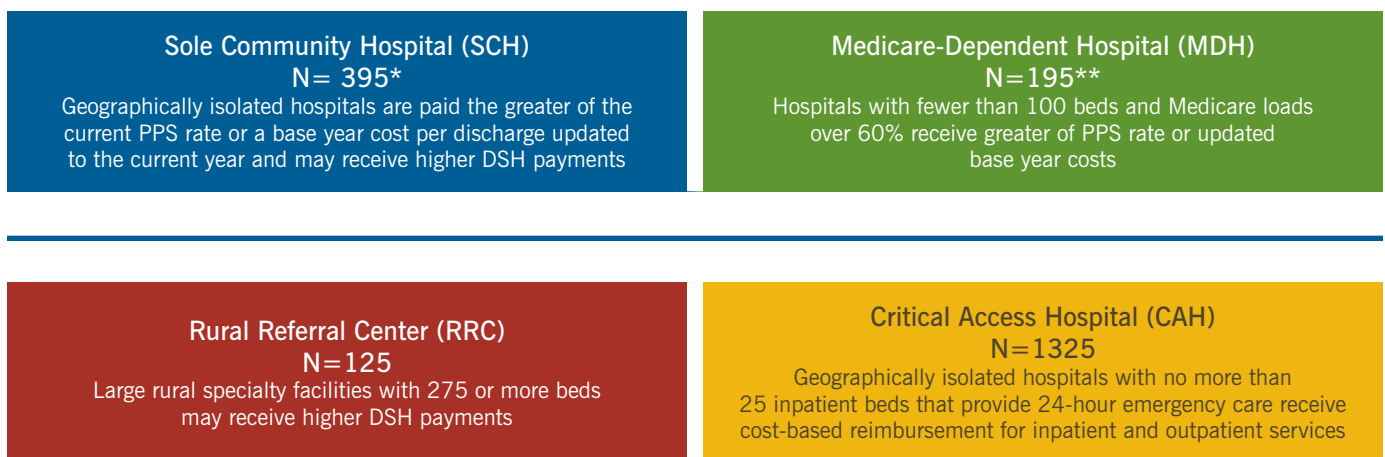
Prior to the passage of the ACA, Congress had taken other steps to raise Medicare reimbursement for designated rural hospitals, many of which

expired or were set to expire. The ACA, and most recently the *Medicare and Medicaid Extenders Act of 2010* (MMEA), extend a number of those Medicare payment provisions, including the outpatient hold harmless provision for small rural hospitals, reasonable cost payments for clinical diagnostic lab services for select rural hospitals, and the Medicare-dependent Hospital program. The ACA also expands the definition of “low-volume hospital” for fiscal years (FY) 2011 and 2012, which increases the number of rural hospitals eligible for payment adjustments under Medicare’s PPS.

Beyond hospitals, the ACA aims to bolster access to care in rural areas by improving payment rates for physicians. Medicare bonus payments are available

Special programs aim to help rural hospitals.

Chart 10: Medicare Programs for Rural Hospitals and Number of Hospitals, by Program Type



Sources: CMS final FY2011 Inpatient PPS Payment Impact file (for all designations except CAH). All figures exclude any urban hospitals that may have these classifications; American Hospital Association. (2002). *Challenges Facing Rural Hospitals*. Washington, DC.

Note: DSH is Disproportionate Share Hospital.

* Includes Sole Community Hospital/Rural Referral Centers (SCH/RRC).

** Includes Medicare-Dependent Hospital/Rural Referral Centers (MDH/RRC).

to primary care physicians, qualifying practitioners and general surgeons practicing in health professional shortage areas (HPSA) beginning January 1, 2011, for a period of five years. To qualify, 60 percent of the provider's Medicare claims must be for primary care services. Yet, some rural family practice physicians may have difficulty reaching this threshold, as they are more likely to provide non-primary care services because of the scarcity of specialists in rural areas.²³

In addition, the ACA charges the Medicare Payment Advisory Commission (MedPAC) with reporting to Congress on the adequacy of Medicare payments to rural health providers. MedPAC's study, which is expected to be delivered to Congress by June 2012, will evaluate several aspects of rural health care, including access to services, adequacy of payments to providers and suppliers,

Critical access hospitals serve patients in the vast majority of states.

Chart 11: Location of Critical Access Hospitals Nationwide, 2009



Source: Department of Health and Human Services. (2009) Critical Access Hospitals. Rural Assistance Center. Baltimore, MD: Centers for Medicare & Medicaid Services. Access at http://www.raconline.org/maps/#map_cah.

and the quality of care provided in rural areas.

Enhanced payments across the spectrum of rural health care – from primary care physicians to hospitals

to ambulance services – encourage providers to remain in practice in rural areas, helping to preserve and protect access to health care in these communities.

Insufficient Access to Capital Hinders Investment in Technology and Facilities

Rural hospitals' ability to meet patients' needs also hinges upon their access to capital to renovate or replace aged facilities, acquire new technologies, modernize equipment and improve operational effectiveness. Yet many rural hospitals have trouble gaining sufficient capital for these ongoing improvements.²⁴ As of 2004, almost

half of CAHs were operating in facilities more than 40 years old.²⁵

These capital constraints hamper rural hospitals' adoption of health information technology (IT), seen as a key enabler to improving the quality, safety and efficiency of health care.²⁶ Studies have shown that rural hospitals, including CAHs, lag behind urban

<3%

Percent of CAHs utilizing EHRs with CPOE capabilities

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from the field

“Our costs are significantly higher than allowed costs. It costs a lot of money to bring a doctor into the community and get them established. Those costs are not covered under CAH reimbursement.”²⁷

Jon Smiley, CEO, Sunnyside Community Hospital, Sunnyside, WA

hospitals in health IT use.²⁸ Tools like electronic health records (EHR) with computerized provider order entry (CPOE) capability – which allow for the electronic capture and sharing of patient information – are not widely used in rural hospitals. As of 2008, less than 3 percent of CAHs were utilizing an EHR with CPOE capabilities.²⁹

Recognizing the benefits and challenges associated with greater use of EHRs, Congress included in the *American Recovery and Reinvestment Act of 2009* (ARRA) measures and funding to support the widespread adoption and

“meaningful use”³⁰ of health IT. However, the law and regulations fall short of providing the kind of help small rural hospitals need to achieve meaningful use.

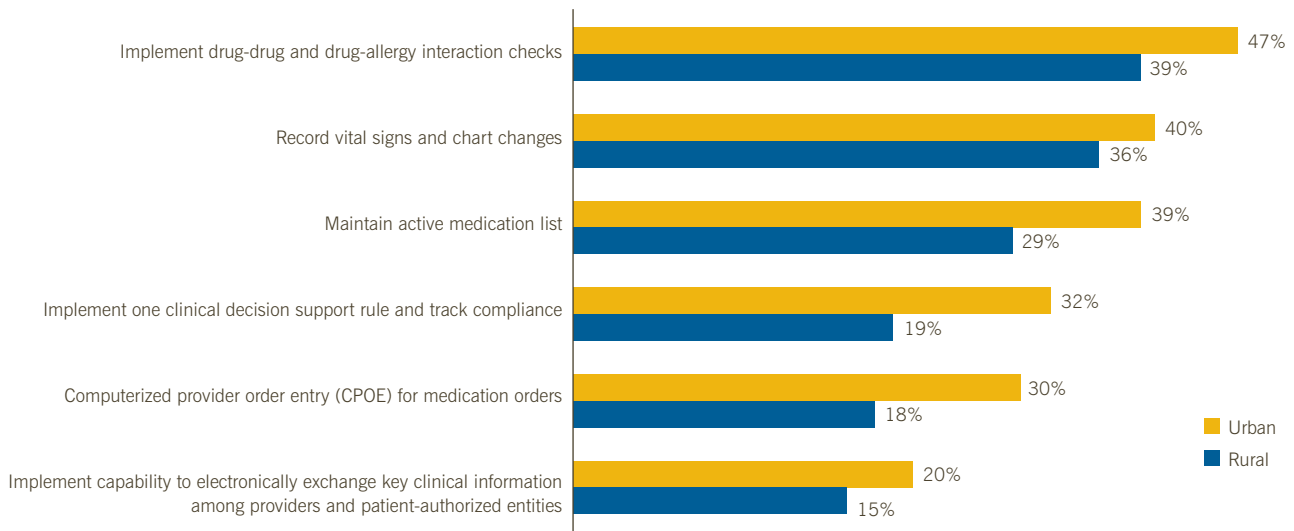
For CAHs, the ARRA incentives cover only part of the cost of software and hardware, not the installation, technical or support services which at two to three times the cost of the equipment can be too much to bear.³¹ For many other small, rural hospitals with modest annual revenues, the meaningful use criteria are out of reach. To date, less than 1 percent of rural hospitals have adopted EHR systems

that would meet the meaningful use requirements with certified systems.³²

Adding to ARRA implementation challenges, rural areas often lack the necessary IT professionals, particularly those that understand health care. Yet, ARRA’s ambitious goals must be met in a short time frame. Hospitals that do not achieve meaningful use by FY 2015 will incur a financial penalty in their Medicare payments.³³ These financial penalties are expected to affect rural hospitals disproportionately as they are less likely to have the staff or financial capacity to meet these timelines.

Rural hospitals are making progress in meeting meaningful use objectives but lag urban providers for many functions.

Chart 12: Percent of Hospitals Reporting They Can Meet Each Meaningful Use Core Objective and Have Certified EHR Technology



Source: AHA analysis of survey data from 1,297 non-federal, short-term acute care hospitals collected in January 2011.

“ ”
from the field

“The challenge is affordability. Scarce resources and declining reimbursement put [health information] technology and support out of reach in the timeframe as outlined. Even if a hospital or its medical staff have the financial resources to obtain the technology, the ability to support and upgrade over time may be cost prohibitive.”³⁴

Billy Watkins, Chief Administrative Officer, Bluffton Hospital, Bluffton, OH

Some rural hospitals have formed strategic alliances with metropolitan or other rural hospitals across a region. These partnerships allow hospitals to

broaden their service offerings and improve quality by leveraging shared resources, such as for implementation of advanced IT systems. Many

of these partnerships use technology such as telehealth and telepharmacy to provide services not otherwise available locally.

Rural IT Case Study: Othello Community Hospital

Othello Community Hospital is a CAH serving the nearly 400 square mile area that encompasses Adams, Grant and Franklin counties in eastern Washington state. Although Othello is characterized by many of the same qualities that make it difficult for other small rural hospitals to implement and utilize health IT, this stand-alone facility has become a leader in this area and continues to expand its use of advanced IT resources.

Othello joined the Inland Northwest Health Services (INHS) network 12 years ago, a regional collaborative that helps hospitals acquire IT capabilities. Upon joining the network, Othello

was able to leverage its membership to receive a basic IT system with general billing, accounting and payroll functions at a fraction of the cost of purchasing a system on its own. The hospital's medical and administrative staff saw the positive impact the IT system had on the facility's business operations and championed the expansion of IT into clinical areas.

Othello continued to roll out IT across the hospital, introducing CPOE, a telepharmacy program, and telemedicine capability. Along with other INHS-member hospitals in eastern Washington and Idaho, Othello created a master patient index to ensure continuity and

limit duplication of patient care. The index allows clinicians to see what tests and procedures have already been performed on patients who move among participating INHS hospitals.

However, even with its success and the availability of ARRA incentive dollars to push its EHR capabilities further, Othello recently put off upgrading to new software. Administrator Harry Geller cited one reason for the delay is that ARRA incentive payments would not have covered the approximately \$900,000 Othello would have to spend on the IT software installation.³⁵

Expanding Insurance Coverage Will Put New Demands on Rural Hospitals

The Congressional Budget Office estimates 32 million people will be newly insured by 2019 as a result of coverage expansions in the ACA—16 million by Medicaid and 16 million in private health insurance. Nationwide, 94 percent of people are expected to have health coverage.³⁶ Rural areas should see large gains in coverage due to their disproportionate share of uninsured and near-poor residents.

Coverage expansions are expected to have a larger impact on rural populations because the rate of uninsured Americans in rural areas exceeds that of urban areas.³⁷ Eighty percent of uninsured individuals in rural areas are

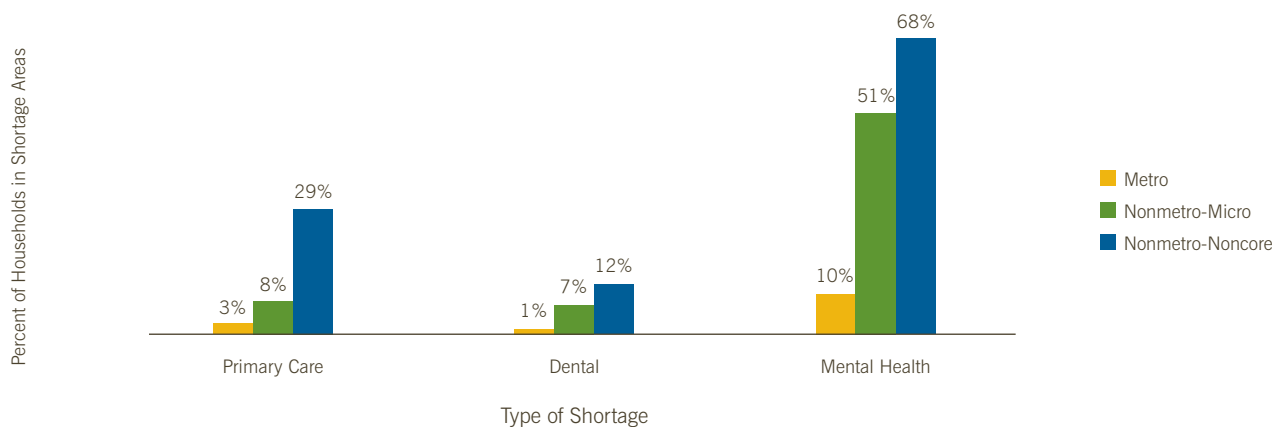
employed, likely due to the prevalence of small businesses and self-employed individuals. These groups currently face difficulty finding affordable, adequate health insurance due to few plan choices and generally higher premiums³⁸ and, as such, are likely to benefit from provisions of the ACA. These include tax credits for small businesses, state-run health benefit exchanges that will offer new marketplaces through which individuals and small businesses can purchase private, commercial coverage, and new insurance market requirements including community rating rules and guaranteed issuance of policies. Other provisions will help the many near-poor residents of

rural areas, including the requirement for states to expand Medicaid eligibility to all individuals under age 65 with incomes up to 133 percent of the federal poverty level (FPL) and premium subsidies for lower-income individuals.

While expanded coverage will reduce uncompensated care, many rural hospitals will have to make up-front investments in order to handle the influx of new patients, which may include helping patients enroll in available programs. Even then, many of the newly insured in rural areas will be covered under Medicaid, which pays hospitals much less than the cost of providing care.

Health professional shortages are more common in remote areas.

Chart 14: Percent of Households in Health Care Professional Shortage Areas, by Type of Shortage



Source: U.S. Department of Agriculture. (2009). *Amber Waves*. Washington, DC: USDA Economic Research Service. Calculations based on the 2004 data from the Area Resource File, National Center for Health Statistics. Note: Among nonmetro counties, micropolitan counties are centered on urban clusters with populations between 10,000 and 50,000, and noncore counties have no nearby urban clusters with a population of 10,000 or more.

rheumatologists, pediatricians, obstetricians/gynecologists, psychiatrists and general internists are in particularly short supply in rural areas.⁴⁵

The ACA bolsters several programs focused on loan repayment and training opportunities to help alleviate the rural hospital workforce shortage, particularly in the area of primary care. Beginning in 2011, \$1.5 billion is available for the National Health Service Corps for scholarships and loan repayment for primary care practitioners who work in HPSAs.⁴⁶ The funding expansion means that nearly 11,000 physicians will be able to participate in the program, giving care to more than 11 million people, an amount triple the program's reach in 2008.⁴⁷

The law also enhances graduate medical education (GME) by redistributing unused residency slots under the Medicare GME program, optimizing the national capacity for health care provider training and prioritizing the redistribution of slots to rural training tracks.⁴⁸ In addition, the ACA creates a Teaching Health Center Graduate Medical Education program which will provide funding for community-based ambulatory patient centers that operate a primary care residency program.⁴⁹

While these provisions begin to fill the gap in the rural health care workforce, the ACA fell short of truly addressing the shortage of rural health care professionals. First, because few teaching hospitals are located in

rural areas, the redistribution of unused slots has limited benefit in increasing the primary care workforce in rural areas. Second, the lag between the start of these programs and their eventual benefit is significant, likely extending far beyond 2014. Finally, most funding is aimed either at physicians in training or those beginning their careers. Programs to retain the existing workforce in rural areas are absent from health reform.

With the expected uptake of health insurance coverage, the already overextended rural health care workforce will struggle even more to meet the needs of people living in their communities as they wait for the workforce provisions to have an impact.

“ ”
from the field

“Recruiting and retaining talented physicians, providers, nurses, ancillary professionals, and other positions is the single biggest challenge in ensuring a competent and quality delivery service in a rural community.”⁴³

James Diegel, president and CEO, St. Charles Health System Inc., Bend, OR

Case Study: University of Washington's WWAMI Program

The WWAMI Program – named for the participating states of Washington, Wyoming, Alaska, Montana and Idaho – was created in 1971 by the University of Washington (UW) as a means to address the national health care workforce shortage by providing access to publicly-supported medical education across a five-state region. WWAMI not only focuses on medical students, but on students in K-12, undergraduates, clinical residents and physicians in community practice.

Each of the program's participating states specifies a number of medical

school seats that are supported through both appropriated state funds and student tuition. The tuition paid by students in Wyoming, Alaska, Montana and Idaho is the same as that paid by residents of Washington State, allowing for medical education in states where no freestanding medical school exists.

In addition to making medical education accessible to rural American students, the UW and the WWAMI Program played a role in developing community-based training programs that target areas of need in rural locations, such as family medicine, women's

health care and general surgery. Rural telemedicine capabilities also were developed by the WWAMI program, which began using the technology to consult with patients located in remote regions in 1975.

Over the last 30 years, more than 60 percent of WWAMI graduates have stayed within the five-state area to practice medicine, and over the last 50 years, nearly half of all graduating students have chosen to practice in the field of primary care. It is estimated that about 20 percent of all WWAMI graduates will practice in HPSAs upon receiving their degree.⁵⁰

Delivery System Reform Requires Flexibility for Rural Hospitals' Unique Circumstances

Like their urban and suburban counterparts, rural hospitals are eager to explore new ways to improve care and reduce costs. The ACA creates a variety of programs and demonstration projects to test new payment and delivery methods. Health IT, clinical integration, assumption of risk by providers and the opportunity to share in savings attributable to quality improvements are central to the design of many of these new models. And while rural hospitals want to engage in these new initiatives, rural hospitals' special circumstances – small size, limited number of community-based

physician partners, and scarce financial resources – may hinder participation absent special accommodations.

The ACA introduces a new delivery model for Medicare known as the accountable care organization (ACO). Beginning in 2012, hospitals may elect to form an ACO in partnership with other providers and facilities who agree to align incentives to improve health care quality and slow cost growth.⁵¹ ACO participating providers will share in Medicare savings resulting from cost reduction and achievement of certain quality targets.⁵²

The ACA also prompts a five-year pilot program on payment bundling beginning in FY 2013.⁵³ Payment for multiple providers involved in a patient's episode of care will be bundled into a single, comprehensive sum that covers all of the services.⁵⁴ Hospitals, physician groups, skilled-nursing facilities and home health agencies may be involved in the pilot, which aims to improve the coordination, quality and efficiency of services associated with a hospitalization.

The ACA promotes quality and patient safety through a new value-

“ ”
from the field

“We don't have the numbers. The Centers for Medicare & Medicaid Services is saying you have to have a pool of at least 5,000 people to start an ACO for Medicare. We may have half that many in the whole county.”⁵⁶

Dennis George, chief executive officer, Coffey Health System, Burlington, KS

based purchasing (VBP) program that will tie Medicare hospital payment to performance on clinical process and outcome measures beginning in FY 2013.⁵⁵ However many rural hospitals will likely be excluded from this program due to an insufficient number of patients. Additionally, different measures may be more appropriate for rural hospitals (e.g., time to transfer). To address this issue, by 2012, the Centers for Medicare & Medicaid Services (CMS) must develop two demonstration projects to test VBP models for

CAHs and other small hospitals that do not qualify for the VBP program. These demonstrations will give small rural hospitals an opportunity to explore how quality and payment could be linked in their unique circumstances.

These new delivery and payment models hold promise to improve quality and reduce costs. Many rural hospitals are already integrated with hospital, nursing home and physician services on the same campus and frequently under the same ownership as well. Even so, small rural hospitals

may be inadvertently excluded from these programs. Most free-standing rural hospitals will be unable to independently meet the minimum 5,000 patient threshold for an ACO required by statute, and many will not have the staff capacity, data analytics capabilities, strong balance sheet and access to capital to manage bundled payments. The small volume of patients treated in many small and rural hospitals also will make it difficult to separate real changes in quality and cost from random variation.

Case Study: The Frontier Community Health Integration Project

In August 2010, the Montana Health Research & Education Foundation (MHREF), a non-profit division of the MHA...An Association of Montana Health Care Providers, received a \$750,000, 18-month grant from HRSA to participate in the Frontier Community Health Integration Project, also known as F-CHIP.

F-CHIP was authorized by the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) to develop and test new models for delivering health care services in frontier areas by improving access to, and integration of, care delivered to Medicare beneficiaries. Recognizing the challenges associated with providing care in geographically isolated areas of the country characterized by extremely low patient volumes, the demonstration will focus on increasing access to care, improving quality of care, streamlining regulatory issues and ensuring adequacy of Medicare and

Medicaid payment for such services as acute care, outpatient care, home health care and long-term care in the frontier setting.

MHREF has partnered with the Montana Office of Rural Health and nine Montana CAHs under F-CHIP. The hospitals – Dahl Memorial Healthcare, Granite County Medical Center, Liberty Medical Center, McCone County Health Center, Pioneer Medical Center, Prairie Community Hospital, Roosevelt Medical Center, Ruby Valley Hospital and Rosebud Health Care Center – have committed to participate in monthly video conference meetings with the Project Director and MHREF staff to drive the F-CHIP project, and to form working subgroups on quality, payment and regulatory issues. The information collected through these subgroups will be used to develop a model delivery system designed specifically for small rural and frontier hospitals.

Early work on the F-CHIP has identified key regulatory and payment barriers facing frontier providers. For example, the cap on the number of swing beds allowed in CAH settings is often problematic for isolated rural hospitals as the demand for their services is hard to predict. In addition, the cumbersome, often duplicative sets of regulations, licenses and surveys required of all hospitals are particularly burdensome for rural hospitals that have limited resources. Early work also has led to a broad outline of a new frontier delivery and payment model, which will likely incorporate elements of a patient-centered medical home. The F-CHIP project hopes to have the framework of a new frontier community health organization model ready for review by HRSA/Office of Rural Health Policy (ORHP) and available to inform CMS in the development and demonstration of this new frontier CAH model by the late summer or early fall of 2011.⁵⁷

Conclusion

Rural hospitals are a vital yet vulnerable component of the American health care system. These institutions will play an especially important role as rural Americans grow older and gain insur-

ance coverage as a result of the reform law, and as new delivery systems are tested in the coming years. For those provisions to meet the unique needs of rural America, rural hospitals must

remain a focus of lawmakers. Many of the ACA provisions can be made to work for rural hospitals through the development of thoughtfully crafted guidance and regulation.

POLICY QUESTIONS

- How can the federal government and states work to support innovations in care delivery and care organization in rural areas?
- What additional workforce efforts will help rural hospitals recruit and retain the staff they need to remain vibrant sources of patient care and economic engines for their communities?
- What types of support might rural hospitals need to provide quality care for the many newly insured individuals who will be covered as a result of ACA?
- How can payment systems be improved to meet the special needs of rural hospitals?
- What can be done to ensure that the special needs of rural hospitals are acknowledged and accounted for in the development of key ACA programs such as ACOs and VBP?

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