National Rural Health Association Policy Brief

Medicare Reimbursement in Rural America

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I. Introduction

Medicare is a federal health insurance program that is focused on assisting people who are 65 years-old, as well as certain younger people with disabilities, meet their healthcare costs and needs. Medicare is a significant investment for Americans, as it accounts for roughly 18% of federal spending.[1] Medicare reimbursement is a crucial element in rural healthcare viability and growth.

According to the America Hospital Association in 2017, Medicare and Medicaid made up 56 percent of rural hospitals' net revenue.[2] However, the current Medicare reimbursement structure does not allow for adequate coverage for Medicare beneficiaries. For example, critical access hospitals (CAHs) are reimbursed at 101% of allowable costs in the current fee-for-service model. Considering the effects of sequestration, services not included in the 101% Medicare reimbursement model, and the impact of state Medicaid policies, many CAHs have negative margins treating Medicare and Medicaid patients. Additionally, the Medicare Payment Advisory Commission found in its March 2020 report to Congress that rural hospitals' (excluding CAHs) Medicare margin was -6.6 percent.[3]

The Centers for Medicare & Medicaid Services (CMS), in response to the current rural hospital closure crisis, has taken numerous steps to increase opportunities for improved reimbursement. CMS has worked to take into account unique needs of rural communities with alternative payment models and value-based payment arrangements.[4] In addition, CMS has started to work on different technologies to increase the access and adaptability of services for rural patients.[4] Conceptually, these reforms offer incentives and potential revenue sources. However, financially-strapped rural organizations often do not have resources, both in staffing and IT infrastructure, to meet the operational and regulatory requirements of these alternative payment models. To spark true, meaningful payment reform for struggling rural hospitals, a change needs to occur at the most basic level: how hospitals receive reimbursement for services rendered.

II. Discussion

To arrive at the crux of the rural healthcare reimbursement issue, "rural" and "urban" need to be differentiated. Inherently, rural means fewer people and resources across wider geographic service areas. To complicate matters, rural populations exhibit poorer health and higher mortality. Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their

urban counterparts.[5] Healthcare delivery in rural settings is complicated by a reimbursement model that rewards quantity over quality, and where viability means clinging to very narrow operating margins. Medicare reimbursement, the leading revenue source for rural hospitals, must adequately support the work of healthcare organizations in rural America.

One of the most glaring differences from the days of rural healthcare growth, to today's decline, is the shifting away from investments in rural health infrastructure. Unlike the days of Hill-Burton, federal healthcare dollars have focused principally on providing health insurance to needy people.[6] As a consequence, healthcare organizations are forced to rely on high-volume/low value strategies to remain viable. Due to lower populations, rural hospitals are inherently disadvantaged.

Rural healthcare organizations must provide primary care and around-the-clock emergency and inpatient services for their communities, which necessitates minimum staffing and equipment requirements. These basic costs of doing business are more difficult to sustain by the inherently sporadic and/or lower volumes of patients served at rural organizations.

Some rural hospitals are able to achieve positive margins that may offset the basic costs of doing business in a low-volume environment. However, revenue margins may be too small to allow for investments in growth, infrastructure, physician and staff recruitment, or improvements in care quality. Furthermore, low operating margins do not allow for the preparation and response to cyber threats, the ongoing opioid epidemic, or the world-wide COVID-19 pandemic.

As healthcare transitions from fee-for-service to value-based care reimbursement models, rural healthcare organizations are being pushed to provide services that create higher value for their patients. These services, including diabetes self-management, community health workers, and integrated behavioral health for example, come with high startup and sustainability costs. Addressing social determinants of health requires numerous internal resources and capabilities. Rural organizations that operate at razor-thin, often negative margins, assume a significantly higher amount of risk when starting these programs.

Promoting viability in rural healthcare is a seemingly unattainable prospect when survival depends on increasing patient volumes and high throughput. Rural healthcare disparities are insurmountable when quality and patient-centered outcomes take a backseat to patient quotas. Additionally, investments solely in health insurance, as opposed to health insurance and infrastructure, disproportionately favor higher populations. True, the current model may be equal, but it is not equitable, and rural hospitals and communities are paying the price.

III. Recommendations - Addressing the crux of Medicare reimbursement gaps

- Ensure equitable reimbursement by Medicare for basic services provided by rural healthcare organizations. Future research should be designed to help overcome structural urbanism[6] by setting reimbursement rates based on the cost to rural healthcare organizations of providing care in rural settings.

- Address reimbursement models in the fee-for-service environment to accommodate for rural, low-volume facilities, but promote high value for patients.

- Encourage and promote investments in infrastructure, the expansion of existing services, and the adoption of new programs in rural areas. An emphasis should be placed on those service lines that facilitate the transition to value-based care.

IV. Other Considerations - There are many initiatives that are designed to augment rural healthcare sustainability that could be addressed in future policy briefs. These may include, but are not limited to, the following:

- Enhance the Medicare reimbursement safety net by increasing bad debt reimbursement rates and stopping sequestration.

- Continue/make permanent legislation that supports rural hospitals, such as the Medicare Dependent Hospital (MDH), Sole Community Hospitals (SCH), and Low-Volume Hospital (LVH) programs.

- Assist rural healthcare organizations, state entities, and payers with education and resources that encourage the adoption and successful implementation of alternative payment models in rural areas:
    i. Global budgets
    ii. ACOs (Rural ACO Improvement Act (S. 2648))
    iii. Merit-based Incentive Payment Systems
    iv. Advanced Alternative Payment Models

- Allow Medicare to make adjustment increases to the Physician Fee Schedule without being held to budget neutrality requirements.

- Support rural organizations as they transition to value-based care by promoting population health initiatives such as addressing social

determinants of health, and implementing chronic care management and behavioral health programs.

- Continue to evaluate wage index disparities among rural hospitals.
- Continue to promote and support the adoption of telehealth programs and technologies.
- Support healthcare organizations that provide care in rural and frontier regions that have large service areas (mobile clinics, connectivity, communications, mileage, etc.)

Reference List

1. Peter G. Peterson Foundation. (2020, July 29). Budget Basics: Medicare. Retrieved September 08, 2020, from https://www.pgpf.org/budget-basics/medicare

2. American Hospital Association (2019). *Challenges facing rural communities and the roadmap to ensure local access to high-quality, affordable care.* Retrieved from https://www.aha.org/system/files/2019-02/rural-report-2019.pdf

3. MEDPAC. (2020). March 2020 Report to the Congress: Medicare Payment Policy. Retrieved from http://www.medpac.gov/-documents-/reports

4. Verma, S. (2019, November 21). *Rural health at CMS: what's been done and what's to come.* Retrieved September 08, 2020, from https://www.cms.gov/blog/rural-health-cms-whats-been-done-and-whats-come

5. CDC.gov (2020). Retrieved from https://www.cdc.gov/ruralhealth/about.html

6. Probst, J., Eberth, J.M., Crouch, E. (2019). *Structural urbanism contributes to poorer health outcomes for rural America.* Health Affairs.