

**Rural Hospitals' Ability to Finance
Inpatient, Skilled Nursing and Home Health Care**

Working Paper Series

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 dealt a severe financial blow to most rural hospitals by reducing Medicare payments for inpatient, outpatient, skilled nursing care, and home health care. We selected a random sample of 448 rural hospitals to investigate how rural hospitals are restructuring their operations in response to the BBA. The objective is to determine if rural hospitals have closed, raised prices, or ceased offering certain services as strategic responses to the BBA. This is the first survey to focus specifically on rural hospitals' strategic responses to the BBA.

The most popular strategy for small rural hospitals is to convert to Critical Access Hospital status. Small hospitals that agree to a limit of 15 acute care patients can usually be declared a Critical Access Hospital and obtain cost-based reimbursement for inpatient and outpatient care. Nineteen percent of the hospitals surveyed converted or are in the process of converting to Critical Access Status, and another 16% are considering a conversion. For the 35% of rural hospitals that have converted or are considering a conversion to Critical Access Hospital status, the BBA may have a positive impact on their financial stability. Large and mid-sized hospitals do not have the option of conversion and were forced to absorb BBA payment cuts.

The reductions in Medicare payments for SNF and home health care have forced the closure of some rural hospitals' post-acute care services. Thirteen percent of rural hospitals that operated a home health agency in 1997 closed their home health agency by October 2000. Fourteen percent of hospitals that operated a skilled nursing facility in October 1997 closed their facility by October 2000.

Fortunately for rural patients, the financial strains experienced by rural hospitals have not caused a major reduction in patients' access to care. Among the 448 rural hospitals that were randomly selected from the population of hospitals that were operating in 1997, none were permanently closed between October 1997 and October 2000. Given this finding and comments by survey respondents, it appears that the Critical Access Hospital provision of the BBA is preventing hospital closures.

It also appears that the vast majority of rural patients still have access to one or more skilled nursing facilities and one or more home health agencies. In all but one of the cases where a hospital closed their skilled nursing facility, another skilled nursing facility was operating within 15 miles of the hospital. In all but one of the cases where a home health agency closed, another home health agency served the community.

Looking forward, we see some improvements in rural hospital profitability. In December of 2000, the Benefits Improvement Act of 2000 (BIPA) was passed. The BIPA will improve payments for skilled nursing care and home health care in rural areas. The BIPA will also allow Critical Access Hospitals to receive cost-based reimbursement for the post-acute care they provide Medicare patients in swing beds. Due to the BIPA and rural hospitals' past cost-cutting efforts, we do not expect to see a further reduction in hospital-owned home health agencies or skilled nursing facilities.

One type of restructuring that will continue is hospitals' conversion to Critical Access Hospital status. Many rural hospitals will convert to Critical Access Hospital status in order to take advantage of cost-based payment for swing bed services and outpatient services. Due to the benefits of the BIPA and the potential for previously closed hospitals to reopen as Critical Access Hospitals, 2001 may be the first year in decades when we see an increase in the number of rural hospitals.

CAH conversions should provide an adequate safety net for all hospitals except those that provide a large amount of uncompensated care. In the case of traditional hospitals, the disproportionate share (DSH) program is designed to assist with the cost of uncompensated care. However, Critical Access Hospitals are not eligible for DSH payments. If Medicare does not help Critical Access Hospitals pay for indigent care, we may see a few rural hospital closures in very poor areas where private payers and donors do not have the resources to fully subsidize indigent care.

Policymakers should consider paying a portion of the bad debt and charity care expenses that Critical Access Hospitals incur when treating non-Medicare patients. If Medicare payments to Critical Access Hospitals are modified to adequately assist hospitals with the cost of indigent care, access to basic inpatient and emergency care will be preserved in even the poorest areas. Further research is needed to evaluate the cost of adding an indigent care benefit to the Critical Access Hospital program.

INTRODUCTION

Congress passed the Balanced Budget Act of 1997 (BBA) to rein in rising Medicare costs. The BBA decreased most rural hospitals' Medicare payments for outpatient, skilled nursing, and home health services. Since the passage of the BBA, rural hospital administrators have testified to Congress that the BBA was financially devastating. Congress responded by increasing Medicare payments slightly in 1999 with the passage of the Balanced Budget Refinement Act (BBRA), and increasing payments in 2000 with the Medicare, Medicaid, and Ship Benefits Improvement and Protection Act (BIPA). The BIPA increased payments to certain hospitals that treat a large proportion of Medicaid patients, increased home health payments in rural areas, and increased payments for skilled nursing care. Many of the provisions of the BBRA and the BIPA are temporary. Therefore, Congress must continue to reevaluate whether current reimbursement levels are appropriate.

When considering hospital requests for higher Medicare payments, policy makers need to understand the degree to which rural hospitals can adapt to the BBA. In particular, it is important to know whether current Medicare payments are forcing hospitals to close or cut back on services. To investigate how rural hospital are adapting to the BBA, a telephone survey of 401 rural hospitals was conducted in the fall of 2000. This paper reports on the hospitals' strategic responses to the BBA and discusses the degree to which services are being reduced. This survey is the only survey that we are aware of that focuses specifically on rural hospitals' strategic responses to the BBA.

BACKGROUND AND LITERATURE REVIEW

Hospital Profitability

In a report prepared by The Lewin Group (2000) for the American Hospital Association and the federal Office of Rural Health Policy, changes in Medicare policies were projected to decrease the average rural hospital's Medicare profit margin down to -3.3% by 2004. Stensland, Moscovice, and Christianson (2000) used a slightly different simulation model and reported that median Medicare margins would fall to approximately zero under the BBA and BBRA. Their model projects a less dramatic drop in margins because it allows for some strategic responses to the BBA such as the closure of unprofitable home health agencies and the conversion of small hospitals into Critical Access Hospitals. Stensland et al. predicted that overall profit margins (which include private payer margins) would drop from 4.5% during 1995-1997 down to 3.2% under BBA and BBRA payment policies. The impact of the payment cuts on rural patients will hinge on whether rural hospitals are able to stay open and whether financial pressures cause rural hospitals to cease offering post-acute services.

Skilled Nursing Care

Between 1991 and 1998 Medicare costs per day at skilled nursing facilities (SNF) rose at a rate of 12% per year and overall costs rose at a rate of 25% per year (Dummit 2000). To create greater incentives to control costs, the BBA introduced prospective payment for skilled nursing care starting in July 1998. Due to the BBA, average Medicare SNF payments per day of care declined from \$268 in 1998 to below \$250 in 1999 (Dummit 2000). As reimbursement tightened, nursing home operators suffered losses. Two of the largest operators of nursing homes, Sun Healthcare Group and Vencor, were forced into bankruptcy. Congress responded to the nursing home industry's troubles by passing the Balanced Budget Refinement Act of 1999

(BBRA) and increased payments for certain high acuity patients by 20%. In this paper, we report on whether the 35% of rural hospitals that offered skilled nursing care in 1997 have started to close their distinct part nursing facilities, and whether alternative sources of care are available in rural areas. After our survey was conducted, the BIBPA was signed into law on December 19, 2000. The BIPA calls for a 16.66% increase in the nursing component of SNF PPS rates. Since the payment outlook for SNFs has improved since our survey, our survey responses from the fall of 2000 may be somewhat more pessimistic than they would have been in January of 2001.

Home Health

In the early 1990s home health providers were allowed to bill Medicare for their reported costs of providing services, and the home health industry was booming. From 1990 to 1997, the number of home health users doubled to 109 per 1000 Medicare beneficiaries, and annual visits doubled to 73 per user (GAO 2000). A dramatic change occurred in 1997 with the start of an antifraud campaign (called Operation Restore Trust) and with the passage of the Balanced Budget Act. Under the BBA, limits were placed on home health agencies fees per visit and aggregate Medicare payments per beneficiary. Following the BBA and the antifraud campaign, Medicare home health expenditures fell from \$18.3 billion in 1997 to \$9.5 billion in 1999 (GAO 2000).

Falling Medicare payments to home-health agencies caused the policy debate to shift away from restraining costs and toward preserving access. Studies by the Department of Health and Human Services' Office of Inspector General (OIG 2000) and by the Government Accounting Office (GAO 1999) found that while the number of home health agencies declined

under the interim payment system, there were only modest decreases in beneficiaries' access to care.

Since October 1, 2000 home health providers have been paid based on a new prospective payment system. Under the new system, an agency providing a patient with 5 visits during a 60-day episode of care receives the same fixed payment as an agency providing a similar patient 60 visits during a 60-day episode of care. If hospitals can reduce the number of home health visits below historical levels, home health may become a profit center for rural hospitals.

In this paper, we will evaluate whether the 60% of rural hospitals that provided home health care in 1997 have reduced the services they provide to rural Medicare beneficiaries and whether alternative sources of local care were available in the fall of 2000. After our survey was completed, the BIPA was passed resulting in a 10% increase in rural home health rates from April 1, 2001 to March 31, 2002. As a result, the current Medicare payment structure for rural home health care is more favorable than when the survey took place.

SURVEY METHODOLOGY

A random sample of 448 hospitals was selected from the population of approximately 2,200 rural short-term acute hospitals that were operational in 1997. Of the 448 hospitals, one hospital merged with another hospital in the community and two hospitals closed between October 1997 and October 2000. One of the two closures was due to damage from a tornado. The damaged hospital was rebuilt and reopened in early 2001. The second closure was due to a long history of financial losses. The second hospital is expected to reopen as a Critical Access Hospital. After excluding the merged hospital and the two temporarily closed hospitals, a potential sample of 445 hospitals remains.

Representatives from 401 of the 445 hospitals completed telephone surveys during August through October of 2000, yielding a response rate of 90%. In 44 cases, the hospital was contacted, but we could not arrange interviews with an appropriate officer of the hospital. Of the 401 respondents, 65% are hospital administrators, 27% are chief financial officers, and 8% are other officers of the hospital such as an acting administrator or vice president of finance. The sample size of 401 hospitals allows us to be 95% certain that the percentage of affirmative responses to yes or no questions will be within 5% of the true national rate of affirmative responses for the nation's approximately 2,200 rural hospitals. As shown in Table 1, the sample of surveyed hospitals tend to be slightly smaller than the average rural hospital, but the operating characteristics of the survey sample and the population of rural hospitals are very similar.

RURAL HOSPITAL RESPONSES TO THE BBA

Changing Prices

The BBA significantly reduced the profitability of Medicare patients for most hospitals. Fifty percent of hospitals indicated that they were raising private payer rates specifically in response to the BBA (see Table 2). The remaining hospitals were increasing rates at the same rate they would have without the BBA or not increasing rates at all. Of those increasing their rates in response to the BBA, the median increase in outpatient and inpatient charges was 6%. Approximately one in eight hospitals were raising their rates by more than 10% as a response to the BBA. Hospitals will receive a limited benefit from raising charges if the hospital lacks the market power to prevent higher discounts to charges or if private payers represent a small portion of the hospital's patient base.

Table 1
Descriptive Statistics of the Rural Hospital Sample

Characteristic (in 1997)	Survey Sample Mean*	Population Mean*	Population Standard Deviation
Hospital beds	63	69	57
Percentage of hospitals with less than 50 beds	49%	51%	50%
Admissions	1,989	2,245	2,808
Total surgeries	1,536	1,742	2,499
Operated a home health agency in 1997	34%	35%	48%
Operated a skilled nursing facility in 1997	58%	60%	49%
Net margin	3.7%	3.4%	9.4%
Net patient revenue	\$17,128,836	\$18,218,352	\$26,646,642
Net income	\$1,225,009	\$1,702,869	\$18,269,541

*A full set of background data was available for 360 of the 401 hospitals surveyed and 2,082 of the 2,200 rural hospitals in the United States.

Table 2
Rural Hospital Responses to the BBA
(n=401)

Hospital Response	Affirmative Responses	Percentage of Applicable Responses
Formally evaluated the effects of the BBA	355	89%
Converted or will convert into a Critical Access Hospital	77	19%
Considering conversion into a Critical Access Hospital	60	16%
Will raise private payer prices in response to the BBA	199	50%
Hospital's home health agency is losing money	111	52%
Closed its home health agency during 10/97 to 10/00	33	13%
Some discharges have been delayed due to a lack of home health services	66	17%
The hospital's skilled nursing facility is losing money	38	28%
Closed its distinct part skilled nursing facility during 10/97 to 10/00	23	14%
Some hospital discharges have been delayed due to a lack of available beds in skilled nursing facilities	114	30%

Critical Access Hospital Conversions

For the smallest hospitals, especially those with high levels of Medicare and Medicaid patients, conversion to Critical Access Hospital status was often cited as an important survival strategy. Critical Access Hospitals are limited to treating 15 acute care patients at one time, but receive cost-based inpatient and outpatient reimbursement from Medicare. The survey indicates that approximately 19% of the nation's rural hospitals have converted or are in the process of converting and up to 35% of the nation's rural hospitals (770 hospitals) may become Critical Access Hospitals. Critical Access status can help aid inpatient, outpatient, and swing bed payments, but it does not affect home health care payments.

Closure of Services And Access to Care

While none of the 448 rural hospitals randomly selected for this study were permanently closed, many have reduced their level of post-acute services. In the sample, 13% of the hospitals with home health agencies closed their agencies and 14% of hospitals with skilled nursing facilities closed their skilled nursing facility since the BBA was passed.

In almost all cases, the closure did not remove the only source of post-acute care for members of the community. In all 33 cases where the hospital closed its home health agency, the community was still served by at least one other home health agency. In all but one of the 23 cases where a hospital closed its skilled nursing facility, another facility existed within 15 miles of the hospital. In one of the 23 cases, a hospital closed its skilled nursing facility even though it did not have swing beds and there were no other skilled nursing facilities within 60 miles of the hospital.

As of the fall of 2000, eight of the 401 surveyed hospitals indicated that there was not a skilled nursing facility within 15 miles of the hospital and in two cases there were no home

health agencies serving the community. As stated above, there was only one situation where the lack of access was due to the closure of a hospital-owned home health agency or a hospital-owned skilled nursing facility.

Even when there are one or more providers offering post-acute services, there can be capacity constraints on providers that lead to delays in discharging patients from the hospital. Approximately 17% of hospitals reported that some discharges were delayed due to a lack of home health services and 30% reported that some discharges had been delayed due to a lack of skilled nursing care services. Less than 4% of hospitals reported that over 10% of hospital discharges were delayed due to a lack of home health or skilled nursing facilities.

DISCUSSION

Most survey respondents stated that the BBA created a severe financial strain on their hospital. A sample of survey respondent concerns and comments are shown in Appendix A. Fortunately for rural patients, the financial strains experienced by rural hospitals did not appear to dramatically affect patients' access to care.

Looking forward, we expect rural hospital profitability to rebound due to changes in home health reimbursement, additional conversions to Critical Access Hospital status, higher inpatient updates, and higher SNF and swing bed payments. Due to rural hospitals' ability to adapt to new payment policies and legislative relief in the BIPA, the vast majority of rural hospitals will be survivors in a post-BBA environment.

Improving Home Health and SNF Profitability

Home health services are expected to have the greatest improvement in profitability. Under the interim payment system, 52% of hospitals surveyed reported that their home health operations were losing money, 35% were breaking even, and only 13% stated their agency was

profitable. The new prospective payment system will allow hospitals to maintain a fixed prospective rate even if they reduce their number of home health visits. As one survey respondent stated “home health may be recovering from a near death experience.” A remaining concern for policy makers will be whether patients needing high levels of care will receive adequate services under a prospective payment incentive structure. There is an incentive not to accept patients that will need an unusually high number of visits relative to their acuity category due to the fixed nature of the prospective payment system.

Skilled nursing facilities should also see an improvement in profitability. Thirty-three percent of survey respondents stated that their skilled nursing facilities were operating profitably, 39% were breaking even, and 28% stated that their skilled nursing facilities were losing money. Skilled nursing facilities profitability should improve due to a 16.66% increase in Medicare payments for nursing services that went into effect on April 1, 2001. The BIPA also allows Critical Access Hospitals to be paid their costs for caring for patients in swing beds. This gives Critical Access Hospitals with SNF and swing beds the advantage of treating patients with high ancillary costs in swing beds. The picture is better than when the prospective payment was first enacted for skilled nursing care and it is expected to improve as the new BIPA payments are phased in.

The Critical Access Program Can Prevent Closures

The surprising fact that none of the 448 hospitals that were randomly selected for this study closed permanently suggests that the Critical Access Hospital program is preventing hospital closures. Due to the Critical Access Hospital program and the reopening of some hospitals, 2001 may be the first year in decades when we see an increase in the number of rural hospitals. Critical Access Hospitals are expected to be financially secure if they can generate

enough profits from their private payer patients to cover the costs of indigent care and bad debts (Stensland, Moscovice, and Christianson 2000).

The Burden of Indigent Care

While none of the hospitals selected for this study permanently closed, several hospitals indicated that they were “just hanging on” and having difficulty absorbing the burden of indigent care. The one hospital in the sample that filed for bankruptcy during the past three years is located in a county with a 1998 per-capita income of under \$12,000 compared to a national average of \$28,872 (BEA, 2000). This hospital was forced to close its skilled nursing facility even though no other nursing facility existed within 60 miles of the community. If hospitals in very poor rural areas cannot fund the cost of indigent care, access to care for all patients is at risk.

The BIPA increased the number of traditional rural hospitals that will qualify for disproportionate share payments when they serve a large number of Medicaid patients, but Critical Access Hospitals are not eligible for disproportionate share payments. If Medicare does not help Critical Access Hospitals pay for indigent care, we may see a few rural hospital closures in very poor areas where private payers and donors do not have the resources to fully subsidize indigent care.

RECOMMENDATIONS FOR POLICYMAKERS

The fact that no hospitals in the survey sample permanently closed and few patients lost access to post-acute care suggests that the financial strain of the BBA has not yet resulted in dramatic reductions in rural patients’ access to care. Given this finding and the passage of BIPA, there does not appear to be an immediate need for broad changes in the way Medicare pays rural hospitals. Congress could give rural hospitals time to adjust to the dramatic changes

in payments that have occurred over the past four years, and only enact small changes to rural hospital payment policies.

Two small changes to the Critical Access Hospital program should be considered. First, Medicare should consider paying a portion of the bad debt and charity care expenses that Critical Access Hospitals incur when treating non-Medicare patients. If Medicare payments to Critical Access Hospitals are modified to adequately assist hospitals with the cost of indigent care, access to basic inpatient and emergency care will be preserved in even the poorest areas. Further research is needed to evaluate the cost of adding an indigent care benefit to the Critical Access Hospital program.

Our survey suggests that 35% of rural hospitals may become Critical Access Hospitals. Given the potential for rapid growth in the program, there is a need to make sure Medicare dollars are being targeted to hospitals that are most critical for rural patients. One way to improve the efficiency of the program is to require that Critical Access Hospitals be located more than 10 miles by road from another hospital. While some hospitals with close competitors may risk closure, we believe the Critical Access Hospital program should be targeted to helping hospitals that are necessary for maintaining access to care in rural areas.

RECOMMENDATIONS FOR RESEARCHERS

In this study, we found that 14% of rural hospitals closed their skilled nursing facilities in the past three years. While another facility was usually available within 15 miles of the hospital, it is not clear whether the remaining facilities have sufficient capacity to meet current or future demands for skilled nursing services. A shortage of beds may be a difficult problem to correct if private sector lenders are not willing to finance new nursing home ventures. Lenders may be reluctant to finance new nursing homes given the recent bankruptcies of two high profile nursing

home operators (Sun Healthcare and Vencor). Therefore, it is important for researchers to project the demand for rural nursing home beds. If we wait to hear rural constituents complaining about a dramatic shortage of long-term care beds, we may not have the time to finance and construct additional capacity.

Further research is also needed on whether SNFs and home health agencies are accepting patients that have the greatest need for nursing and ancillary services. It is not clear that acuity adjustments in the prospective payment systems provide adequate financial incentive for providers to accept patients with the greatest needs.

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Appendix A:

Quotations from Survey Respondents – 8/00 to 10/00

- The BBA is endangering access to care in rural areas. We have been significantly impacted and Congress needs to address these issues.
- The administrative burden of the APC system is unacceptable.
- The BBA has been financially devastating. It hit us hard because we are 87% to 90% Medicare dependent.
- Right now we're holding our own. But without relief from administrative burdens and reimbursement issues, we may have to close.
- Communicating with legislators has been very frustrating because they really don't understand what they signed.
- [The] reimbursement issue is not as important as the regulatory part. We don't have the resources or staff to keep up with changing and often conflicting regulations.
- We haven't been affected that severely because we plan and manage well.
- The BBA has affected continuity of care. It has disrupted the flow of care from acute care to skilled nursing facilities to home health.
- Our hospital has been operating for 50 years, and this will be the first year our operating budget has been negative.
- I have been to Washington and my impression is legislators don't really believe we're being hurt out here.
- The whole mix of things with compliance is very complicated. We have been able to maintain our margins and our sanity, barely.
- It has really had a minimal impact on us. The affect has been more psychological due to the negative publicity the BBA has gotten.
- It is a financial crisis. If we can't get relief, there will be a lot more hospitals closing in rural areas.
- We are 20% self-pay/no-pay and 60% Medicare/Medicaid. These demographics magnify the issue in our area.

- At the beginning, we thought it was much worse. It seems to be leveling out.
- Another year like this one and we won't be open.
- We have maintained services up to now, but unless there are changes... we will have to cut services.
- I can tell you, as a seasoned hospital administrator, that unless significant relief is forthcoming, the whole rural infrastructure will collapse. We can't seem to get anyone's attention!
- Morale has been very low – we can't increase wages to attract staff. There is a major nursing shortage in rural areas because we can't pay them as much as larger areas can.
- Ironically, because of the decrease in home health services, our SNF occupancy is up and more profitable.
- The administrative burden is overwhelming. Also, the tenuous future of the hospital has made it difficult to recruit physicians.
- Clinicians are being forced to make treatment decisions based on who's paying the bills. Obviously, this is wrong, and the BBA contributes to this.
- Our circumstances are a little unusual because of the number of surgeries we do and the way we staff our ER. So our bottom line remains relatively strong.
- In general, the BBA has put an undue strain on the hospital due to reduced payments and staff cuts.
- We are doing fine with Critical Access status.
- Critical Access designation was a do or die option.
- We would not have survived without Critical Access status.
- Even though we were forced into Critical Access, it has worked out well for us.

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