Saving Rural Health-Care Access

1. A Number of Rural Washington State Hospitals Are At Real Risk of Closure.

Rural hospitals across the country have been closing at a disturbing—and accelerating—rate for decades now. In the eight years running through January 2018, 83 rural hospitals closed[1], an average of another every five weeks—and the closure rate was *six times* higher in 2015 than in 2010[2]. The financially weakest have gone first; but those were just the canary in the coal mine. The same problems that forced those closures exist in Washington State: it just took longer to approach critical status here. Right now, there appear to be 21 rural healthcare facilities in the State that *are* in critical status.

The key financial indicators are three. First is Operating Margin, the net from delivering patient services, healthcare facilities' real business. The 2016 national average Operating Margin for non-profit hospitals was +2.8%[3]. By comparison, every one of the endangered facilities in Washington has long been running a *negative* Operating Margin, from a loss of -3.0% to as much as an amazing -25.2%: *they each lose money, typically a lot of money, doing their basic job*.

The next key measure is Total Margin, which is the overall net for the facility. It is crucial here to realize that ***"breaking even" is not sufficient for continuing viability.*** All businesses have occasional needs for non-trivial outlays outside their normal day-to-day expenses, whether capital or operating, whether planned or unexpected. To meet such special expenses, businesses need a reserve fund to draw on, and such reserves need regular replenishment—meaning that a hospital needs to average a Total Margin greater than zero.

While there is no bright-line value for a minimum viable Total Margin, a review of the literature will show that the most commonly cited is value +4%, though a few say +3%. None of the endangered facilities has more than a +3.2% Total Margin, and the unweighted average for the 21 is actually negative (-0.7%); six of the 21 individually run negative Total Margins.

And we must remember that the Total Margin, unlike the Operating Margin, *includes tax revenue*. If those facilities had no tax support, all but one would be losing money, not just on patient care but *overall*, every year (and that one exception is *barely* over zero). Without tax support, all of those facilities would long since have been out of business. But community taxes, high as they are in many areas (some approaching half a thousand dollars a year per resident) are still not enough to bring any of those endangered hospitals up to a viable Total Margin, even if we use the very conservative value of +3.5% to define "viable".

In short, they are bleeding money every year: their reserves fall lower and lower, and soon—in several cases *very* soon—they will be tapped out on reserves, unable to make needed capital purchases or to meet even a relatively minor financial hiccup, and will have to close down.

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1 From January 2010 to January 2018, an 8-year span, 83 rural hospitals closed: that's over 10 a year average.
2 "2016 Rural Relevance: Vulnerability to Value Study" by iVantage Analytics.
3 "The 2017 median operating margin was 1.9 percent compared to 2.8 percent in 2016." (Fitch Ratings)

And we can put numbers on that, too. The standard financial measure "Days Cash On Hand" is the yardstick. The 2017 national average Days Cash On Hand for non-profit hospitals was 214 days[4]. The average for the threatened hospitals is *51 days*—and five of them have *less than a week's worth* (the *median* for the 21 is six weeks' worth versus that national average of over thirty weeks). All of those hospitals have very weak reserves, and many of them are, as one CEO put it, "running on fumes".

Every year these hospitals continue to operate, they get closer to financial disaster, and for many that disaster is now more or less right around the corner. That is no overwrought handwaving: *the numbers show it*.

2. The Reason For the Problem Is Simple: Underpayment.

Why are those hospitals so financially pressed? It's very simple: *they are not getting paid what it costs them to provide their services*. And they, unlike normal businesses, cannot simply raise their prices to cover costs and a small "profit" margin. The percentage of patients who actually pay their own bills (that is, who are are completely uninsured) is the only class for which the hospital actually *can* fully determine how much they will be paid, and it is a small fraction (c. 5% to 8%) of their patient base (and in any event as a class those "self-pay" patients only pay about 6% of their billings[5]). So, for hospitals, *payments are effectively set by insurors, not the hospitals*.

Those endangered hospitals are all rural. Rural residents are well known to be, on average, sicker, poorer, and older than the overall population. It is not surprising that the typical rural healthcare facility's patient base is about two-thirds Medicare or Medicaid patients. And the fact is that *Medicare and Medicaid do not pay the full costs their covered beneficiaries incur*.

In 1997, Congress created the category "Critical Access Hospitals" (all the threatened hospitals are so classified) and required that they receive payment at 101% of "cost" from Medicare. But not all *actual* costs were or are included in what Medicare considers "allowable" costs, so Medicare payments have *never* covered the full cost to a hospital of treating Medicare patients.[6] Then the 2013 "sequestration" rules reduced that nominal 101% to 99%—thus assuring that *Critical Access Hospitals will lose money on every Medicare patient they treat*.

And that is just Medicare. In the Washington State *Medicaid* program, the legislature initially required that hospitals be paid 100% of their costs; but when the state changed the Medicaid program to a "managed-care" structure, it removed the requirement that payments be reconciled to actual costs. Thus, the supposedly "cost-based" Medicaid payments also, for most hospitals, fall well short of the actual costs of treating Medicaid patients—so *most Critical Access Hospitals will also lose money on the Medicaid patients they treat*.

And even private insurors' payments, though typically better than Medicare and Medicaid, are often below true costs.

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4 "[T]he median days cash on hand climbed from 195.5 in 2016 to 213.9 in 2017..." (Fitch Ratings)
5 "Uninsured accounts pay approximately 6% on the dollar, analysis finds", *Becker Hospital Review*
6 "On average, only 90% of costs were covered." *Innovative Payment for Emergency Care in Rural Washington State*

When one realizes that small rural hospitals have for decades been getting seriously underpaid, the notion that they are inefficient and just need to get going on cost-cutting is seen for the nonsense that it is. These hospitals have, over those decades, pared away every conceivable inefficiency and implemented every conceivable cost-saving measure, just to try to stay afloat. But no amount of inspired management can make a budget balance when payments are necessarily less than costs.

(In fact, cutting costs has very little to do with underpayment. Consider a billed cost of, say, $1000 to Medicare; the hospital will get paid $990. Now suppose they somehow cut the cost of that service by an amazing and unlikely 10%: they bill $900 and get paid $891. Their loss goes from $10 to $9. Their loss is cut by that 10%, *but it is still a loss*. Drastic cost-cutting beyond what they have already done—absurd, but presume it—would only slow down the bleeding a bit. *Cost-cutting **cannot** stop the bleeding.)*

So why is anyone surprised or puzzled by the fact that those hospitals are chronically in financial trouble?

3. Small Rural Hospitals Are a Distinct, Special Class.

Many hospitals of all sorts are under financial stress—arguably half the hospitals in the state. But, while some larger urban and suburban hospitals may be operating with Total Margins less than +3.5%, many others are doing very well. Small rural hospitals, however, are virtually *all* doing poorly: *it is **inherent** in just being small and rural that a hospital will almost certainly be in financial trouble.*

The reason is simple: the relation between costs and revenues is, for hospitals above a certain size threshold, pretty much a straight-line one: if patient traffic decreases, revenues decrease, so costs will correspondingly be reduced, typically by shrinking staff size. But once a hospital has reached the size threshold of minimum possible staffing, that relation completely breaks down, because *costs cannot be further reduced even if the number of patients is smaller.*

An Emergency Department, for example, must be staffed 24/7 regardless of the volume of traffic. For small hospitals, the bare minimum staffing needed for 24/7 ER coverage will virtually always be enough to handle a fair deal more patient traffic than it actually sees—*but that bare-minimum staffing cannot be cut back without reducing the ability of the ER to do what it is there to do—respond immediately to emergencies.* That inheres in the very definition of "bare minimum". And the same sort of threshold principle applies to other services as well, from a family-practice clinic to a skilled-nursing facility.

And that is by no means the only difference between small rural hospitals and larger facilities. For large hospitals, the biggest problem may be variability of income; but the biggest problem small rural hospitals face is the huge variability in *costs* associated with being both small and rural. A facility with few full-time physicians on staff will, should one of them unexpectedly leave, suddenly have to bring in a locum while they try to recruit a replacement (which can take months or even, for rural facilities, *years*); that substantial extra cost will be a large *percentage* jump in their budget.

In a bigger hospital, with numerous physicians, such a change is only a ripple on the pond.

And there are many, many other such things—a piece of major lab equipment fails well before its expected lifetime—that will be minor, almost insignificant, in a large facility that are, in budget terms, almost catastrophic for a very small facility.

Two things are needed to satisfactorily compensate healthcare facilities in that special class of "small, essential, rural": first, a clear and definite way of identifying such facilities and distinguishing them from other, larger operations; and second, a method of allocating and sizing compensation that will keep these vital facilities viable on a long-term basis. The Washington Rural Health Access Preservation (WRHAP) Group's paper "Identifying Crucial Rural Healthcare Facilities" does the first; the WRHAP Group's Alternative Payment Model (APM), discussed farther below, does the second.

The only alternative to providing adequate funding to meet community needs, such as an ER, is to close the facility altogether (a disaster, as discussed a little farther on).

The way small hospitals are paid is bizarrely at odds with the way most public services are funded. No one expects a fire department or a police department to "make a profit". *Yet, unlike those other "public goods"[7], even publicly owned "non-profit" hospitals are in effect* ***required*** *to make a profit to remain open.*

Can we imagine a community's fire department being closed down because there aren't quite as many fires annually as they could fight with the minimum equipment necessary to be a fire department at all? But we seem willing to close down hospitals if not quite enough members of the community get sick or injured to use those facilities to their maximum capacity.

To repeat: by their very nature, these vital small rural hospitals cannot survive as things are. Their special nature—a size such that to function at all they must necessarily run higher cost/revenue ratios than larger facilities—requires that they be funded in ways appropriate to that special nature, a public good. *The alternative is to watch them start closing down, soon.*

> (It is eminently noteworthy that when our neighbor state Oregon—viewed by CMS and others as a national leader in Medicaid payment reform—in 2014 designed a new Medicaid APM, that APM expressly exempted rural hospitals meeting criteria very similar to those independently developed in the WRHAP "Identifying Crucial Rural Healthcare Facilities" paper. In Oregon, they left those exempted rural facilities on the standard cost-based payment system, but we in Washington have a better alternative, the WRHAP value-based APM, discussed farther below. Indeed, SHB 1520, passed in 2017, expressly *requires* the state Health Care Authority [HCA] to implement an APM specifically for the WRHAP hospitals.)

4. Kill the Hospital, Kill the Community.

Small rural hospitals are typically essential. As used here, that term, "essential", means that a given hospital lies at least some threshold travel-time distance away from the next-nearest facility. And that has major implications.

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7 "A commodity or service that is provided without profit to all members of a society, either by the government or a private individual or organization."

The non-rural majority of Americans scarcely realize what they take for granted. If an urbanite or suburbanite slips and falls on a sidewalk and is lying there bleeding profusely, the first thing a bystander will do is shout is "Calling an ambulance!" and dial 911 on his or her mobile, in the perfectly reasonable belief that an ambulance will indeed arrive within minutes to begin treatment. In a rural community, *Call an ambulance* or perhaps *Drive her to the ER* can well mean *a 20- or 30-minute or even longer delay before treatment can be commenced.* The feelings of a victim of trauma or heart attack or stroke, and of his or family, during such a painful (likely in a literal sense) delay can scarcely be imagined. Pain, and fear. *And medical opportunity for good outcomes sliding away, minute by minute.*

Now take that scenario and add, say, a *further* half hour or so (and maybe more) to it. That is what closing a rural hospital does. *People will die who could have lived.* And others will be crippled or diminished in what should have been avoidable ways. *Time is heart; time is brain.* In stroke, for example, an average of *two million brain cells a minute* die till treatment intervenes. Then consider cases of severe trauma, and the picture gets darker yet.

The non-emergency necessity is less immediately obvious, but *every bit as crucial*, because small rural hospitals are almost always the principal—and often only—source of primary care in their communities. And those communities are almost invariably older, poorer, and less healthy than average. For a great many members of such a community, a trip to see a medical provider—unless they reside within a very few minutes' travel of the facility, which many will not—is a major enterprise. The poorer may not even own a car; the elderly may be unwilling or actually unable to drive on busy roads or in urban traffic.

Adding substantial *further* travel time to their trip would materially discourage visits for everything from routine periodic checkups to receiving attention for non-emergency but still potentially significant medical needs, from an earache to abdominal pain. Not infrequently in such a scenario, patients will end up in a hospital receiving expensive care that could have been avoided by a timely visit to a primary-care provider, a visit long travel times sharply discourage—a harm to the patient *and* an added cost burden to the state's health-care system.

> (The old definitions that determined "Critical-Access" status in complicated terms of mileages and road status have been—or should be—superseded by actual travel-time data as today readily available from, for example, Google Maps. In the WRHAP "Identifying Crucial Rural Healthcare Facilities" paper, the threshold value used was a drive time of *over* 25 minutes on a clear weekday afternoon from ER door to next-nearest ER door. Those standards are not loose: indeed, by those standards almost half of the state's Critical Access Hospitals do not qualify as "small and essential".
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> And while the increase in travel time in the event of a closing would not be the same for every community member, if the facility is—as will normally be the case—roughly central within its community, for the majority of patients the increase *would* be approximately the ER-door-to-ER-door travel time, since rural roads tend to be few and orthogonal, such that for a patient—or ambulance—to access a road to or from the next-closest facility would typically involve traveling right by approximately where the closed facility had been located, so that the added travel time would truly be *added* time for most patients.)

But the harms to patients from closing an essential hospital, while terrible to contemplate, are only a part of the story.

Roughly one in five Americans lives in a rural area[8]. Nonetheless, *rural America suffers from the "out of sight, out of mind" syndrome.* To the urban and suburban majority, "rural" evokes a vague melange of images from L'il Abner to Petticoat Junction. When the desperate case of rural communities comes up, a common, if often-unspoken, reaction is "Well, if they don't like it, why don't they just move?"

This is why: rural communities are almost universally founded on the production of a vital resource, be it foodstuffs, timber, or minerals. Those resources have two qualities: they are vital to the nation; and *they are not portable.* Farmland, forests, mines: they are where they are, and that is not in cities or suburbs. *Those who generate production are inescapably tied to their rural locations.*

(And the same applies to the various attractions that currently draw so many tourists and visitors to Washington's rural areas; those attractions are immobile.)

That has two corollaries. First, it is simple morality that those tied to a rural community by vital economic activity should not be denied access to health care, and most especially to life-saving emergency care.

But, as a close second, there are other important consequences to the closure of a rural community's only hospital, "snowball" effects. *Without proximate medical services, especially emergency-care services, a community immediately becomes a clearly undesirable place to live in or visit.* (And recall that ruralites, being older and less-well-off, typically have greater than average needs for medical care.)

Supporting infrastructure or other businesses *will not want to come into that community*; worse, existing ones may well opt to withdraw. Even individuals whose families have been generations in the community will feel a need to relocate to some other rural community where they can ply their trades with health care still available to them and their loved ones.

That starts a vicious cycle. The hardest-hit will be those who own the resources, because they cannot take those resources with them: *a farmer cannot pack his 160 acres into a suitcase*, to be unpacked somewhere in a suburb or city. Often, with the accompanying collapse of the infrastructure, they too have to surrender and sell out for what they can get. And all that is beside the reality that in most rural communities, the healthcare facility is itself one of the largest employers—often *the* largest employer—whose loss will further accelerate that vicious cycle of economic (and thus social) collapse.

Rural communities that have lost their local hospitals typically dry up and become shadows of their former selves within a very few years. As one of the countless articles on this topic put it, *"If you want to watch a rural community die, kill its hospital."*[9] Rural hospital closures kill not only individuals, they kill communities: the long, clear track record shows that these are not imaginings but demonstrable historical realities. The loss to the individuals is matched by the loss to the region and the nation of vital-resource productivity and economic activity.

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8 The Federal Office of Rural Health Policy put it in January 2017 at approximately 18% of the population.

9 *Georgia Health News*, September 22, 2017: "A hospital crisis is killing rural communities."

5. Only a Relatively Small Amount of Money Is Needed.

For most of the threatened hospitals, the difference between what they get and what they need to be and stay solvent is not all that great in the context of multi-billion dollar healthcare spending. Washington State's annual Healthcare budget is approximately $13.4 billion dollars[10]. The cumulative *total* shortfall of the 21 at-risk hospitals is approximately $15.3 million. But, of that $15.3 million, $4.9 million, almost a third of the total, was for one facility alone (one that seems now on course for approaching break-even for 2018). Limiting the amount for that facility to the average shortfall of the other 20, the total dollar need for all 21 threatened hospitals would be about $11 million. That is well under one one-thousandth of the State's total healthcare budget, and scarcely over three times the amount recently expended by the legislature to rescue just *two* hospitals (neither even a Critical Access Hospital).

The real problem, though, is not just more dollars: it is that a payment *methodology* is needed that will rationally and fairly *match payments to the various diverse individual operational needs of each small rural facility* in a way that will allow that District to best use its income to serve its community's needs.

And if "a laser focus on cost" makes even small increments of funding seem hard to find, there needs to be an emphasis on "viewport". The tendency is to look at particular hospitals' own revenues and costs. But it is (or should be) well known that the great majority of payor expenses for rural residents are for services and procedures those patients receive *away from* their home hospital facility[11] (typically treatments or procedures not available at the rural facility). ***Rural hospitals are not the main generators of medical spending on their patients.***

It is as true as ever that "an ounce of prevention is worth a pound of cure." If patients' local medical facilities had the financial ability to deliver care beyond the barest minimum, especially more and better preventive care (including behavioral-health assistance), those patients would be healthier and thus less likely to need those expensive out-of-District procedures or treatments. Looking through the *global* viewport instead of the District-specific viewport emphasizes the importance of adequately funding these "medical home" facilities. *That needed small increment might well reduce overall healthcare spending* (besides producing a healthier, more productive populace)[12].

6. A Solution Already Exists.

In 2017, the Legislature passed SHB 1520, requiring the state Health Care Authority (HCA) to implement a new payment system to sustain emergency rooms, primary-care clinics, and other essential services for the WRHAP group; from the bill[13] text *[emphases added]*:

10 usgovernmentspending.com
11 "Analyses of Data on Utilization & Spending on Healthcare Services for Residents of WRHAP Communities", p. 9
12 " How and Why the Proposed WRHAP APM Benefits All"
13 SHB1520: text.

> Payments for services delivered by public health care service districts participating in the Washington rural health access preservation pilot to recipients eligible for medical assistance programs under this chapter **must** be based on an alternative, value-based payment methodology established by the authority...[T]he payment methodology **must** provide sufficient funding to sustain essential services in the areas served, including but not limited to emergency and primary care services. The methodology **must** adjust payment amounts based on measures of quality and value, rather than volume. As part of the pilot, the health care authority **shall** encourage additional payers to use the adopted payment methodology for services delivered by the pilot participants to individuals insured by those payers...Funds appropriated for the Washington rural health access preservation pilot will be used to help participating hospitals transition to *a new payment methodology*...

The text of the bill is clear and unequivocal: as of its enactment, state law *requires* that the HCA implement a value-based APM *specific to the WRHAP Districts* that assures that each such District receives sufficient funding to *sustainably* provide essential community health-care services in its service area. The bill requires the HCA to *encourage* other payors to use the new APM, but *other payors' participation is not a condition of the requirements on the HCA to itself implement the required new APM*.

The bill became law on July 23 of 2017. *Well over a year later, the payment system hasn't changed*. No new methodology has been implemented; there is not even a draft proposal from the Authority for a new methodology to meet the requirements of the law. Nor does it appear that the Authority has even taken a meaningful look at the WRHAP APM. Their position seems to be that if Medicare is not also on board, no such WRHAP-specific APM can be implemented. *But that is not what the law says*.

> (Note that "global-budget" models—such as the HCA is apparently driving toward as a statewide payment method—while potentially beneficial for larger hospitals, are grossly inappropriate for small rural hospitals. A global budget is intended to enable hospitals to reduce avoidable hospital admissions without fear that revenues for admissions will fall faster than their costs. At typical community hospitals with dozens or hundreds of beds, costs change in fairly small and predictable ways from year to year, so it is feasible to establish a global budget and just update it every year. In contrast, small rural hospitals have very few admissions, so there is little opportunity for the significant reductions in admissions that global budgets are designed to encourage, while the *costs* at small rural hospitals often, as we have already noted, vary significantly—one might even say dramatically—from year to year *for reasons beyond the control of the hospital*, making it extremely difficult to establish a fixed budget in advance. Advocates of the benefits of the Maryland global-budget payment system fail to recognize that *Maryland has no Critical Access Hospitals at all;* and that the smallest rural hospital in Maryland is four times the size of the smallest hospitals in Washington State. Moreover, the Maryland global budget system is highly complex[14]—and doesn't even work well in Maryland[15] [16].)

These threatened facilities cannot wait for some unspecified actions two or three years down the road (the HCA has said that 2020 is the very earliest possible start year for any new program), because by then some of those hospitals may well be long since shuttered. Simply put, *immediate action needs be taken to preserve these endangered hospitals*.

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14 "How Hospitals Are Paid in Maryland"

15 "After 2 years, Maryland's global budget program was not associated with changes in hospital or primary care use that were clearly attributable to the program." *JAMA Intern Med. 2018;178(2):260-268*

16 "Maryland ER wait times are the worst in the nation", WMAR Baltimore, 3 February 2017.

Nor is it as if the HCA would have to construct an appropriate WRHAP-specific APM from scratch, since the Washington Rural Health Access Preservation Group has already developed an APM that addresses all the issues raised here. The Group comprises 13 Public Hospital Districts that all belong to that clearly identifiable class of threatened small rural medical facilities. That Group labored diligently and arduously for *over three years* on the task. Being itself composed of most of the Districts in the state that lie in the "stressed" class, the Group is especially competent to address the in-the-trenches issues involved. It is the Group's very strong belief that it has succeeded in producing an APM that is *fair to communities, fair to Districts, and fair to payors*. That APM recognizes that a rural hospital is a "public good" in the same sense as a fire department or a police force, something essential to its community and thus something that has to be rationally compensated sufficiently to maintain its operation, just as SHB 1520 requires. And that APM was available when SHB 1520 was enacted (and was widely expected to be the APM the HCA would implement).

This paper will not address that APM itself, on the ground that it would be ludicrous to attempt to compact the Group's extensive work product into a summary paper such as this one is. The documents and a mountain of supporting data are readily available[17], and are essential reading. The whole focus of this paper is simply to demonstrate the *need* for *a special APM applicable to a special class of hospitals: small essential stressed rural non-profits*—a need the legislature has recognized and has acted on. (And the WRHAP Group has a related paper, "Identifying Crucial Rural Healthcare Facilities", that demonstrates a reliable, clear, simple way of specifying the members of that class.)

It may also be worth noting that the WRHAP APM is not state-specific: using the class-identification tools developed next in that related paper, appropriate target facilities in any state could readily be identified, and the WRHAP APM applied to compensating them. The Center for Medicare & Medicaid Innovation has been inviting proposals for Alternative Payment Models to serve as pilot programs for exploring payment approaches that could work nationally. *The WRHAP APM is such a model.*

When Oregon, a state much like Washington, implemented a new Medicaid payment system for hospitals, it expressly excluded a class of rural hospitals almost identical with the class this paper deals with. If the HCA has an APM it wants to impose on all hospitals in this state, it can and should—indeed, is by SHB 1520 *required* to—carve out an exemption for the WRHAP-style class of hospitals and give them a different APM: the WRHAP APM. That requires no new authorizing legislation, and the two key components—a clear and definite way of identifying class members and the actual APM itself—already exist.

State law requires the HCA to implement a payment model specific to the thirteen WRHAP Districts, a payment model that funds those Districts sufficiently to allow them to to provide *sustainable* essential services to their communities. That is exactly what the WRHAP APM would accomplish.

There is no reason for delay.

17 WRHAP Group web site, "Library" page.