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Is it time to change how the U.S. pays rural hospitals?

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When the COVID-19 pandemic hit and hospitals had to cancel lucrative elective procedures, it dealt a financial blow, **especially to rural hospitals** with tight operating margins. But for 18 rural facilities in Pennsylvania, it wasn't so bad.

They were operating on a **global budget model** being tested by the Center for Medicare and Medicaid Innovation to determine whether providing more financial stability to rural hospitals can help them stay open while delinking volume and revenue and creating incentives to investment in population health.

There isn't much evidence yet about whether global budgets can stop the trend of rural hospital closures, but it helped those Pennsylvania facilities weather the pandemic, said Gary Zegiestowsky, executive director of the Pennsylvania Rural Health Redesign Center Authority, the agency administering the model.

"This was a lifeline for giving financial stability to enable these hospitals to keep operating at full staff and to deal with everything that was going on with the pandemic and COVID," Zegiestowsky said.

Rural reckoning: COVID-19 highlights long-standing challenges facing rural hospitals. Will it create momentum for change?

So-called global budgets—in which hospitals are paid a fixed amount by Medicare and other payers to treat a population—have grabbed the attention

of advocates and hospital leaders as a potential way to stop hospital closures that leave communities sicker and without access to care.

Value over volume

CMMI launched the Pennsylvania pilot program in 2019, making it the first alternative payment model solely focused on rural health.

The voluntary model is now in its third performance year with 18 hospitals and six payers enrolled. The program aims to improve community health through value-based care, preventing rural hospital closures and cutting costs.

Under the model, the budget for each hospital is determined by historical net patient revenue for inpatient and outpatient services, with payers providing a fixed amount of money on a regular basis to cover treatment costs.

Each hospital must also put together and get approval of "transformation plans" that lay out how they intend to improve quality, increase access to preventive care and generate efficiencies and savings.

CMMI also announced a similar model this month called CHART that will be tested in Alabama, South Dakota, Texas and Washington state with the goals of addressing social determinants of health and increasing financial stability for rural providers through upfront investments and capitated payments.

It's a unique approach to the million-dollar question policymakers, experts and advocates have been trying to answer for decades: How do we keep rural hospitals open?

Rural hospital closures are linked to a number of factors including high uninsured rates, competition from larger, newer facilities farther away,

Medicare payments cuts and declining patient volume.

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"Right now, the entire payment system is paid on volume, and paying hospitals for volume has always been and always will be a losing proposition," said Alan Morgan, CEO of the National Rural Health Association.

"Clearly, you don't have the volume in a rural setting that you have in urban. That basic concept, which works extremely well in an urban context, just has never worked well in a rural context."

CMMI's efforts on global budgets a "step in the right direction," Morgan said. "Hopefully we can really quickly focus in on the CHART model and take the lessons learned and see how that can be applied to a much broader, nationwide approach," he said.

The CHART and Pennsylvania models come as the U.S. healthcare system tries to shift toward value-based care and away from fee-for-service, which disadvantages smaller providers.

Impact of COVID-19

While rural health advocates have been making that argument for a long time, it became even more urgent when COVID-19 came and hospitals needed to suspend outpatient services, which make up more than three-quarters of rural hospitals' revenue, according to the Chartis Center for Rural Health.

In a March survey, 80% of the 18 hospitals' leaders said the program reduced financial pressures and 95% said it helped them stay open during

the pandemic.

While it's too soon to say how effective the Pennsylvania program will be at stopping closures and improving health, Zegiestowsky is optimistic it will be successful and replicated elsewhere, he said. More than a dozen states have already reached out to Pennsylvania about the model, according to the state's health department.

In the past, Congress' response to rural hospital closures has been to create new designations that increase payments for qualifying facilities.

Congress created the Critical Access Hospital designation in 1997, which gives certain rural hospitals cost-based reimbursement. This payment shift slowed negative trends in the early years, but they picked up again during the Great Recession a decade later, according to the Kaiser Family Foundation.

Congress devised another policy last year that will pay rural hospitals to shed inpatient services while maintaining and building on outpatient services.

But the global budget model takes a different approach by allowing rural hospitals to keep their special payment designations while changing the way those funds are delivered. In Pennsylvania, Medicare pays participating hospitals a flat amount every two weeks, which can

PENNSYLVANIA RURAL HEALTH MODEL HOSPITALS

- Armstrong Center for Medicine & Health, Kittanning
- Barnes-Kasson County Hospital, Susquehanna
- Bradford Regional Medical Center, Bradford
- Clarion Hospital, Clarion
- Chan Soon-Shiong Medical Center, Windber
- Endless Mountains Health Systems, Montrose
- Fulton County Medical Center, McConnellsburg
- Geisinger Jersey Shore Hospital, Jersey Shore
- Highlands Hospital, Connellsville
- Indiana Regional Medical Center, Indiana
- UPMC Kane, Kane
- Wayne Memorial Hospital, Honesdale
- Monongahela Valley Hospital, Monongahela
- Meadville Medical Center, Meadville

promote stability during periods when volumes and revenue are down.

- Punxsutawney Area Hospital, Punxsutawney
- Penn Highlands Tyrone, Tyrone
- Washington Health System Greene, Waynesburg
- Washington Hospital, Washington

The idea has intrigued hospital leaders from across the country who see it as a potential solution to one of their biggest problems.

"I was a rural hospital CEO in a prior life. We would know if we didn't break even in the winter months, we were in trouble in the summer months," said John Henderson, president of the Texas Organization of Rural and Community Hospitals. "Fixed monthly payments could provide budget certainty "without riding the roller coaster of claims," he said.

Refinements needed

Global budgets could play a major role in keeping rural hospitals financially sustainable in the future as the U.S. healthcare system tries to move away from fee-for-service, said Eric Roberts, an assistant professor of health policy and management at the University of Pittsburgh. But it has to be done right, he said.

"There's a potential value in a global budget mechanism for rural hospitals but how it's executed is really key for whether the hospital is actually going to have the resources it needs to serve the community, and that requires careful refinement of the model," Roberts said.

Biweekly Medicare payments helped stabilize revenue at struggling hospitals in the short term but didn't improve overall profitability in 2019, the first year the Pennsylvania program was in place, according to a Centers for Medicare and Medicaid Services study found. "We're just going out of business slower," one hospital CEO told the agency. The study concludes

that the jury is still out on the long-term consequences of the Pennsylvania payment model.

High fixed costs mean achieving savings that can be invested in communities is challenging, some Critical Access Hospitals reported to CMS. The Pennsylvania program may not be sustainable over time because of federal policies such as the Medicare payment cuts stemming from budget sequestration, meaning participating hospitals aren't actually being reimbursed based on their costs, facilities reported.

"We're still losing money, it's just not as much maybe," one Critical Access Hospital executive told the CMS.

Policymakers need to resolve a lot of questions in order to accurately set budgets for hospitals participating in programs like this, Roberts said. "We have to be a little bit more thoughtful than just saying, 'What did the hospital get paid last year?' because of the policy differences that preexisted global budgets," he said. "It may require us to revisit how we should set the starting level budgets if certain hospitals were already operating at negative margins in the beginning," he said.

"There's a rationale for broad adoption, but in practice, there's a lot of other things that need to be addressed," Roberts said. "With a large uninsured population, on its own, a global budget isn't the panacea, because we don't have a payer for a large part of the population to allocate funds for."

Whether a state has expanded Medicaid under the Affordable Care Act plays a part in a model's performance, Roberts said. Twelve states have yet to open the program to more low-income adults, leaving more than 2 million people uninsured—and leaving rural hospitals vulnerable to closures.