

## **Small, Rural Hospitals: A Fight for Survival**

Julie W. Robinson<sup>1</sup>

Grant T. Savage, PhD<sup>2</sup>

<sup>1</sup> Graduate Assistant, Culverhouse College of Commerce, University of Alabama

<sup>2</sup> HealthSouth Chair & Professor, Culverhouse College of Commerce, University of Alabama,  
gsavage@cba.ua.edu\*

\* Corresponding author

### **Abstract**

Declining reimbursements, resulting from the 1997 Balanced Budget Act (BBA), have placed an enormous strain on small, rural hospitals that are typically dependent on Medicare patients for the majority of their revenue. Under the BBA, new managed care and private options are available, payments to hospitals are reduced, Part B premiums are increased, and a prospective payment system (PPS) is authorized for outpatient, home health, and skilled nursing services. The Balanced Budget Refinement Act of 1999 (BBRA) attempts to rectify some of the reductions in reimbursement. Nonetheless, to take advantage of the BBRA and to address declining reimbursements from other sources, rural hospitals should expand outpatient services, embrace telemedicine and telehealth initiatives, and actively seek alternative funding.

**Keywords:** Medicare reforms, rural health policy, hospital strategy

## **Small, Rural Hospitals: A Fight for Survival**

Rapid changes in technology, reimbursements, and regulations between 1980 and 1989 resulted in the closure of more than 200 small, rural hospitals (Hart, Amundson & Rosenblatt, 1990). As we enter the 21st century, rural hospitals servicing populations in non-metropolitan counties throughout the U.S. are once again facing immense pressures, especially from aging populations and from public and private payers. These pressures are most intense for small hospitals, with fewer than 100 beds. Most rural hospitals are dependent on Medicare for the majority of their revenue, and the 1997 Balanced Budget Act (BBA) has drastically reduced their Medicare reimbursements (Coburn, Fluharty, Hart, MacKinney, McBride, Mueller, & Wakefield, 1999). Rural hospitals cannot continue business as usual, even with the recent relief provided through the 1999 Balanced Budget Revision Act (BBRA). To reduce the negative impact the BBA has had and to take advantage of the provisions in the BBRA, small rural hospitals should expand outpatient services, embrace telemedicine and telehealth initiatives, and actively seek alternative funding from foundations and other sources.

### **Background**

Medicare was enacted in 1965 as Title XVIII of the Social Security Act and began in 1966 under President Lyndon B. Johnson. The program currently is managed by the Health Care Financing Administration (HCFA) which was formed in 1977 as an agency of the federal Department of Health and Human Services.

The Social Security Administration maintains the data that determines Medicare eligibility. Medicare provides coverage for people aged sixty-five and older, for people who are disabled and eligible for Social Security, and for people with permanent kidney failure. Medicare has two parts, A and B. Medicare Part A provides hospital insurance and is financed

through a 2.9 percent payroll tax. Employers and employees each pay half the tax. A premium payment is not required, but beneficiaries do pay a deductible of \$764 on hospital stays each year. Federal actuaries initially estimated future expenditures for Medicare Part A so that a payroll tax could be established based on potential costs. However, the government's 1965 estimates were based on a worker to beneficiary ratio of 5:1; in 1995 that ratio was 3:1, and it is projected to be 2.2:1 by 2020 as the Baby Boomer generation matures (Barton, 1999).

Medicare Part B is known as Supplementary Medical Insurance (SMI). It helps pay the cost of medical equipment and supplies, outpatient hospital services, and physician services. General tax revenues provide 75 percent of the funding, while beneficiaries pay a monthly premium that funds the remaining 25 percent of Part B. The SMI program covers 80 percent of the allowed charge for health services (Barton, 1999; The Century Foundation, 1999).

### **Changes and Controversies in Medicare**

In 1997 Congress passed legislation signed by President Clinton to balance the federal budget, thereby authorizing major reductions in Medicare funding. Unresolved issues with the BBA were the conflicting interests of the small, rural hospitals, the Health Care Financing Administration, and Congress. Rural health care facilities believed the federal government was balancing the budget at their expense. Congressional proponents of BBA insisted that measures had been taken to reduce the inequalities rural health care facilities historically have experienced. From the small, rural hospitals' perspective, however, the Health Care Financing Administration's implementation of the BBA created an expectation gap, and made BBA reforms an important issue for hospitals and rural communities.

As issue management experts have argued (Wartick & Mahon, 1994), expectation gaps between "what is" versus "what ought to be" tend to become the focus for conflicts and are the

impetus for social and organizational change. Indeed, these conflicts were perceived as so severe that lobbying efforts from the health care provider community and other stakeholders in 1999 resulted in revisions to the 1997 legislation (Jones, 2000). The major aspects of both the BBA of 1997 and BBRA of 1999 are discussed below.

### **The Balanced Budget Act of 1997**

Under the auspices of the Balanced Budget Act of 1997, Medicare had drastic budget reductions. Measures were enacted to reduce the projected growth of Medicare spending by \$116.4 billion by 2002. The impact of this funding decline for Medicare has been compared to the impact in the 1980s of the Prospective Payment System (PPS) on hospital insurance (Arent Fox Alerts, 1998). Many of the provisions were to be phased in through 2002. New managed care and private options, reduced payments to hospitals, increases in Part B premiums, and a PPS for outpatient, home health, and skilled nursing services were a few of the major changes.

### **Managed Care and Private Options**

Managed care is becoming increasingly the norm for employer-based health insurance, according to research conducted by The Century Foundation. One study notes that in 1993, 78 percent of workers in firms with 1-24 employees, and 65 percent of those with 25-49 employees had access to traditional fee-for-service health insurance. Only two years later, both those figures had fallen to 30 percent. (The Century Foundation, 1999:2).

As of October 1999, approximately 16 percent of all Medicare beneficiaries were enrolled in managed care plans (Shay, McBride, & Mueller, 2000).

Medicare+Choice allows private insurance companies to offer managed care coverage to beneficiaries. Everyone who has Medicare Parts A and B is eligible, except those who have end-stage renal disease. Managed care plans often encourage preventive health, especially if they are

based on a fixed payment per patient. For example, the majority of managed care plans cover annual physicals, eye exams, certain immunizations, ear exams and outpatient prescription drugs. Proponents of Medicare managed care believe Medicare+Choice has the potential of cutting costs and perhaps improving the quality of care. However, the savings have yet to be seen.

The Health Care Financing Administration is taking steps to educate Medicare recipients of the benefits of managed care plans. In the *Medicare & You 2000* (1999) handbook, the HCFA uses easy to read graphs to show the results of a survey it conducted. The survey measured the communication skills of managed care doctors as viewed by a sample of Medicare managed care plan members. This booklet is just one of the ways HCFA is attempting to educate beneficiaries about the reform.

According to a 1997 U.S. Congressional Budget Office report, Medicare paid about 5 percent more for the beneficiaries who enrolled in HMOs than it would have spent if the participant had remained with traditional coverage (The Century Foundation, 1999). One of the reasons for these higher costs was the process of risk selection. This is the practice of managed care plans marketing to healthier beneficiaries who want lower out-of-pocket costs and more benefits. Less healthy beneficiaries are more likely to stick with what they know. The possible effects of this selection bias are increased premiums and payroll tax rates for those receiving traditional fee-for-service Medicare. In accord with the BBA, a new risk adjustment procedure is being instituted during 2000. This adjustment takes into account the prior hospitalization experience of beneficiaries as a factor for determining the per capita payments for Medicare+Choice plans. Another change Congress has made under the 1997 BBA is to fix the growth rate of managed care plans at a lower rate per capita than in Medicare's traditional fee-

for-service section. In the past, the rate had been a percentage of the program's expected fee-for-service costs. This measure is anticipated to save \$23.2 billion.

These Medicare reform proposals that rely on competition among managed care organizations, however, ignore many seniors living in rural areas. For example, according to a study by Families USA, a consumer advocacy group, Alabama has nearly 240,000 rural Medicare beneficiaries, and only participants in Walker County have access to a Medicare HMO ("Rural Medicare HMOs," 1999). Moreover, national data shows slow growth in Medicare+Choice for rural (2.5%) versus urban (20.3%) communities, with extreme regional variation in the growth and decline in managed care enrollments during 1999 (Shay, McBride, & Mueller, 2000).

### **Reduced Payments to Hospitals**

The second major BBA reform reduced payments to hospitals, constituting almost 30 percent of the expected Medicare program savings over the next five years (The Century Foundation, 1999). This reduction is where rural hospitals have suffered the most since they derive the majority of their revenue from these reimbursements (Rural Policy Research Institute, 1999). According to Robert A. Berenson, Director of the Center for Health Plans and Providers, a division of the Health Care Financing Administration, one in four Medicare beneficiaries live in rural areas (Berenson, 1999). The BBA froze payment increases under the prospective payment system for the 1998 fiscal year, while setting rates for 1999 through year 2002 slightly below the expected increases in medical costs (The Century Foundation, 1999).

### **Increase in Part B Premiums**

A third BBA reform was to increase Part B premiums. In 1997, monthly premiums were \$45.50. Under the BBA they increase to \$64.00 in 2002. Since the elderly spend an average of

21 percent of their disposable income on health care (The Century Foundation, 1999), this increase undoubtedly will place a strain on low-income beneficiaries. According to The Century Foundation, about 78 percent of Medicare beneficiaries have incomes below \$25,000.

### **Prospective Payment System (PPS)**

A PPS sets pre-determined rates for different categories of medical services. Since 1984, Medicare has had PPS for inpatient services based on diagnostic-related groups (DRGs); the BBA authorizes a PPS for outpatient services, which is slated for implementation during 2000. The BBA of 1997 reduced cost-based outpatient services as conversion was completed to a PPS. At the same time, the BBA immediately imposed a PPS for skilled nursing services and introduced an interim payment system with conversion to a PPS after 2000 for home health service payments. Taken together, these measures had unforeseen negative impacts on reimbursements for rural hospitals, all which provide outpatient services and 72% of which offer either or both home health and skilled nursing services (Coburn et al. 1999).

From 1990 to 1996, the rate of Medicare spending on home health and skilled nursing services grew at a fast pace. Understandably, the PPS for skilled nursing services and reductions in home health reimbursements was one of the earliest BBA reforms implemented, but with unanticipated adverse results. For example, between mid-1997 and mid-1999 over 2,500 Medicare-certified home health agencies were closed, and home health payments decreased 38% from 1997 to 1998 (National Association of Home Care, 1999). Indeed, Congressional testimony on revisions to the BBA in 1999 focused on the hardships such closures have created for the elderly (Berenson, 1999).

## **The Balanced Budget Revision Act of 1999**

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 was signed into law on November 29, 1999, providing approximately \$17 billion in additional funding over the next five years. Many of the provisions of the BBRA have a direct impact on rural health care delivery and access to services for rural Medicare beneficiaries. The following discussion highlights these provisions drawing on analyses from the Rural Policy Research Center (Mueller, 1999) and reports from the Health Care Financing Administration (2000).

Section 202 in the BBRA benefits rural hospitals with 100 or fewer beds by allowing them to receive the same payments for outpatient services as they would have received without the implementation of a PPS. This relief extends until January 1, 2004. Section 404 extends the Medicare Dependent Hospital program to October 1, 2006, benefiting rural hospitals with fewer than 100 beds which have 60% or more of their inpatient services attributable to Medicare. These designated hospitals receive enhanced payments. In addition, the BBRA increases the attractiveness of the Critical Access Hospital (CAH) designation. The CAH designation is appropriate for very small hospitals (15 beds or less) with low daily patient census that provide limited inpatient services for an average of no more than 96-hours per patient. The BBRA provides CAHs with all-inclusive rates for inpatient and outpatient services and eases their use of swing beds.

### **Recommendations**

Clearly, small rural hospitals that depend on Medicare patients for the majority of their revenue must take an active role to benefit from the BBRA of 1999 and to counter the negative impacts from the BBA of 1997. While some rural facilities that are strategically positioned with ample community support may be able to muddle through the changes wrought by the BBA and

the BBRA without major reorganization, other hospitals will have to take radical steps. We suggest that at least three different approaches should help rural hospitals survive:

1. Expanding outpatient services
2. Embracing telemedicine and telehealth initiatives
3. Seeking alternative funding sources.

### **Expand Outpatient Services**

To address reduced reimbursements from Medicare, small rural hospitals may expand outpatient services while cutting back on similar inpatient services. Of course, all rural hospitals are already offering some outpatient services. According to a recent study by the Project HOPE Walsh Center for Rural Analysis, rural hospitals obtained more than two-fifths of their total revenue from outpatient services in 1995 (Center for Health Affairs, 1998). In the past, Medicare paid for hospital outpatient services based on hospital-specific costs. Under the 1997 BBA, Congress has enacted several reforms that authorize the implementation of a hospital outpatient PPS. As of August 2000, hospitals will be paid for outpatient services based on their national median costs, and services will be classified into Ambulatory Payment Classification (APC) groups, similar to DRGs for inpatient services.

Fortunately, under the BBRA of 1999, all rural hospitals of 100 beds or less are exempt from the outpatient PPS until January 1, 2004. Moreover, Critical Access Hospitals (CAHs) benefit from a PPS exemption, and receive all-inclusive rates for inpatient and outpatient services. Hence, expanding outpatient services and reducing inpatient beds is definitely advantageous, both for medium-sized rural hospitals with slightly over 100 beds and for small hospitals with daily inpatient census counts close to the CAH 15-bed constraint (Mueller, 1999). CAHs also have advantages since they are not required have the same level of physician staffing

as do secondary and tertiary care hospitals, and may rely more heavily on nurse practitioners and physician assistants (HCFA, 2000).

For medium-sized rural hospitals, attracting non-Medicare as well as Medicare patients can help to offset the future possible adverse effects of the PPS for outpatient services.

Outpatient services appear to be ideal niche for small rural hospitals due to their low number of beds and the fact that, when possible, people prefer to drive to larger hospitals for tertiary or quaternary inpatient services (Rural Policy Research Center, 2000).

### **Embrace Telemedicine and Telehealth Initiatives**

The 1997 BBA includes several new provisions authorizing payment for telemedicine and encouraging telehealth initiatives. The purpose is to bring urban expertise to rural providers, while increasing access to specialist and preventive care for rural populations (Berenson, 1999).

Telemedicine allows for medical consultations and telehealth advice to take place through the Internet, via wide-area networks, or over the telephone. As a noted physician and expert on medical monitoring devices notes: During the next decade diseases requiring medical intervention will be much the same as those being treated today. The site of care may, however, be moved away from the community general hospital to a non-hospital site or to a higher order or specialty hospital at a distance (Wilson, 1999: 1).

The Telecommunications Act of 1996 includes subsidies to help rural health care providers gain access to a variety of telecommunications services at lower rates. According to the Federal Communication Commission (1997), in addition to discounted services, rural providers located in an area without toll-free access to the Internet can receive subsidized toll-free access for up to 30 hours of connection time or \$180 a month, whichever is less. As of

January 1998, a pool of \$400 million a year has been available for funding (American Hospital Association, 1999).

A national survey of telemedicine programs reveals a dramatic growth in telemedicine from 1993 , 1997. The study found a total of 80 active telemedicine programs in 38 states and Washington, D.C, as compared to 12 active programs in 1993 (Grigsby & Allen, 1997). The majority of these programs use broadband technology and are located in academic medical centers or community hospitals; however, after decades of refining, telemedicine is now less expensive and easier to use. New Internet-based alternatives have been created for smaller projects, as opposed to the high-end systems used by NASA and in Pentagon programs; moreover, ordinary telephone service (POTS) is the preferred mode of transmitting voice, video and data.

Systems that use narrow-band lines have the advantage of being accessible to roughly 99% of the population and are inexpensive to operate. Although speed and picture resolution are lower quality than in broadband applications, early reports from the field indicate that POTS is a satisfactory method of employing telehealth to deliver healthcare services. The advances in narrow-band technology along with the availability of a national infrastructure to deliver services with this technology create unprecedented opportunities (Zajtchuk & Gilbert, 1999). Radiology for example, is a common application in rural telemedicine (Hassol et al. 1997) and its use in emergency departments is expanding (Baker & Festa, 1999). Moreover, it would be advantageous for rural hospitals to adopt telemedicine and telehealth initiatives not only to expand access to health services but also to improve the quality of patient information (Shepperd, Charnock, & Gann, 1999).

## **Seek Alternative Sources of Funding**

Small, rural hospitals cannot absorb the Medicare cuts in the BBA of 1997 for an extended period of time and expect to remain unscathed. These vulnerable facilities must seek federal, community, and private funding in order to remain open. For example, a clinic in Bessemer, Alabama, staved off closing its doors after an anonymous donor and Jefferson County each donated \$125,000. The clinic serves more than 2,000 patients. Most of these patients are senior citizens with little or no Medigap insurance.

There are several grant programs specifically targeted at rural areas. In fact, the United States Department of Agriculture (1999) offers financial support through a program called Discover Rural Development. Funding is also available from the Health Resources and Services Administration's (1999) Federal Office of Rural Health Policy through its Rural Health Outreach Grant Program, which makes funds available to rural facilities to expand existing services and enhance health services delivery. Other sources of funding are listed at Pennsylvania State University's (1999) Office of Rural Health web site. These types of grants could be used to expand outpatient services and/or adopt a telemedicine or telehealth system. Clearly, a grant writer may be a small, rural hospital's best asset.

If rural hospitals do not have the staffing and expertise to write grant proposals, they should look toward community volunteers and seek alliances with state and local university programs in health care management. On the one hand, retired and other individuals in the local community may be both experienced and willing to help draft grant proposals. On the other hand, students in health care management undergraduate and graduate programs typically must fulfill internship or other practicum requirements and can be a valuable resource for writing grants, especially when supervised by experienced faculty members and administrators.

## **Conclusion**

Clearly, if rural hospitals can implement each of the recommendations they should be able to survive the changes wrought by the BBA and the BBRA, all other matters being equal. However, reality suggests that none of the proceeding recommendations is equally applicable to every rural hospital; each hospital faces its own unique situation. Hospital CEOs and their boards should assess their strengths, weaknesses, and resources, and then craft a strategy that best fits their opportunities and goals. It may not be feasible for a small, rural hospital to expand outpatient services or to adopt telemedicine and telehealth systems. Grant writers may not already be on staff, easily trained, or available for hire. The money or support may not be there.

Such barriers, nonetheless, are not insurmountable, and one or more of these recommendations should still be practicable. In any case, these recommendations should help rural hospitals take advantage of the opportunities under the BBA of 1997 and the BBRA of 1999. Even if rural hospitals can only implement one of these recommendations, they should be better able to sustain their mission of providing quality health care to local, and often isolated, communities.

## References

- American Hospital Association. (1999). *Small or rural hospitals: Telehealth and FCC universal service funding*. Retrieved October 19, 1999, from <http://www.aha.org/memberserv/smallrhtele.html>
- Arent Fox Alerts. (1998, 28 September). *HCFA announces a Prospective Payment System for outpatient services*. Retrieved October 19, 1999, from [http://www.arentfox.com/alert/hcfa\\_pps.html](http://www.arentfox.com/alert/hcfa_pps.html)
- Baker, S.R., & Festa S. (1999). The use of teleradiology in an emergency setting with speculation on the near future. *Radiologic Clinics of North America*, 37, 1035-44.  
[https://doi.org/10.1016/S0033-8389\(05\)70142-1](https://doi.org/10.1016/S0033-8389(05)70142-1)
- Barton, P. B. (1999). *Understanding the U.S. health services system*. Chicago, IL: Health Administration Press.
- Berenson, R. A. (1999, 14 July). *Testimony before Senate Appropriations Subcommittee on Agriculture, Rural Development, and Related Agencies*. Retrieved November 12, 1999, from <http://www.hcfa.gov/testmony/1999/rural1.htm>
- Center for Health Affairs. (1998). *CHA news: Project HOPE Walsh Center for Rural Health Analysis*. Retrieved November 12, 1999, from <http://www.projhope.org/CHA/news/summer98/walshs98.html>
- Century Foundation. (1999). *Medicare reform, 1-5*. Retrieved August 25, 1999, from [http://www.tcf.org/publications/basics/new\\_medicare/WhatsNew.asp](http://www.tcf.org/publications/basics/new_medicare/WhatsNew.asp)

- Coburn, A., Fluharty, C.W., Hart, J.P., MacKinney, A.C., McBride, T., Mueller, K., & Wakefield, M. (1999). *Implementation of the provisions of the Balanced Budget Act of 1997: Critical issues for rural health care delivery* (Research Report P99- 5). Columbia, MO: Rural Policy Research Institute.
- Federal Communications Commission. (1997, 5 September). *Updated frequently asked questions on universal service for rural health care providers* (CC Docket No. 96-45). Retrieved July 18, 200, from [http://www.fcc.gov/Bureaus/Common\\_Carrier/Public\\_Notices/1997/da971932.html](http://www.fcc.gov/Bureaus/Common_Carrier/Public_Notices/1997/da971932.html)
- Grigsby, B., & Allen, A. (1997, August). Telemedicine programs: Fourth annual review. *Telemedicine Today*, 42(8), 30-38, 42.
- Hart, G., Amunndson, B., & Rosenblatt, R. (1990). Is there a role for the small rural hospital? *Journal of Rural Health* 6(2), 101-18. <https://doi.org/10.1111/j.1748-0361.1990.tb00194.x>
- Hassol, A., Irvin, C., Gaumer, G., Puskin, D., Mintzer, C., & Grigsby, J. (1997). Rural applications of telemedicine. *Telemedicine Journal*, 3, 215-225. <https://doi.org/10.1089/tmj.1.1997.3.215>
- Health Care Financing Association. (1999). *Medicare & you 2000*. Baltimore, MD: U.S. Department of Health and Human Services.
- Health Care Financing Association. (2000). *HI & SMI trustees report: Medicare amendments since the last report*. Retrieved July 20, 2000, from <http://www.hcfa.gov/pubforms/tr/hi2000/seciia.htm>

- Health Resources and Services Administration. (1999). *Federal Office of Rural Health Policy: information on the Rural Health Outreach Grant Program*. Retrieved November 22, 1999, from <http://pathsrvr.rockford.uic.edu/hrsa/ruralhp.html>
- Jones, W.J. (2000). Medicare and the rules of national policymaking: If A, then B. *Journal of Healthcare Management*, 45(2), 84-88.
- Mueller, K. (2000). *Rural implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999* (Research Report P99-11). Columbia, MO: Rural Policy Research Institute.
- National Association of Home Care. (1999). HCFA data reflect staggering drop in home health outlays. Retrieved November 22, 1999, from <http://www.nahc.org/NAHC/NewsInfo/99nr/hhout.html>
- Pennsylvania State University. (1999). *Pennsylvania Office of Rural Health: Federal grant opportunities relevant to rural health*. Retrieved October 19, 1999, from: <http://www.cas.psu.edu/docs/casdept/aers/porh/federal.html>
- Rural Medicare HMOs are scarce. (1999, September 11). *Daily Mountain Eagle*, p. A3.
- Rural Policy Research Institute. (1999, 2 November). *Rural by the numbers: Health*. Retrieved July 18, 2000, from <http://www.rupri.org/rnumbers/health/index.html>
- Shay, B., McBride, T., & Mueller, K. (2000). *A report on enrollment: Rural Medicare beneficiaries in Medicare+Choice plans* (Rural Policy Brief 5:1). Columbia, MO: Rural Policy Research Center.
- Shepperd, S., Charnock, D., & Gann, B. (1999). Helping patients access high quality health information. *British Medical Journal*, 319, 764-766.  
<https://doi.org/10.1136/bmj.319.7212.764>

- United States Department of Agriculture. (1999). *Discover rural development*. Retrieved October 21, 1999, from <http://www.rurdev.usda.gov/rd/index.html>
- Wartick, S.L., & Mahon, J.F. (1994). Toward a substantive definition of the corporate issue construct. *Business & Society*, 33, 293-311.  
<https://doi.org/10.1177/000765039403300304>
- Wilson, C.B. (1999). The impact of medical technologies on the future of hospitals. *British Medical Journal*, 319, 1287-1289. <https://doi.org/10.1136/bmj.319.7220.1287>
- Zajtchuk, R., & Gilbert, G.R. (1999). Telemedicine: A new dimension in the practice of medicine. *Disease-a-Month*, 45, 197-262.  
[https://doi.org/10.1016/S0011-5029\(99\)90009-3](https://doi.org/10.1016/S0011-5029(99)90009-3)