Center for Mississippi Health Policy

ISSUE BRIEF

RURAL HOSPITALS

Economic and Health Implications in Mississippi

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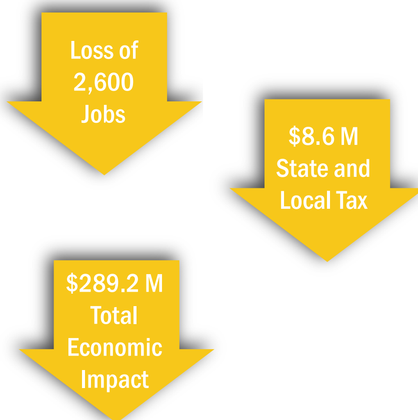
In 2015, the Center for Mississippi Health Policy commissioned a study by researchers from the Social Science Research Center (SSRC) at Mississippi State University to examine the economic impact of rural hospitals on Mississippi communities. This issue brief summarizes the findings of the SSRC report and examines policy options for rural hospitals.

The healthcare delivery and financing systems in the United States are evolving rapidly, and the impact on small rural hospitals is made evident by increasingly common news of closures or employee layoffs. Since 2010, 58 rural hospitals have closed nationally, mostly in the South, including two in Mississippi. Another 283 hospitals nationwide have been identified as "vulnerable," with 22 of those in Mississippi-the highest percentage in the country (see Figure 2). In 2014, the Office of the State Auditor produced a report on "The Financial Health of Publicly Owned Rural Mississippi Hospitals" which identified rural public hospitals at risk of closure in the state. The SSRC report provides an updated look at the financial health of hospitals in the state, both publicly and privately owned.

SSRC identifies nine "most at risk" hospitals around the state (see Figure 1). Four hospitals were identified as having the highest level of risk of closure, three of which were not included on the state auditor's "watch list" from the 2014 report. For comparison's sake, the six hospitals on the state auditor's list were included in the SSRC analysis, bringing the total number of "most at risk" hospitals to nine. The economic impact analysis determined that the closure of all nine "most at risk" hospitals would lead to a loss of an estimated 2,600 jobs, approximately $8.6 million in state and local tax revenue, and a total economic impact of $289.2 million.

IMPACT OF CLOSURE OF NINE "MOST-AT-RISK" HOSPITALS:



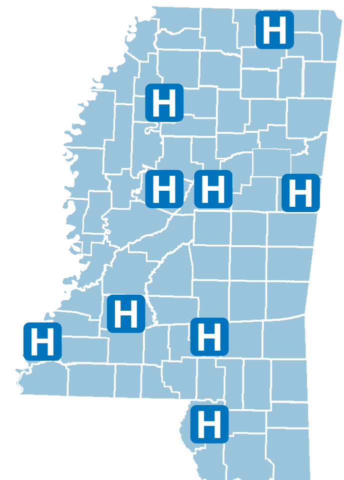
Source: McDoom, Chang, Gnuschke, and Mirvis. (2015). Social Science Research Center.

FIGURE 1. NINE HOSPITALS IN MISSISSIPPI AT GREATEST RISK FOR CLOSURE (SSRC, 2015)

Level 3 Risk
- Covington County Hospital
- Holmes County Hospital & Clinics
- Tippah County Hospital
- Highland Community Hospital

Level 2 Risk
- Montfort Jones Memorial Hospital
- Hardy Wilson Memorial Hospital

Stable*
- Noxubee County General
- Tallahatchie County General Hospital
- Natchez Regional Medical Center



**These three hospitals were listed on the Auditor's report as "most at-risk" and are therefore included in the SSRC report's estimates of greatest potential for closure.*

Note: Some of these hospitals are owned by larger hospitals or health systems.

Policy Impacts on Hospital Stability

CRITICAL ACCESS HOSPITAL

"Critical access hospital" is a Medicare designation for a hospital that meets the following criteria:

- Has no more than 25 inpatient beds
- Has an annual average length of stay no more than 96 hours for acute inpatient care
- Provides 24-hour, 7-day-a-week emergency care
- Is located in a rural area, at least 35 miles drive away from any other hospital or CAH (fewer in some circumstances).

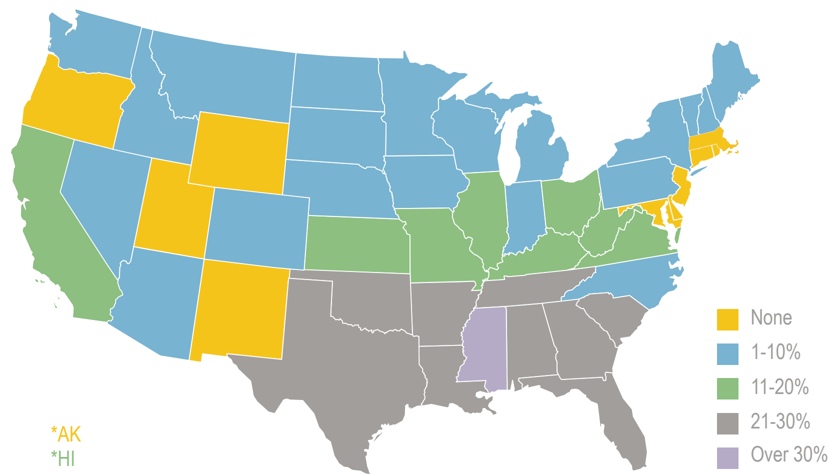
Source: Center for Medicare and Medicaid Services. (2014).

Changes to Medicare payment policies in the 1980's designed to provide incentives for hospitals to become more efficient (e.g. the prospective payment system which pays hospitals a fixed amount based on the diagnosis) were especially challenging for rural hospitals. In response, the federal government enacted programs that were designed to help small rural hospitals survive financially, such as the Critical Access Hospital (CAH) designation, the Medicare-Dependent Hospital Program, the Medicare Rural Flexibility Program, and the Low Volume Hospital Program. The Medicare Payment Advisory Committee has noted that these programs have improved the financial stability of rural hospitals significantly.

CAH designation is cited as being particularly helpful to small rural hospitals. This program allows qualifying facilities to be paid on a "cost-based" reimbursement rather than the prospective payment system. Recently, there have been proposals offered in Congress to make changes to CAH designation which could impact rural hospitals negatively. The scheduled expiration of some of the more favorable policies and a shift to value-based purchasing by the Medicare program also threaten to reduce reimbursements to rural hospitals.

CAH designation is cited as being particularly helpful to small rural hospitals.

FIGURE 2. PERCENTAGE OF RURAL HOSPITALS CLASSIFIED AS "VULNERABLE," BY STATE (IVANTAGE, 2015)



OTHER FACTORS CONTRIBUTING TO FINANCIAL INSTABILITY OF RURAL HOSPITALS

- Rural populations tend to be older, poorer, less educated, and less healthy.
- Rural residents are less likely to have health insurance coverage.
- The rural hospital payer mix is more likely to have a higher proportion of patients with Medicare and Medicaid which generally pay less than private payers.
- Small size and lack of capital mean fewer resources to invest in upgrading equipment or investing in new technologies.
- Severe shortages of health care providers make recruitment difficult.
- Lower patient volumes, particularly combined with a less favorable payer mix, put rural hospitals at a disadvantage financially and can also have implications for quality of care.

Source: McDoom, Chang,Gnuschke, and Mirvis. (2015). Social Science Research Center.

The passage of the Affordable Care Act (ACA) has had both positive and negative impacts on rural hospitals. On the positive side, the Act was designed to reduce the number of uninsured, and Mississippi has seen a drop in the percentage of adults who lack health insurance coverage. Among the many other provisions of the health reform law, however, hospitals are struggling to meet requirements related to adopting electronic medical records, improving quality by reducing hospital readmissions, and coping with changes in reimbursement. One major reimbursement issue is the scheduled reduction in Medicaid Disproportionate Share (DSH) payments that at least partially compensate hospitals for providing care for the uninsured. Under the ACA, DSH payments are set to be reduced substantially as the Health Insurance Marketplace and Medicaid expansion are implemented. States like Mississippi that have not expanded Medicaid will not have that particular coverage growth to offset the DSH cuts.

Policy Options for Rural Hospitals

Administrators of small rural hospitals cite the need for continuation of the favorable reimbursement policies that have sustained their facilities. Third-party payers, however, are seeking to improve efficiencies and lower costs and are not supportive of continuing payment policies that do not meet these goals. Payers are interested in seeing improvements in the health status of their covered members. A mutually beneficial resolution would allow the facility to remain financially viable, retaining health care professionals in the community, while providing the services targeted to meet the population's health care needs at a reasonable cost. Some hospitals have considered converting to a different type of facility, such as a rural health clinic offering after-hours care. In some states hospitals are transforming themselves into health care "hubs" in their communities and focusing on improving the health status of the population. Such creative approaches, however, often require flexibility in laws, regulations, and policies. Current payment policies rarely reward such efforts.

Better alignment of economic and health incentives would help small rural hospitals adapt more effectively.

Better alignment of economic and health incentives would help small rural hospitals adapt more effectively. The IRS now requires non-profit hospitals to conduct a community health needs assessment and develop an implementation plan every three years. Service needs identified in these plans, however, may not be financially beneficial to the facility. Financial incentives encourage hospitals to identify and offer lines of services (such as cardiology or sleep labs) which will generate sufficient revenue. While this strategy might improve hospital finances, it does not necessarily address the most pressing community health needs. The migration of payment policies from rewarding volume to value will help better align financial and health goals, but will require a significant investment in systems needed to measure and evaluate performance as well as strong executive leadership and management skills.

Some rural hospitals have noted success from engaging consultants to assist in implementing operational and financial recovery programs. The Mississippi State Department of Health's (MSDH) Office of Rural Health has grants available to assist hospitals in a variety of ways to improve financial operations (see sidebar). In 2013 and 2014, the MSDH Office of Rural Health commissioned evaluations of several hospitals around the state by Stroudwater Associates. Some of the actions the consultants recommended included the following:

- Ensure that all charges are captured for cost reports
- Review and update chargemasters and improve collections
- Improve admission practices and appropriateness
- Establish Emergency Room redirect programs
- Market outpatient services
- Build relationships with primary care providers and position the hospital for population health focus
- Determine service area population needs
- Prioritize quality improvements

MSDH OFFICE OF RURAL HEALTH ASSISTANCE
SMALL RURAL HOSPITAL IMPROVEMENT GRANT
Currently being used by 45 small rural hospitals in Mississippi for activities related to value-based purchasing, accountable care organizations or shared savings, payment bundling/prospective payment system, and care transitions.

MEDICARE RURAL HOSPITAL FLEXIBILITY GRANT
Currently being used by 33 Critical Access Hospitals in Mississippi to fund projects that aim to improve rural healthcare infrastructure.

Source: Mississippi State Department of Health,Office of Rural Health. (2015).

Summary

Rural hospitals are a vital part of their communities for both economic and health related reasons. A variety of factors, however, has made it increasingly more difficult for small rural hospitals to survive and thrive. The economic impact of the closure of local hospitals can be substantial, as these institutions are often some of the largest employers in the area and purchase services and products from other local businesses. From a health care perspective, these hospitals may be providing a safety net for vulnerable populations who lack resources to access care from other providers.

Federal payment policies have been foundational to the financial status of small rural hospitals. Congress has taken several policy actions in the past that were designed to support small rural hospitals, but many of these provisions are scheduled to expire or have been targeted for change.

The State Department of Health's Office of Rural Health has provided technical assistance to many small rural hospitals in Mississippi to help guide them in making management improvements. Others have sought help from their own consultants. Often the strategies employed are focused on increasing revenue to improve the hospital's financial condition, which may or may not be consistent with meeting the key health care needs of the community.

Each hospital's situation is unique, and solutions need to be tailored accordingly. Some small Mississippi hospitals have undergone comprehensive financial and operational evaluations, taking into account the health care needs and consumer desires of their communities, and have demonstrated that they can be successful. It will take strong local leadership, a willingness to adapt to a changing health care environment, and supportive payment policies to ensure that these hospitals meet the economic and health needs of their communities.

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