



GEORGE MASON UNIVERSITY

## Rural Hospitals and Rural Economic Development

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Chairman Cochran, Senator Harkin, members of the Subcommittee, I am Mary Wakefield, director of the Center for Health Policy, Research and Ethics at George Mason University. I want to thank you for holding a hearing on rural health care again this year and I am pleased to participate in it. This morning I will address two major topics in my testimony: First, the relevance of health care to rural economic development, and second, the financial health of rural hospitals.

There is an old expression that says, “If you have your health, you have everything. If you lose your health, you lose everything.” On a larger scale, it is also true. Communities that have good access to health care can survive and grow. But communities that lose local health care and good access to services, lose their ability to prosper. Health care service is a key to economic survival. It is as much a cornerstone of the local economy as schools and business. Health care service is not only an essential service, it is an economic engine that generates hundreds of thousands of dollars in additional revenue for local areas. Every health care dollar spent locally recycles through that local economy one and a half times.

### **Rural Economic Development**

The economic statistics offered today come from a substantial body of national research developed over the last decade, much of it pioneered out of Oklahoma State University, and the Universities of Nebraska and Kentucky – and supported by the Agency for Healthcare Research and Quality and the USDA. Health care provides 10 to 15 percent of the jobs in many rural counties. When the secondary benefits of those jobs are included, health care accounts for 15 to 20 percent of all jobs. Also, when industry and business consider location, schools and health services are the most important quality-of-life factors influencing their choices. In addition, a strong health care system also attracts retirees.

The economic impact of individual practitioners is also important to consider. One Oklahoma study of a small community revealed that if a single physician were to move away or retire, a total of 8.4 jobs would be lost within the local economy as a result of that departure.

One study of the economic impact of National Health Service Corps physicians on rural communities found that each generates more than five jobs and over \$233,000 in income to the local economy. In addition to the fact that the Corps provides essential access to health services for communities in need of practitioners, this is another good reason to reauthorize this program.

Unfortunately, too much health care spending takes place outside of rural communities. For example, an average rural county of 22,000 residents generates \$73 million annually in health expenditures, but only about \$35 million is spent locally. The money that rural citizens pay out for health insurance premiums and Medicare taxes does not return to the local community in the form of payment for services at nearly the same rate it flowed out of the community.

The movement of both services and dollars out of rural communities impacts both rural residents and the economy of their communities. Some of this loss is unavoidable where there is a need for highly specialized services. But a significant portion could stay in rural areas if the health system were organized to encourage local utilization. The trend in the health care industry is to move care and related expenditures from high-cost acute care settings back to the home sites of patients and providers. The lower intensity, lower cost of care of the sort that predominates in rural communities can be advantageous in an era of cost containment.

Small communities can provide a broad array of primary, preventive, wellness, home health, and residential care. Larger rural communities of 40,000 to 50,000 can provide a wide range of fairly sophisticated services. But delivering affordable, cost-effective care requires knowing the real needs of the community.

### **Rural Hospitals and Rural Health Services**

When considering rural economies, why should we be especially concerned with rural hospitals? -- Because in rural areas, they are a lynchpin for the development of local and regional health care services. There is little service redundancy in rural areas, especially in small towns. In contrast, metropolitan areas are flush with services – multiple hospitals, nursing homes, home health agencies, and ambulance companies, not to mention freestanding surgical centers, freestanding radiology centers, freestanding clinical laboratories, ambulatory care clinics and the like. But in rural towns, there are fewer providers in most service categories and gaping holes in some types of service, like obstetrics and kidney dialysis.

The rural system is also highly inter-dependent. A rural town's only hospital very likely has the only outpatient surgery unit, the only radiology unit and the only clinical laboratory. Its outpatient clinic may be the only primary care practice in town, and it may have the only ambulance service and the only home health agency. The importance of rural hospitals as coordinators of services for their communities can be seen in these statistics: In 1996, approximately two-thirds of rural hospitals provided home health services and one-third provided nursing home care in a nursing home facility. Twenty-one percent of rural hospitals in 1996 provided both.

While not every hamlet can afford a hospital, rural communities minimally need a hospital within reasonable distance to anchor their local primary care, support emergency services, and stabilize the ill and the injured.

Rural hospitals have been able to keep going, thanks to a patchwork of special "fixes" and protective policies enacted by Congress in the last decade. For example, some rural hospitals can apply for payment reclassification to a higher urban wage area rate. Some are exempted from the inpatient PPS by virtue of their classification as sole community hospitals, or status as Medicare-dependent, or their willingness to become limited service hospitals with a restricted average patient length of stay. This latter

will have a complex and reverberating impact on both rural health and the rural economic picture.

The BBA introduces four new prospective payment systems: one for outpatient care, another for skilled nursing -- already being phased in, another for home health, and yet another for ambulance services<sup>1</sup>. These new payment systems will have a compound impact on rural hospitals and the rural health infrastructure. Seventy-two percent of all rural hospitals will come under two of the new Medicare PPS payment policies and 21 percent will be affected by at least three of them. They will also have a substantial effect because rural hospitals are more dependent on Medicare reimbursement than urban

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<sup>1</sup> The fourth is an ambulance fee schedule. Until now, Medicare has paid hospital-based ambulance services on a cost basis.

hospitals. Medicare patient expenses in 1998 accounted for 47 percent of their total patient care expenses, compared to 36 percent of urban hospitals'.<sup>2</sup>

A year ago at this time there was great concern that the BBA, with its new Medicare prospective payment mandates and its reductions in inpatient care payments, was creating a financial crisis for rural hospitals and other rural providers. While there were a lot of assumptions at that time, there were no post-BBA data on which to base any corrections in our course of action.

Nevertheless, given the severity of projections for the impact on rural hospital outpatient revenues using 1997 data, Congress agreed to a temporary hold-harmless provision for them in the Balanced Budget Refinement Act of 1999. This provision (through year 2003) is not insignificant to rural Americans: It protects rural hospitals of up to one hundred beds. That's 1,785 hospitals or fully 82 percent of all rural hospitals.

Mr. Chairman, today we have some data by which to measure the impact of the BBA so far on rural hospitals. The February Medicare cost reports are in and analyzed and the Medicare Payment Advisory Commission has issued its June Report. For the first time, this report not only compares rural hospitals with urban hospitals but it looks at rural hospitals on a number of dimensions that include five major subgroups: The report provides some data on very small hospitals of under 50 beds, those with 50-100 beds, and those hospitals operating under special programs – namely rural referral centers, sole community, and small Medicare-dependent facilities. These breakouts give policy makers a much more detailed picture of the condition of rural hospitals and make it possible to track and target – when necessary -- new policies and programs to those groups most in need.

What do the data tell us for 1998 -- the first year BBA policies began to have an effect on hospital revenues? The picture is not reassuring. There is a decline in Medicare margins for inpatient care, and rural hospitals' revenues on average have decreased more<sup>3</sup> While urban hospitals' overall average margin was 15.8 percent in 1998 – a decrease for them of 2.3 percent – rural hospitals' margins were down to 5.2 percent with a 4.3 percent decline in just one year.

In 1997, the average Medicare inpatient margin of rural hospitals had been half as large as urban hospitals: 9.5 percent compared to 18.1 percent. One year later it was only a third of the urban hospital margin. The poorer financial profile of rural hospitals under Medicare is also reflected in the percent with negative Medicare inpatient margins. Thirty-nine percent of all rural hospitals had negative inpatient margins compared with about half that proportion of urban hospitals at 20.6 percent.

The lowest Medicare inpatient margins reported by MedPAC for any hospital groups are for two, somewhat overlapping categories: very small rural hospitals with

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<sup>2</sup> MedPAC. June 2000 report. Table C-16, p. 189.

<sup>3</sup> MedPAC Report to the Congress. June 2000. Table C-3, p. 178.

fewer than 50 beds and government-owned rural hospitals. In 1998, the “very smalls” had a margin of 2.6 percent and rural government-owned hospitals had a margin of 1.8 percent. Within these two categories, the bottom 10 percent had negative margins starting as low as minus 26 percent. It’s hard for any business to survive long with these kinds of margins.

Another reading on the BBA’s impact to date is available in the form of Medicare payment-to-cost ratios reported by the American Hospital Association’s annual survey. This survey takes into account all expenses attributable to the patient, not just Medicare’s allowable costs. In 1998, the overall Medicare payment for rural hospitals was 6.4 percent less than their costs – down further from their 3.9 percent loss in 1997. Compare this to urban hospitals whose overall Medicare payments exceeded their costs by 1.9 percent in 1998.<sup>4</sup>

This downward turn in 1998 for rural hospitals and Medicare revenues is especially worrisome because it reflects just the leading edge of changes due under the BBA. The worst may well be yet to come with the extension of prospective payment over more forms of service. Over the past several years, rural hospitals have diversified their services, enabling them to meet a wider range of health care needs for rural communities. But without adequate revenues from these services -- outpatient care, nursing home care, home health and ambulance services, it can be difficult to keep the doors open.

Yet none of the new prospective payment systems contains any special payment adjustments for rural hospitals. Worse, they may be imposed without correcting some fundamental problems in the calculus of the Medicare formulas. I would like to focus on those problems because they now represent an important opportunity for Congress to put rural health care on a more level playing field with the rest of the nation.

### **Policy Opportunities**

There are three areas that offer an opportunity to correct Medicare payment inequities. These are flaws, omissions, or inequities in the program’s payments that can be corrected at little cost to the Medicare fund. Addressing them could go a long way toward protecting rural health care access. Left unchanged, and replicated in the forthcoming PPS formulas, these flaws will compromise rural health services – eliminating them in some instances, and adversely impacting rural economies in the process.

First, there is the long-recognized bias toward urban hospitals in the payments that Medicare makes to hospitals shouldering a disproportionate share of low-income patients. These are known as DSH, or Disproportionate Share Payments. Second, Medicare reimbursement formulas do not recognize or compensate small, low-volume rural hospitals for the higher per-unit cost they incur in providing care. Third, Medicare’s

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<sup>4</sup> MedPAC. June 2000 report. Table C-15, p. 188.

geographic wage adjustment, which is supposed to account for differences in urban and rural labor rates, is flawed and under-compensates many rural hospitals.

### **Disproportionate Share (DSH) Payments**

Let me begin with the DSH payments. Under the present complex allocation formulas, hospitals with the same proportion of low-income patients can have very different payment adjustments. Current policy particularly favors urban areas. Almost half of urban hospitals receive DSH payments compared with only about a fifth of rural facilities. Also, urban facilities receive payments that are steeply graduated by hospital size.

As a consequence of this inequity, more than 95 percent of all DSH payments go to urban hospitals. How much money are we talking about? In 1998, total Medicare DSH payments added up to six percent of Medicare's total inpatient PPS payment, which was \$75.6 billion. That's \$4.5 billion -- and urban facilities received 95 percent of it.

The Medicare Payment Advisory Commission has made a recommendation every year since 1998 to redress this situation by treating all hospitals equally. The commission proposes that payments should be made according to each hospital's share of low-income patient costs. What would this change mean for rural hospitals as a group? It would increase the total of Medicare's inpatient PPS payment to them by 6.5 percent. It would decrease the total inpatient payment to urban hospitals by only one percent.

### **Absence of Low-Volume Adjustment**

Let me now turn to the second issue that relates to the unique circumstances rural health care systems face: That is the problem of fixed overhead costs coupled with low patient-volume. Medicare's prospective payment policy was designed to promote efficiency and eliminate waste. The decision to pay all providers the same base price for the same procedure, irrespective of hospital size, was deliberate. The prospective payment for a procedure was based on the average cost per case incurred by a presumably efficiently operated hospital. Also, it was not unreasonable to assume that a uniform price would be an incentive for smaller providers to merge and achieve economies of scale that could result in lower costs and higher margins.

I would like to suggest to the committee that this design feature was sensible policy for urban providers, but not, certainly, for all rural providers -- for whom major economies of scale are simply not achievable. In terms of low volume and fixed overhead, there are good lessons government programs can learn from the private sector. For example, even as we attempt to draw large managed care plans into rural areas to serve Medicare beneficiaries, the private sector is telling us that the market dynamics are difficult; and given payment rates, they cannot afford to do business in low-volume, low-density places.

Basically, the “one-size fits all” approach to Medicare payment policy ignores the population distinctions between rural and urban populations and their order of magnitude: Urban hospitals serve populations in the tens and hundreds of thousands. Forty percent have 200 or more beds and 75 percent have a hundred or more beds. Rural hospitals serve populations numbered in the hundreds and the thousands. Eighty-two percent have fewer than one hundred beds.<sup>5</sup>

Since many rural towns have few or only one provider for particular services, it is critical in these regions to take into account the relationship between a provider’s volume and the unit costs. An X-ray machine and a minimal staff are required for a radiology lab, whether it takes five X-rays a day or 50. These fixed costs in low volume facilities result in high costs per unit of service. And almost all services have fixed costs associated with them - costs that can’t be eliminated through attempts to improve efficiency.

### Rural Ambulance Service

A good example of the unique problems with high fixed costs and low volume is rural ambulance service. The availability of ambulance service is one of the top priorities for developing viable health systems in rural communities. Medicare payment must be adequate to sustain such a critical service. HCFA will soon publish a proposed rule on the Medicare ambulance fee schedule that was developed through a negotiated rulemaking committee. This schedule recognizes the need to adjust rates to compensate for the higher costs per transport where population density is low, although there is a methodological obstacle of not having a scale of rurality for making graduated payments. The proposal for a 50 percent add-on to the mileage rate on the first 17 miles is a temporary proxy for the higher cost of low-volume suppliers and the negotiated rule-making committee urged development of a method that could address low-volume payment as soon as possible. This will be extremely important to the new Critical Access Hospitals and the effort to integrate them with rural ambulance service.

Mr. Chairman, I believe that it is time for the Congress to consider including a low volume adjustment for small, isolated rural providers for all of the prospective payment systems: the new systems as well as inpatient PPS. Such an adjustment would be possible to design using available data. Most importantly it would be inexpensive – in the range, according to one estimate, of only \$500 to \$1,500 for every million dollars in Medicare inpatient payments. This is because total Medicare payments to small rural providers are a tiny proportion of total Medicare payments. In 1996 the Prospective Payment Advisory Commission estimated that rural hospitals of under 50 beds received only two percent of Medicare inpatient PPS operating payments and those of 50-99 beds received only four percent.

I am attaching to my testimony today a paper by Dr. Graham Atkinson, which offers a fuller discussion of policy approaches to accomplish this.

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<sup>5</sup> MedPAC. June 2000 report, p. 44.

## Medicare Geographic Area Wage Adjusters

The last problem in need of a policy solution has to do with the Medicare Geographic Area Wage Index. Currently, the hospital wage index used to adjust Medicare inpatient payments for geographic variations in labor costs generally undercompensates rural hospitals and overcompensates urban hospitals. While the index should rightly reflect area labor costs that are beyond a hospital's control, it should not reflect a rich occupational mix that results from a hospital's desire to enhance its staffing. But in fact, the current index is calculated on averages in actual payrolls rather than the relative differences in wage scales.

The rural inequity in the wage index has unfairly depressed rural hospitals' inpatient payments for close to two decades. Now it is to be used in the new prospective payment systems rather than just the one for which it was designed. The rural underpayment built into the current inpatient system is about to be extended to a much larger proportion of Medicare payments to rural hospitals, not to mention freestanding rural nursing homes and home health agencies. Mr. Chairman, there is a new urgency to the need for Congress to address the rural inequity in the Medicare area wage index.

As far back as 1988 and at least four times since then, the Prospective Payment Advisory Commission expressed concern over the inappropriate treatment of occupational mix in the wage index.

Since then, MedPAC has recommended improving the crudely drawn definition of hospital labor market areas, which is based on the MSA, non-MSA dichotomy and on the arbitrary boundaries of states. In fact, rural labor markets are treated as statewide and ending at the state line. This ignores legitimate variations in the labor market across a state's rural areas, as well as the reality that labor market areas often include parts of two or more states. The result is that neighboring hospitals on opposite sides of the state boundary are often compensated very differently for the same procedure. For example, a North Dakota rural hospital across the border from a neighboring hospital in Minnesota will be paid eight percent less by Medicare for all its Medicare cases: It will get only \$3,515 from Medicare for a simple pneumonia and pleurisy case, compared to the \$3,821 paid to the Minnesota hospital.

Thanks to Congressional action to alleviate large wage index differences near labor market borders, some hospitals today can apply for reclassification to an adjacent area. However, both HCFA and ProPAC analysts have said this has not solved the problem. ProPAC specifically recommended a more accurate delineation of labor market areas.

An enormous problem now on the horizon is the fact that this flawed hospital inpatient wage index is inappropriate to apply to skilled nursing facilities and home health agencies as they move to prospective payment. The mix of employees and the wages paid by these providers differ substantially from those of hospitals. Yet HCFA is using the inpatient wage index for these providers.

By way of example, when the state of Wisconsin recently used its own nursing home wage data to calculate an appropriate wage index for rural Wisconsin, the result was a much higher index than the hospital-based one proposed by HCFA in the May 2000 Federal Register notice. Rural Wisconsin's was 98 percent of Milwaukee's wage index, not 93 percent as calculated by HCFA using the hospital index. Lest this seem too trivial, let me add that the state calculated it would mean a six or seven million-dollar difference a year in reimbursements for rural Wisconsin nursing homes. Mr. Chairman, the wage index is certainly not an easy topic to tackle, but it is a crucial one for rural areas, and I will leave your staff with a policy brief on the topic by Anthony Wellever just published in conjunction with the Rural Policy Research Institute.

### **Monitoring the Whole System**

As we move further into the post-BBA era, it will be important to monitor reform's effect on the whole rural health care system. That's to say, the highly interdependent nature of rural health care providers makes it important to have the latest financial information on the combined impact of all recent and future Medicare policies, including the new prospective payment systems.

Studies which look only at how many home health agencies have closed, for example, will miss the point in rural areas: If a rural hospital operates the only home health agency, it is more likely to keep that service open to ensure patients have access to post-hospital care -- even though home health may very well move from a profit center to a loss center for the hospital. A more valid measure of home health access would be to look at operating margins for hospitals with hospital-based home health agencies before and after the new interim payment system was imposed.

### **Seeing the Economic Stakes**

Mr. Chairman, our nation's population has shifted from largely rural to urban in just three generations. Even so, rural Americans today number 61 million people -- exceeding the population of France and many other European nations combined. Consequently, we need to ensure that our national policies do not defeat rural economics, or compromise rural beneficiaries' access to quality health care services. Special Medicare payments to rural providers should not be considered add-ons. Medicare payments per enrollee are already 18% less per rural beneficiary than per urban beneficiary -- even with the modest programs focusing on rural needs. There is a legitimate cost of sustaining health care services in rural areas. And there is a tremendous return on investment, when we realize the economic impact of the health care sector.

Fortunately, federally supported research on this subject is not gathering dust on university shelves. Through an important new national initiative, for example, rural communities are looking at their own economic profiles. Today there is a project underway in fifteen states called "Operation Rural Health Works," in which local data is

collected to demonstrate the multiplier effect of locally spent health care dollars on services and employment for individual communities. It's a joint project supported by USDA's Cooperative Extension, the Health Resources and Services Administration, and the Minnesota-based Rural Policy Research Institute. This and other research endeavors on rural health care systems and their relationship to rural economies will help to illuminate challenges and policy opportunities for sustaining health care and strengthening communities for millions of rural Americans.

Mr. Chairman, thank you for your attention. I would be happy to answer any questions.