REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-23

Subject: Rural Hospital Payment Models

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Referred to: Reference Committee J

At the June 2023 Annual Meeting the House of Delegates adopted Policy D-465.996. The second resolve of the adopted policy asks that the American Medical Association (AMA) study alternative payment models for rural hospitals to examine their feasibility, and that the study include a discussion as to the feasibility of the patient-centered payment and standby capacity payments models. Consistent with Policy D-465.996, this report examines alternative payment models, including patient-centered payment and standby capacity payment models, that could assist in efforts to ensure that rural hospitals remain financially viable and able to provide care to rural patients.

BACKGROUND

Nearly one-fifth of the U.S. population, about 60 million people, live in rural areas. Individuals living in these areas are more likely to be sicker, older, and underinsured than their urban and suburban dwelling counterparts. They also have higher rates of smoking, hypertension, and obesity. These factors along with higher poverty rates, lead to health disparities for rural Americans. Additionally, rural populations are more likely to be beneficiaries of Medicare or Medicaid with nearly half of rural hospital revenue coming from these sources. A more in-depth look at the state of health care for rural populations can be found in CMS Report 09-A-21, Addressing Payment and Delivery in Rural Hospitals, and CMS Report 09-A-23, Federally Qualified Health Centers and Rural Health.

RURAL HOSPITALS

Rural hospitals are those that exist and serve communities outside metropolitan areas and make up about a quarter of all American hospitals.[1] These hospitals are geographically isolated, often making them one of the only, if not the only, source of health care in the community. These hospitals are a vital point of access to communities that are often older, sicker, and less insured than urban and suburban communities.

Rural hospitals are incredibly vulnerable not only to many of the issues facing health care generally but often face additional unique challenges like low patient volumes and higher fixed costs. As a result of lower patient volumes many rural hospitals face challenges in both reporting and being assessed by quality metrics. A full discussion of the complications faced by rural hospitals in relation to quality metrics can be found in CMS Report 09-A-21. Additionally, nearly a third of all rural hospitals in the U.S. are at risk of closing and a third of those hospitals are in jeopardy of immediate closure.[2] An estimated 136 rural hospitals closed completely between 2005 and 2021

with 19 closing in 2020 alone.[3] Nearly 100 additional facilities no longer provide inpatient services and have either converted to a Rural Emergency Hospital or provide limited outpatient services.[4]

These closures are often a result of payment rates that do not cover costs. Rural hospitals face a unique financial situation as many insurers do not pay them enough to cover the cost of providing services in low-population and rural communities.[5] Specifically, many private payers and Medicare Advantage plans pay rural hospitals less than the actual cost to deliver services.[6] While rural hospitals can sometimes also lose money when providing services to Medicaid beneficiaries, 19 states offset these losses with additional payments to hospitals via bolstered reimbursement rates.[7] Traditional Medicare, not Medicare Advantage, beneficiaries are the most financially beneficial patients for many rural hospitals. This is because Medicare explicitly pays more to cover the higher costs to deliver health services in these rural settings for hospitals classified as Critical Access Hospitals (CAHs). Of note, while all CAHs are rural hospitals, not all rural hospitals qualify as CAHs. For a hospital to qualify as a CAH it must go through a specific certification process and meet criteria related to its size, location, services provided, and average patient length of stay.[8] In addition to the payment shortfalls facing rural hospitals, they are also more susceptible to the workforce challenges that many hospitals and medical practices are facing.[2]

Another important factor impacting the financial viability of rural hospitals is the Affordable Care Act's (ACA) Medicaid expansion. Starting in 2014 states were able to opt into an expanded Medicaid coverage for nearly all adults with an income level up to 138 percent of the Federal Poverty Level along with enhanced federal matching for these extended populations. Currently, 40 states and the District of Columbia have implemented this expansion and are often referred to as "expansion states."[9] This is essential to understanding the full state of rural hospitals as research has demonstrated that rural hospitals fare financially better in expansion states compared to non-expansion states. This improvement is thought to stem from a lessening in uncompensated care as more patients are insured. Specifically, rural hospitals in Medicaid expansion states were shown to have increased operating margins and were less likely to face full or partial closures.[8] While many rural hospitals still struggle in expansion states, the situation is grimmer for the 34 percent of rural hospitals in non-expansion states.[8]

PATIENT-CENTERED PAYMENT MODEL

Research demonstrates that patient-centered payment and care models tend to yield positive impacts for patients and providers. Improved patient outcomes in these models include improved health and well-being.[10] Physicians and health care teams also report improved patient interactions, cost-effectiveness, and work environments. However, some studies have found patient drawbacks like an increase in personal and financial costs to patients.[7] Many of the studies done on this type of model focus on the broader patient-centered care models, not specifically on patient-centered payment models. Additionally, these studies are focused on outpatient instead of hospital inpatient settings. Accordingly, these studies need to be taken with some caution regarding their applicability to rural hospitals. A joint report from the AMA and the Center for Healthcare Quality and Payment Reform (CHQPR) has shown promise for this payment model but was not specific to rural health. Specifically, the report demonstrated that the patient-centered payment model yields higher-quality and lower-cost care through increased flexibility for physicians to deliver care and increases in physician payments.[11]

STANDBY CAPACITY PAYMENTS MODEL

Generally, standby capacity payments for hospitals would provide hospitals with advance payment for the populations of their respective communities regardless of how many health care services are

actually rendered.[9] Advocates of this type of payment system suggest that all health insurance plans, both public and private, should provide participating hospitals with a standby capacity payment for their community populations.[12] Though payment could hypothetically come from any payer, it seems most likely that the funding would, at least initially, come from local, state, and/or federal government entities to prevent critical rural hospitals from closing. For rural hospitals, standby payment would combat the issue of fixed costs that are often overwhelming for these hospitals. All hospitals are required to always maintain an emergency standby capability[13] to ensure that hospitals are ready if and/or when an emergency occurs. Larger hospitals are more likely to be able to incorporate this into their cost structure, but many rural hospitals are unable to cover the cost of emergency standby capability due to lower payments and smaller patient volumes. The struggle for many rural hospitals to absorb these costs means that standby capacity could be particularly advantageous. The amount of the standby capacity payment would be dependent on the population of the community, services provided by the hospital, and the hospital's operating costs. The AMA[5] and CHQPR[9] have supported standby payment for rural hospitals.

Much of the research on standby payment does not focus specifically on rural hospitals. The research does yield a number of distinct advantages to the patient and physician, such as an increase in quality of care, a decrease in costs, and the potential to aid in the mitigation of unsustainable cost trends. However, experts suggest that these payments alone would not be sufficient to address health care value generally or in rural hospitals particularly.[14] Experts suggest that standby payment models should be paired with incentives to improve care outcomes and that the Centers for Medicare & Medicaid Services (CMS) lead the payment reform. As low payment rates from Medicare Advantage plans are a key contributor to the problems facing rural hospitals the government would need to require that these plans provide more financially sustainable compensation.[12]

GLOBAL BUDGETS/PAYMENTS MODEL

Global budgets or global payments are similar to standby capacity payments in that they are a predictable and reliable payment to the hospital. However, this type of payment is constructed on fixed payments to hospitals or other providers that are based on the range of services that would be billed for individually in a traditional fee-for-service (FFS) arrangement during a specific time period, rather than the size of the community.[15] Generally, global payments are made at a predetermined point, which could be incremental or after a set of services are provided by a hospital. An important aspect of global payment systems is that they are made on behalf of a group of patients, like Medicaid beneficiaries, instead of individual patients. For global payments to be successful, contracts delineate specific standards and outcomes for the range of services included in the contract. Commonly, covered services are broad and include physician services, hospital services, diagnostic testing, prescription drugs, and may include expanded services like home health or hospice care.[12] The global payment system aims to improve patient outcomes and increase access to preventative services. It may include bonuses to physicians or hospitals if quality benchmarks are reached, which aims to promote high-value care.

The use of global payments or budgets has grown, as the model is used by some private payers as well as some Medicare Advantage plans and Medicaid managed care plans. A particularly relevant and promising implementation of this model was launched by the state of Pennsylvania with the support of CMS in 2019. The Pennsylvania Rural Health Model (PARHM) was created to allow rural hospitals in Pennsylvania to stay open and provide high-quality health care services that improve the health of the communities they serve.[16] PARHM was implemented as a CMS innovation model and is in an ongoing evaluation stage through 2024. As with many rural

communities, rural populations in Pennsylvania have poorer health outcomes than their urban counterparts.

The PARHM model is a potential answer to issues facing rural hospitals. In this model, payment is based on historical net patient revenue for both inpatient and outpatient services adjusted for factors like inflation and service line changes.[13] Participating hospitals are also able to access supports in identifying and implementing areas of transformation focused on prevention services, quality improvement, and community-based services, as well as advancing both community health goals and health equity. This model currently includes 18 rural hospitals, Medicare, Pennsylvania Medical Assistance (Medicaid), and five private payers; Geisinger Health Plan, Highmark Blue Cross Blue Shield, UPMC Health Plan, Gateway, and Aetna.[17]

Each participating PARHM hospital receives regular and consistent payments from participating payers based on the FFS portion of the budget. These consistent payments have shown promising results in the initial years of evaluation. Importantly, hospitals who participate have expressed strong commitment to the model and indicated that participation has allowed the hospitals to attain greater financial stability and remain open.[15] Although some participating commercial payers have expressed concern over the sustainability of this type of model, the model is continuing to be evaluated and will remain under a trial/evaluation period through 2024. Evaluators have indicated that future reports will assess the sustainability and impact of the model on health outcomes in the communities served. However, one main outcome is clear—rural hospitals at risk of closing are able to not only remain open but improve their financial stability.[15] In an era where many rural hospitals are closing or struggling to stay open, this is a potentially promising outcome to ensure that rural communities have access to health care services.

RELEVANT AMA POLICY

The AMA has extensive policy on both rural hospitals and rural health generally. Policy D-465.998 outlines the AMA's support to ensure that payments to rural hospitals from both public and private payers are adequate to cover services rendered. Additionally, this policy works to ensure that coordination of care and transparency are encouraged in rural hospitals. Finally, the policy encourages rural residents to select health insurance plans that pay rural hospitals equitably. Notably, this policy specifically calls for supporting the development of capacity payment models for rural hospitals.

In addition to the aforementioned policy, the AMA has multiple policies that outline the importance of economically supporting rural hospitals and advocating for their financial stability. Policy H-465.979 recognizes the importance of rural hospitals and supports organizations that are advocating for their sustainability. Policy H-465.990 addresses the concerning trend of rural hospital closures by encouraging legislation that reduces financial constraints on these hospitals. Policy H-420.971 supports eliminating the payment differentials that are seen between urban and rural medical care, and Policy H-240.970 advocates for reimbursement to rural hospitals for patients returning from tertiary care centers.

In addition to payment and reimbursement related policies, the AMA has policies that support reasonable designation and certification processes for rural hospitals. Policy D-465.999 focuses on encouraging CMS to support state development of rural health networks, oppose the elimination of CAH necessary provider designations, and to pursue steps to ensure that the federal government fully funds its obligations in the Medicare Rural Hospital Flexibility Program. Policy H-465.999 urges Health and Human Services to take a realistic approach to the

certification of rural hospitals and recommends that state licensing and certifying agencies surveil the process for issues with the certification and accreditation process.

The AMA also has a number of policies related to improving the health of rural Americans. Policy H-465.994 supports the development and implementation of programs that improve rural health, urges rural physicians to be involved in community health, and calls for the AMA to disseminate its efforts related to rural health improvement. Policies H-465.982 and H-465.997 focus on efforts to support and encourage the study and development of proposals to solve access issues in rural communities. Policy H-465.978 encourages the recognition of payment bias as a factor in rural health disparities and advocates for the resolution of these biases. Policy H-465.989 focuses on the monitoring and defense against adverse impacts of the Budget Reconciliation legislation along with AHA. Finally, Policy H-465.986 encourages the study and dissemination of results on the Rural Health Clinics Program and its certification and how to best incorporate mid-level practitioners with physician supervision.

DISCUSSION

The AMA is committed to improving the health of rural communities through maintaining and expanding access to care in those settings. AMA policy and advocacy have focused on ensuring that rural hospitals remain open and able to serve their communities. One potential method of ensuring the maintenance of rural hospitals is to focus on transforming payment models. Patient-centered payment, standby capacity payment, and global budgets/payment models all provide potential alternatives to the traditional FFS payment models that are generally used in American health care settings. In its study, the Council is encouraged that each of these models has some distinct advantages that indicate they could be leveraged to ease the burden many rural hospitals are facing.

In order to support rural hospitals with adequate payment to stay open and to encourage additional innovative strategies to address the payment issues facing rural hospitals, the Council recommends new policy that encourages the AMA to support efforts to create and implement proposals to transform the payment models utilized in rural hospitals. This policy would support such proposals from any entity including CMS and interested state medical associations.

Finally, the Council recommends that Policies H-465.978, Recognizing and Remedying Payment System Bias as a Factor in Rural Health Disparities, and D-465.998, Addressing Payment and Delivery in Rural Hospitals, be reaffirmed. Each of these policies works to both acknowledge and encourage action to remedy payment disparities and issues facing rural hospitals.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support and encourage efforts to develop and implement proposals for improving payment models to rural hospitals. (New HOD Policy)

2. That our AMA reaffirm Policy H-465.978, which recognizes the payment bias toward rural hospitals as a factor in rural health disparities and encourages solutions to help solve this bias. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-465.998, which advocates for improvements to the payment and health care service delivery in rural hospitals. (Reaffirm HOD Policy)

4. That our AMA rescind Policy D-465.996 as having been accomplished with this report. (Rescind HOD Policy)

5. That our AMA report back no later than A-26 on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM). (Directive to Take Action)

Fiscal Note: Less than $500.

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