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Report to the Chairman, Committee on
Appropriations, House of
Representatives

June 1990

RURAL HOSPITALS

Federal Leadership and Targeted Programs Needed





United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-229962

June 12, 1990

The Honorable Jamie Whitten
Chairman, Committee on Appropriations
House of Representatives

Dear Mr. Chairman:

In response to your request, we have identified and reviewed programs targeted at assisting rural hospitals. This report provides information on federal, state, and hospital programs that address problems for rural hospitals. Recommendations to the Secretary of Health and Human Services and matters for congressional consideration are included in the report.

We are forwarding copies of this report to the Secretary of Health and Human Services and other interested parties.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 275-5451 if you have any questions about the report. Other major contributors are listed in appendix VI.

Sincerely yours,

A handwritten signature in cursive script that reads "Lawrence H. Thompson".

Lawrence H. Thompson
Assistant Comptroller General

Results in Brief

Multiple, interrelated factors contribute to the financial distress of at-risk rural hospitals. Compared with successful small rural hospitals, distressed ones have fewer patients on average per day, less technology, a more limited scope of services, and higher costs per discharge.

At least 10 federal initiatives address problems facing rural hospitals either directly or indirectly. But despite these efforts, a number of rural hospitals that are the sole source of care within a community are financially distressed and at risk of closure. Many other rural hospitals also are financially distressed and have not fully benefited from federal initiatives. Problems remain, due in part to shortcomings in program design, inadequate targeting, insufficient publicity, and a lack of effective monitoring.

Many state governments and hospital administrators have attempted to address the problems of rural hospitals. Their strategies vary considerably. While many of the efforts appear promising, little information is centrally available on their relative merit or impact. Rural hospitals would benefit from the federal government facilitating an exchange of information among states and hospital administrators.

Principal Findings

Multiple Problems Affect Survival of Rural Hospitals

The problems faced by rural hospitals can be categorized broadly as

- low patient volume, which results in higher costs per case;
- difficulty competing for patients and physicians due to a limited scope of services and fewer technological resources;
- limited patient and nonpatient revenues; and
- regulatory constraints.

As a result, the financial viability of many rural hospitals is threatened. (See p. 15.)

Federal Programs Need Monitoring and Focus

The federal initiatives that address rural hospitals' problems do so by (1) helping them lower their costs per patient, (2) recruiting physicians to underserved areas, (3) increasing their Medicare reimbursement, or (4) providing grant funding and general assistance. But problems remain.

Many rural hospital administrators are implementing strategies to (1) modify services or staffing, develop outreach programs, (2) recruit health professionals, or (3) obtain new technology or adopt new management programs. Rural hospitals are also joining together in local alliances and in group purchasing organizations. The consolidated purchasing power from these organizations has enabled some hospitals to reduce their costs for supplies and equipment.

While many of the hospital-initiated activities are widely used, others reflect unique approaches to long-standing problems. Since little centralized information is available on the outcome of these efforts, hospitals and state officials are not able to build on success and avoid failure. (See p. 36.)

Recommendations

Because of the rapid changes occurring in the health care industry and the complexity of the problems facing rural hospitals, it is unrealistic to expect that every rural hospital will remain open as a full-service, acute-care facility. To help preserve rural residents' access to hospital care and achieve greater impact from the many efforts underway, GAO recommends that the Secretary of HHS (1) improve the monitoring of and technical support provided to sole community hospitals and (2) assure that ORHP has the resources to monitor and evaluate the impact of federal efforts that assist rural hospitals. (See p. 49.)

Matter for Congressional Consideration

If congressional intent is to preserve rural residents' access to hospital care, the Congress should require that essential rural hospitals that are financially at risk be given priority when applying for federal grants to assist rural hospitals. (See p. 50.)

Agency Comments

HHS disagreed with GAO's assessment of HHS's role in evaluating the programs and provisions that assist rural hospitals. HHS, however, did not present evidence that caused GAO to substantially alter its major finding on this issue. HHS also disagreed with GAO's draft recommendations (1) to refine the SCH eligibility criteria and (2) to give essential, financially at-risk rural hospitals priority when they apply for federal grants. GAO considered HHS's comments in finalizing the report and the recommendations.

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Concern about growing health care costs led the Congress, in 1983, to establish a prospective payment system (PPS) for hospital inpatient services provided to Medicare beneficiaries. The intent was to control costs by giving hospitals financial incentives to deliver services more efficiently and reduce unnecessary use of services. Under Medicare, PPS pays hospitals a predetermined amount for each patient diagnosed with a similar problem.² PPS increases a hospital's financial risk since it is reimbursed a fixed amount regardless of the cost of treating the patient.

From 1980 to 1988, 408 U.S. hospitals closed—half in rural areas. Although the majority of rural hospitals are financially viable, more than a third incurred losses in fiscal year 1987, and about 1 in 8 had losses in 3 consecutive years (fiscal years 1985-87).³ Small rural hospitals are disproportionately represented among closed hospitals and hospitals that are financially at risk. While about three-quarters of all rural hospitals have fewer than 100 beds, over 90 percent of the closed or financially at-risk hospitals had fewer than 100 beds.

Objectives, Scope, and Methodology

In this report, we provide an assessment of the problems confronting at-risk hospitals and the strategies/programs that attempt to address these problems. Another GAO report, soon to be issued, will present findings from a more in-depth analysis of the extent to which Medicare and other factors contribute to the financial distress of rural hospitals.

Objectives and Scope

Our objectives were to identify and describe programs and initiatives that may increase the chances of survival for rural hospitals considered at risk of failure. We examined federal, state, and hospital-based programs that addressed problems of rural hospitals.

Of the numerous programs and activities that target rural health care concerns, this report discusses only those having an impact on nonfederal, short-term general rural hospitals. For the purpose of this report, rural hospitals are defined as those located outside a metropolitan statistical area.⁴ We selected particular programs by assessing their

²The predetermined amount is based on the average cost of treating that type of patient and adjusted for some sources of hospital cost variation, including local wages, patient mix, teaching status, and urban/rural location.

³When fiscal year data are cited in this report, we refer to hospital data for cost reporting periods beginning during that fiscal year.

⁴This is the definition of rural generally used by Medicare's PPS.

Administration's Area Resource File, the Medicare Cost Reports, and a computerized file developed for the Prospective Payment Assessment Commission by a private consulting firm, Systemetrics/McGraw-Hill, Inc.

To obtain the views of rural hospital administrators, we mailed a questionnaire in the fall of 1989 to a random sample (n=360) of all rural hospital administrators identified in the 1987 AHA survey (N=2,634). Sixty-seven percent of the hospitals responded. Because local alliances⁷ are increasingly used as a survival strategy by rural hospitals, we mailed the same questionnaire to administrators of all (N=77) rural hospitals participating in selected alliances in five states (Kansas, Nevada, Mississippi, Vermont, and Wisconsin). The response rate was 68 percent. We asked administrators in both groups for information on their hospital's characteristics (e.g., bed size and ownership) and strategies for survival. In addition, we asked them to identify any constraints or challenges faced by their hospitals.

From discussions with rural health care experts and a search of the literature, we identified federal programs that assist rural hospitals. We included all programs that specifically target rural hospitals for special consideration. As a result of these efforts, we identified seven programmatic efforts under the Health Care Financing Administration (HCFA), two initiatives administered by the Public Health Service (PHS), and a new program recently authorized by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). We interviewed officials representing HCFA and PHS. While not attempting a comprehensive evaluation of each program, we identified issues of concern that may require congressional attention.

Because of concern about the impact of closures on access to care, we reviewed Medicare's sole community hospital (SCH) provision.⁸ This provision assists rural hospitals that are the only source of care reasonably available to Medicare beneficiaries. We interviewed HCFA officials at headquarters, telephoned HCFA officials in each regional office, reviewed SCH application files at two HCFA regional offices, used national data bases to analyze the financial status of SCHs, and telephoned selected hospital officials. Also, we reviewed administrative appeal decisions and court cases related to the SCH status.

⁷A state or local network of hospitals that seeks to further the common interest of its members.

⁸Originally authorized by section 223 of the 1972 Social Security Amendments.

Constraints and Challenges Facing Rural Hospitals

Understanding the underlying causes for the financial distress of so many rural hospitals is a necessary first step in assessing whether federal, state, and hospital strategies are effective in addressing problems. Using our comparison of successful and distressed hospitals, a literature review, and information obtained from a survey of rural hospital administrators, we categorized rural hospitals' problems into four areas:

- low patient volume, which results in higher costs per discharge;
- lesser ability to compete for patients and physicians due to a limited scope of services and fewer technological resources;
- limited patient and nonpatient revenues; and
- regulatory constraints.

These problems are interrelated, and their underlying causes vary. Their combined impact, however, is to restrict rural hospitals' flexibility in responding to a changing environment and, for many, to threaten their financial viability.

Low Patient Volume Raises Costs, Leads to Financial Distress

Very low patient volume is a direct cause of financial distress. Hospitals with few patients experience higher costs per patient, because certain costs, such as those for equipment maintenance and wages of core employees, are fixed and are difficult or impossible for hospital administrators to control. For example, rural hospitals with fewer than 50 beds and very low patient volume (10- to 20-percent occupancy rates) had average costs per patient about 9 percent higher than those with higher patient volume (20- to 29-percent occupancy).¹

While low patient volume is a direct cause of financial distress, it is usually the result of a combination of other factors. These include (1) low population density in the surrounding area, (2) inadequate supply of physicians in the community, and (3) patients' preferences to go elsewhere. As the primary reasons for low patient volume likely differ from location to location, it is unlikely that a single remedy will be appropriate nationwide.

On average, hospitals with very low patient volume (less than 10 inpatients on the average day) were located in areas with lower population density and were more likely than other hospitals to be over 35 miles from the nearest hospital. This suggests that in some instances the hospital's community may be too small to increase patient volume, thus

¹There were 233 and 286 rural hospitals in the lower and higher occupancy groups, respectively.

Similarly, physician malpractice concerns have been a major factor in limiting obstetrical services. Many rural hospitals have discontinued such services, survey responses indicate, and more are considering it. Such actions are mainly due to physician decisions to discontinue providing obstetrical services because of professional liability concerns.

Keeping their hospitals technologically current was another major challenge for rural hospital CEOs we surveyed. Specifically, survey respondents cited difficulties in modernizing buildings and equipment, largely because of problems in acquiring capital. Hospitals making profits can save for future capital needs; however, the many that are breaking even or losing money must seek funds through local government subsidies, fund-raising, loans, or bond issues.

Limited Hospital Revenues Reduce Profitability

Small rural hospitals' median costs per patient were about 20 percent higher for distressed hospitals than for successful hospitals. Some successful hospitals also experienced high costs per patient, but were better able to cover their higher costs with higher revenues. Among the factors that can limit hospital revenues are (1) its patient/payer mix, (2) Medicare's PPS, and (3) the community's economic environment.

High Proportions of Medicare and Uncompensated Care Limit Hospital Revenues

The patient mix of distressed small rural hospitals is characterized by higher proportions of Medicare patients and uncompensated care.⁴ At 34 percent of the distressed hospitals, Medicare inpatient days accounted for over 60 percent of all inpatient days in fiscal year 1987. This was the case at only 21 percent of the successful hospitals. Further, distressed hospitals' uncompensated care amounted to 5.4 percent of their patient charges in 1987, compared with a median of 3.7 percent for successful hospitals.⁵

As a result, distressed hospitals had fewer patients for whom they were assured of recovering the full cost of treatment. Hospitals often face limited revenue from other payers as well, but hospital administrators expressed most concern over Medicare's payment policies.

⁴Uncompensated care consists of bad debt and charity care.

⁵American Hospital Association, unpublished data.

Hospitals in areas with low per capita income or high or increased unemployment rates are more likely to be financially distressed. For example, counties with increases in unemployment of 4 or more percentage points had nearly twice as many distressed hospitals as counties with declines in unemployment. Communities with these characteristics are likely to face fiscal pressure due to a relatively low or declining tax base and increased demands on public funds. Thus, they are likely to be less willing or able to subsidize a hospital than communities with less fiscal pressure and stronger economies. Private funds, such as endowments, in these communities also may be more scarce.

Regulatory Constraints: A Major Concern to Hospital Administrators

State CON requirements, hospital licensure, and provider licensure and certification requirements were viewed as significant constraints by rural hospital CEOs we surveyed and interviewed. These administrators reported that such requirements add administrative cost (for example, staff time spent complying with paperwork requirements) and restrict the types and level of staffing, further contributing to rural hospitals' problems.

State CON requirements were viewed as inequitable because they require hospitals to undergo a review procedure to establish the need for new technologies, but may allow physicians or private enterprises to purchase equipment without such review. This gives physicians or private enterprises that acquire such equipment an advantage in competing for patients.

Certification requirements also were the subject of concern for many hospital administrators surveyed. Specifically, administrators told us that it was difficult for them to comply with licensure and certification standards requiring a minimum level of staffing. They believed these standards were geared more toward larger hospitals and consequently were overly stringent given the scope and nature of their operations.

Some administrators expressed concern about state regulations that restrict their ability to use certain types of health professionals. In some states, licensure requirements make it difficult for hospitals to employ technicians who are cross-trained to perform two functions, such as lab and X-ray. The use of cross-trained technicians, such as lab or X-ray technicians, could allow hospitals to reduce their staff without reducing services.

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Table 3.1: Major Rural Hospital Problems Addressed by Federal Initiatives

Initiative	Problem addressed			
	Low patient volume/high fixed cost	Limited inpatient revenue	Recruitment of health care professionals	Multiple problems ^a
Sole Community Hospital Provision	X	X		
Essential Access Community Hospital Program	X	X		X
Rural Health Clinic Act	X		X	
Medical Assistance Facility Demonstration	X		X	
Transition Grant Program				X
Rural Referral Center Provision		X		
Lugar Provision		X		
National Health Service Corps			X	
Office of Rural Health Policy				X
Swing Bed Program	X	X		

^aProvides grant money or general assistance to rural hospitals

The Sole Community Hospital Provision: Insufficient to Protect Essential Hospitals From Risk of Closure

A major federal effort designed to assist essential rural hospitals is the SCH provision. It offers a special Medicare payment rate to rural hospitals that provide the sole source of care reasonably available to Medicare beneficiaries. It has been ineffective, however, in protecting these hospitals from large Medicare losses. Furthermore, many of these hospitals are in financial distress and at risk of closure because they are losing money on both Medicare and other patients.

Improved payment made possible by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) (P.L. 101-239) should alleviate large losses under Medicare. However, many of these distressed SCHs likely will remain financially troubled and may need broader assistance to protect community residents' access to care.

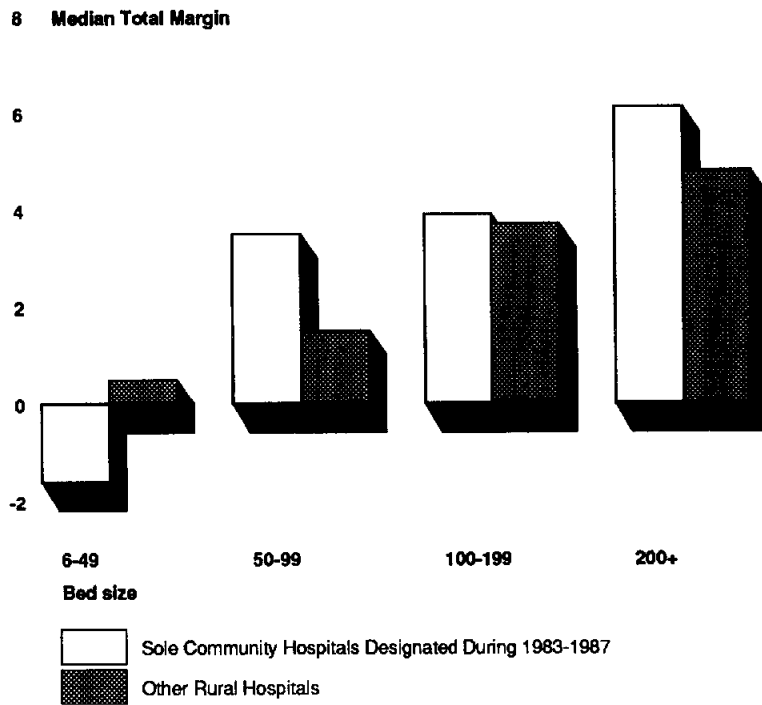
Reimbursement Improved, but Some SCHs Remain in Financial Jeopardy

Under Medicare's SCH provision, designated hospitals may receive Medicare payment that (1) considers their historic cost of treatment, rather than the average cost of treatment; (2) reimburses 100 percent of their capital costs, rather than a fraction; and (3) allows for increased payments in some cases when a hospital experiences more than a 5-percent decline in discharges.

by shifting from HCFA central office to fiscal intermediary application approval. HCFA now plans to issue instructions on all provisions regarding SCHs, which presumably will clarify the provisions for future applicants.

Improved awareness of the volume adjustment and SCH provision, and increased Medicare payment as a result of OBRA 89, will help some essential hospitals. However, many SCHs with fewer than 50 beds likely will remain at risk of financial failure due to losses on non-Medicare business. In fiscal year 1987, SCHs with fewer than 50 beds were far less profitable than other hospital groups, as fig. 3.1 shows.

Figure 3.1: Overall Profitability of SCHs and Other Rural Hospitals (Fiscal Year 1987)



Note: Total margin is a measure of overall profitability calculated (total revenue – total cost)/ total revenue

Source: GAO analysis based on Medicare Cost Reports and SCH designation data provided by HCFA

applicants know how their application will be evaluated and what documentation is required to prove eligibility. Of the 26 (likely eligible, but not designated) hospitals we called, 7 did not know about or misunderstood the current SCH designation criteria.

Because record keeping and reporting on SCH applications and decisions are not required, HCFA has limited information on the problems encountered by applicant hospitals. Such information could serve as a basis for improving program instructions. In the two regions we visited, better instructions might be helpful to applicant hospitals, since many hospitals that were denied later were approved. Lacking explicit guidance, some hospitals have paid consultants to assist them in preparing an application requesting SCH designation and in guiding them through the process. Two hospitals that used consultants spent almost \$10,000 each.

New Legislation Offers Alternative Designation, Increased Support for Essential Hospitals

The Essential Access Community Hospital program, created by OBRA 89, may also help essential rural hospitals by providing ways to increase their patient volume and Medicare revenue. It offers essential access hospitals a different designation and provides for new grant money to establish a program to assist designated rural hospitals in seven states. The major features of the program include the following:

- Criteria for designating essential access hospitals that differ from SCH criteria. Unlike SCH criteria, close proximity to a limited-service hospital does not disqualify a hospital from eligibility.
- Designation of a new type of facility. Called “rural primary care hospitals,” these facilities will provide 24-hour emergency care but generally limit inpatient medical care to those patients requiring stabilization before discharge or transfer to a hospital.
- An important role for states, which must develop a state rural health care plan and designate essential access hospitals in order to qualify for a grant.
- Formation of “rural health networks” to link rural hospitals through communication systems and patient referral and transfer agreements. One effect may be to strengthen essential access hospitals by increasing their patient volume through increased referrals and transfers.
- Grants available to designated essential access hospitals, as members of a rural health network, to improve their communications systems and emergency transportation systems.

If funds are appropriated, the new program will offer broader assistance than the SCH provision to essential access hospitals. Also, it

app. I).⁷ This suggests that hospitals face particular barriers in establishing RHCS.

To identify barriers to growth of RHCS, during 1988 ORHP interviewed rural health interest groups, clinic officials, and federal and state officials. Rural health experts believe the findings apply to the lack of growth of both provider-based (that is, hospital) and independent clinics. Barriers identified through the study were

- lack of publicity and information about the RHC provisions;
- restrictive state nurse and medical practice acts, which discourage the establishment of RHCS;
- clinic difficulties in recruiting and retaining the services of nurse practitioners or physician assistants;
- delays in obtaining Medicare certification;
- little technical support available to assist small clinics in setting up the record-keeping system required to complete the Medicare Cost Reports; and
- the amount of time and paperwork required to get an area designated as medically underserved discourages the establishment of new clinics.

Thus, it appears from this study and others⁸ that a government provision to assist rural communities in existence for 10 years has been used only minimally because of problems in implementing it. OBRA 89 requires HHS to distribute information about RHCS to states and health care facilities. It also reduces the amount of time a mid-level practitioner must be present from 60 to 50 percent. While improved information should correct one of the major problems identified, problems regarding use of mid-level practitioners are complex and likely will persist despite the relaxed staffing requirements in OBRA 89. State regulations regarding use of mid-level practitioners vary considerably. Thus, policies defined by both federal and state governments will determine the extent to which the intent of the RHC act is realized within a particular state.

⁷Because the number of RHCS operated by a hospital was unavailable from HCFA's central office, we contacted each regional office for this information.

⁸Other studies were conducted by the Subcommittee on Rural Development of the Senate Agriculture, Nutrition and Forestry Committee (1979), the HHS Office of the Inspector General (1979), and GAO (1982).

risk or essential hospitals, such criteria were not precluded by the legislation.

Since federal grant funds are limited, including the essential nature and financial status of a hospital in review criteria may provide better use of federal moneys. Of 2,361 rural hospitals, 766 had net financial losses during the 3-year period covering fiscal years 1985-87. Of these hospitals, 119 had both net financial losses and appeared to be isolated—that is, the sole source of care within a geographic area (see app. II). When we reviewed the transition grant awards, we found that only 15 of the 119 financially distressed and isolated hospitals received grants. However, 37 financially secure¹⁰ hospitals received grants. While many of the at-risk hospitals may not have applied for a grant, HCFA's broadly defined funding criteria did not give priority consideration to these hospitals. Without some effort to target funding, financially secure hospitals may receive federal support at the expense of essential, financially at-risk hospitals.

Medical Assistance Facilities: Reimbursement Issues Present a Challenge

In June 1988, HCFA awarded the Montana Hospital Research and Education Foundation a planning grant to design a demonstration and evaluation of a new category of rural health care facility—the medical assistance facility. The MAF demonstration project will test the feasibility of a facility that would provide emergency care to ill or injured patients before their transfer to a hospital or inpatient medical care for 96 hours or less. A rural hospital could become a MAF if it was located at least 35 road miles from the next nearest hospital and in an area with fewer than 6 people per square mile. While admissions would require physician approval, much of the day-to-day care of the patients would be provided by a nurse practitioner or physician assistant.

The successful implementation of the MAF project is important because the Congress established a similar type of facility, called a “rural primary care hospital,” through the Essential Access Community Hospital Program in OBRA 89 (see p. 25). That program expands the MAF concept to seven states and, if funds are appropriated, will provide grants that hospitals may use to convert to the new type of facility or to become part of a rural health network.

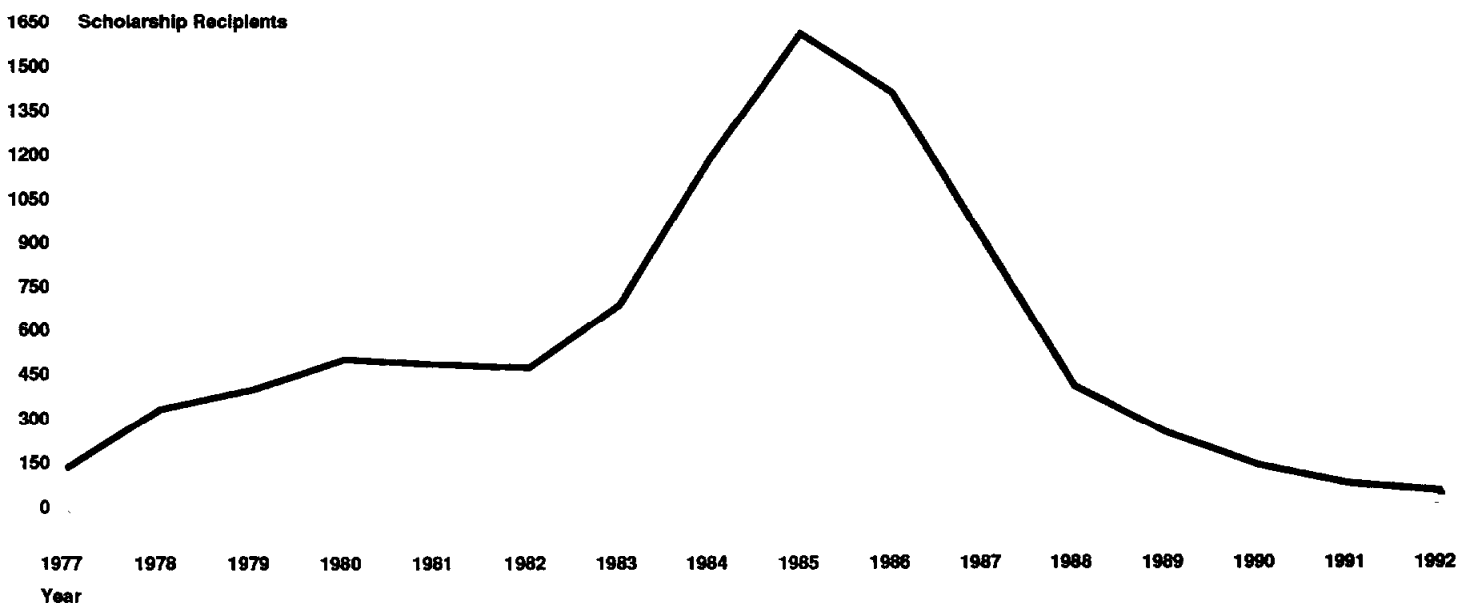
¹⁰We defined financially secure as a 3-year average total margin in the top 25 percentile of rural hospitals under 100 beds

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If recent trends continue, the number of NHSC placements, urban and rural, will continue to decline.

Until recently, the Corps' primary recruiting tool was a scholarship program that gave medical students tuition assistance. Upon completing residency training, scholarship recipients were to repay NHSC with service in a health manpower shortage area. But the supply of scholarship recipients is declining (see fig. 3.2) because relatively few new scholarships have been awarded since fiscal year 1985.

Figure 3.2: Number of Scholarships and Year First Available



Note: Includes physicians and other types of health professionals (for example, dentists, nurse practitioners, doctors of osteopathy)

Source: Based on data provided by PHS

In testimony before the House Subcommittee on Health and the Environment (Feb. 1987), a PHS official stated that NHSC is being reduced because the Corps' past successes and the natural diffusion of physicians into shortage areas has made it unnecessary to place as many health professionals as in the past. NHSC now is shifting its fiscal and operational focus from federal to state administration, and its recruiting mechanism from a scholarship program to a loan repayment program.

referral centers and the Lugar provision,¹² have eligibility criteria that qualify relatively few hospitals for the special reimbursement. The third reimbursement mechanism, the Swing Bed Program, permits hospitals with fewer than 100 beds to temporarily use acute-care beds for long-term care patients.

Rural referral centers are paid based on Medicare's standardized payment amount for hospitals in smaller urban areas (P.L. 98-21). A rural hospital qualifies as a rural referral center if it meets a set of conditions related to bed size or the level of discharges and the complexity of cases treated. As of 1989, 226 hospitals were reimbursed as rural referral centers. Their higher PPS reimbursement rates have resulted in these hospitals, as a group, earning higher profits on their Medicare patients than any other category of rural hospitals.

The Lugar provision, enacted in 1988, allows hospitals in a rural county adjacent to one or more urban areas to be treated, for reimbursement purposes, as if located in the metropolitan statistical area to which the largest percentage of workers in the county commute. As of January 1989, 29 counties were redesignated under the Lugar provision, allowing 53 rural hospitals to be reimbursed at a higher urban rate.

Through the Swing Bed Program, rural hospitals with fewer than 100 beds¹³ are allowed to temporarily use acute-care beds as skilled nursing beds. The program allows a rural hospital to be reimbursed for skilled nursing services provided to Medicaid or Medicare beneficiaries and intermediate care services provided to Medicaid beneficiaries. Hospitals are reimbursed on a per diem basis according to each state's average Medicaid rate. The American Hospital Association survey of hospitals identified 1,056 community hospitals participating in the Swing Bed Program as of 1988.

Coordinating Office Should Determine Impact of Federal Efforts

The HCFA and PHS efforts described in the preceding sections are not well linked, sufficiently monitored, or evaluated for their combined impact on rural communities. Five of the federal efforts are structured to provide additional Medicare payments to hospitals that meet eligibility criteria. For these payment provisions, administrative effort is focused on such activities as eligibility determinations and little effort is placed on

¹²Public Law 100-203, introduced by Senator Richard Lugar.

¹³When originally enacted in 1980 (P.L. 96-499), the program included only rural hospitals with fewer than 50 beds. In 1987, P.L. 100-203 expanded eligibility to hospitals with fewer than 100 beds.

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Our review suggests that HHS could better use ORHP in monitoring and evaluating federal rural health initiatives. Although ORHP has broad responsibility for rural health issues, we found no evidence that it had been directed to assess the impact of federal efforts that assist rural hospitals, or that it had the resources to do so. Although the units responsible for program implementation ultimately must support program changes, ORHP is in a unique position to independently assess the operations and combined impact of federal initiatives and to develop recommendations for change that would further national rural health policy goals. To the extent that ORHP is to be a credible resource in advising the HHS Secretary on rural health policy, it must be well informed about the operations and impact of departmental rural health initiatives.

- education loan repayment programs for physicians and nurses and initiated a rural family practice project to attract physicians to rural areas.
- Oregon targets assistance to hospitals with fewer than 50 beds. Health professionals affiliated with these hospitals are eligible for a tax credit, a loan forgiveness program, and continuing education opportunities. Further, these hospitals are eligible for capital improvement grants and for 100-percent reimbursement of their Medicaid allowable costs. Additionally, Oregon Health Sciences University may reserve up to 15 percent of the positions in each medical school class for students who agree to serve in rural areas.
 - Washington has established a rural health system project that provides financial and technical assistance for up to six project sites. In choosing project sites, the state will consider areas with less-than-adequate access to health care and sites with a financially vulnerable hospital. Other assistance provided by Washington to rural hospitals includes authorization of a new category of health facility and a loan repayment program for physicians and nurses.
 - California has established a state demonstration project to test the concept of hospital conversion for small rural hospitals. All three of the demonstration hospitals are located in Health Manpower Shortage Areas. The Alternative Rural Hospital model is based on a “building block approach,” in which the needs of the individual community determine the scope of services.

Other States Provide Assistance in Selected Areas

Although not attempting to develop comprehensive programs, some states provide assistance to rural hospitals in selected areas or are considering such efforts (see table 4.1). Almost half of the states have established an office of rural health (located in a state agency or sponsored by a university). Other strategies proposed and adopted by state governments include: (1) regulatory reform, (2) financial assistance, (3) physician recruitment, (4) medical liability remedies, and (5) technical assistance.

Regulatory reform efforts include changing requirements for the licensing of services (that is, for hospitals and alternative facilities) and for CON review. Financial assistance efforts provide support to hospitals for capital improvements, service modifications, and intervention when closure appears imminent.¹ Physician recruitment efforts primarily use

¹For example, a 1989 report to the state legislature by the Minnesota Department of Health recommends establishment of a hospital subsidy fund to preserve access to health care in geographically isolated areas.

**Chapter 4
States and Hospitals Undertake Strategies to
Assist Rural Hospitals**

Table 4.1: State Initiatives That Assist Rural Hospitals

State	Office of rural health	Regulatory reform	Financial assistance	Physician recruitment	Medical liability	Technical assistance
Arizona	X	X			X	
Arkansas	X	X	X			X
California	X	X	X ^b		X	X
Colorado		X				
Florida		X	X	X ^c	X	X
Georgia	X	X ^a				
Hawaii					X	
Idaho	X					
Illinois	X					
Iowa		X ^a	X			X
Kansas	X					
Kentucky					X ^a	
Maine				X ^c	X ^b	X
Minnesota			X ^a			
Mississippi	X ^b					
Missouri					X	
Montana	X	X			X	
Nebraska	X			X		
Nevada	X	X		X		
New Mexico	X			X ^c		
New York			X		X ^a	X
North Carolina	X	X		X ^c	X	X
North Dakota	X				X	X
Oklahoma						X
Oregon	X	X	X	X		X
South Carolina		X		X ^c		
South Dakota	X					X
Texas	X	X		X ^c	X	
Utah	X	X ^a				X
Virginia					X	
Washington	X	X	X		X	X
West Virginia				X ^c	X	X
Wisconsin	X	X	X			
Wyoming		X				

^aStudy being completed

^bBill pending

^cNational Health Service State Corps Program.

bank. Thus, patients could spread the cost of the care over a number of payments, and the hospital was guaranteed payment for the care provided. As a result of these efforts, the hospital succeeded in increasing its market share and was currently reporting profits on obstetrical services.

On-Site Patient Liaison at a Tertiary Medical Center

The hospital placed a salaried employee as a patient liaison at the tertiary medical center 120 miles away. It did so to maintain contact with patients referred there and ensure that patients returned to the local health care system for follow-up care. Not only did the program help maintain continuity between patients and the referring hospital, but it improved communication between the two institutions.

Hospital-Operated Clinic Staffed by Mid-Level Practitioner

To improve its market share, one hospital established a rural health clinic and hired a physician assistant to staff the facility. Community leaders of the neighboring town had approached the hospital to help recruit a physician for the community. After more than a year of unsuccessful search, the hospital administrator suggested hiring a mid-level practitioner. When residents of the area strongly objected to this, the hospital in conjunction with the state board of family physicians commissioned a study to evaluate the town's needs. When the study determined that these could be met by a physician assistant, community leaders accepted the plan. The resulting linkage between the clinic and the hospital has improved the hospital's market share.

Hospital-Operated Fitness and Rehabilitation Center

With the goal of increasing its revenue sources, this rural hospital constructed a free-standing, 27,000-square-foot fitness center adjacent to the hospital. The center includes a lap pool, a half-court gym, an indoor track, an aerobics area, and weight machines. There are separate areas for patient rehabilitation, including physical and occupational therapy. Among a variety of uses for the facility are health and fitness classes, wellness programs, and rehabilitation services. Memberships are sold to individuals (that is, hospital employees and nonemployees) and local businesses.

Physician Recruitment, Retention Important to Hospital Success

Successful recruitment of physicians is often reported as a major factor related to the success of a rural hospital. Provider recruitment and retention efforts were the second most frequently reported activity of hospital administrators (see table 4.2). Of these, 27 percent were staff development efforts that targeted physicians, nurses, or other health professionals. Successful health care provider recruitment improved the hospitals' market share and quality of care, hospitals indicated.

Figure 4.1: Physician Recruitment Poster

REWARD!



\$5,000 REWARD

**FOR A FAMILY PRACTICE PHYSICIAN
WITH OBSTETRICAL AND SURGICAL SKILLS**

A reward of \$5,000 is offered to any individual who is first to identify and arrange an interview for a family practice physician who meets the criteria and commits to a three-year contract.

The physician can assume an existing practice on a solo basis or on a salaried basis with Intermountain Health Care. The salaried arrangement includes clinic personnel, rent, utilities, equipment and supplies, computer accounting system, malpractice insurance, etc., in a new clinic building.

This is a great opportunity for an enterprising physician who wants to live in a moderate-sized, central Utah, value-centered community.



A SELF-REFERRED PHYSICIAN IS ELIGIBLE FOR THE BOUNTY!

Of the nine state hospital associations we contacted,³ eight sponsor a GPO. The one association that does not sponsor a GPO offers group purchasing services through a national firm. Through GPOs, hospitals can purchase at a lower cost such items as pharmaceuticals, medical-surgical supplies, furniture, and medical and office equipment. In addition to these core items, some GPOs offer other service options. For example, through the Illinois GPO, hospitals are given the option of purchasing, at a lower cost, malpractice insurance for emergency room physicians. The program has been so successful that the association plans to expand the option to include other hospital-based physicians. The North Carolina, Mississippi, and Texas hospital associations reported that they offer a maintenance insurance program for their members. This option provides a less expensive alternative to the traditional service or maintenance contracts. The North Carolina association projects that through this option, costs will be from 25 to 30 percent less than individually negotiated contracts.

Most hospital association officials we contacted indicated that they believe most rural hospitals are involved in at least one group purchasing arrangement. Savings vary from hospital to hospital. Directors of GPOs estimate that hospitals save from 12 to 20 percent through group purchasing arrangements.

Through membership in a local alliance, one hospital administrator saved \$25,000 on the purchase of a single piece of equipment. Another hospital saved \$40,000 on monitoring equipment for the hospital's intensive care unit through a regional group purchasing arrangement.

Linkages and Alliances With Other Hospitals Used to Improve Status

To address problems associated with being located in a remote area or being smaller, a number of rural hospitals are attempting a relatively new strategy—joining local networks or alliances. These structures allow hospitals to share knowledge, information, staff, and purchasing arrangements without losing their autonomy.

Several terms are used to describe the forms of state or local alliances now emerging—cooperative, consortium, or affiliation. Their general purpose is similar: to further the common interest of their members. Alliances differ from multihospital systems in that member hospitals

³We contacted one state hospital association in each region of the United States. The associations were located in California, Montana, Texas, North Dakota, Mississippi, Illinois, New York, North Carolina, and New Hampshire

result of its affiliation with the larger hospital, delicensed some of its underutilized acute-care beds and is converting the bed space to utility apartments for the elderly. Also, smaller hospitals in the alliance were supported in their efforts to recruit and retain physicians because of the linkage with the larger hospital. Physicians practicing at the smaller hospitals were less isolated professionally because they had direct access to other physicians and an opportunity to participate in educational conferences hosted by the larger hospital.

In Nevada, a rural hospital alliance successfully lobbied for passage of a bill designed to address problems of the state's rural hospitals. The bill, passed during the 1989 legislative session, requires the state board of health to adopt licensure regulations for rural hospitals that consider their unique operating problems. In addition, the legislature appropriated \$75,000 for a study by the alliance that would help develop the new regulations. All 10 of Nevada's rural hospitals belong to the alliance, formed in 1988. It has shown that such organizations can influence legislative decisions.

Because they offer a less threatening environment than do multihospital systems, alliances appeal more to management and governing bodies of small rural hospitals. Rural hospitals can achieve the benefits of affiliation with other hospitals without compromising their independence to pursue their own interest, administrators contend. One difficulty alliances face, however, is building and maintaining trust among hospitals that are competing for patients and funding.

Many Initiatives Promising, but Impact Unclear

While many of the state- and hospital-initiated strategies appear promising, little information is centrally available on their merit or impact. For example, although many states have adopted regulatory reform efforts, there is little information on the extent to which rural hospitals are taking advantage of these efforts. Also, many hospitals are engaging in similar activities while knowing little of the experience of other communities. Although we did not attempt to determine the financial impact for any of the activities described, rural hospital administrators reported that their facilities were benefiting from the self-initiated activities.

be assigned to the Office of Rural Health Policy, since it is HHS's coordinating office for rural health initiatives. However, regardless of the assignment of the responsibility in HHS, HCFA should play a primary role in performing or supporting this function since HCFA administers 7 of the 10 federal efforts that assist rural hospitals.

Additionally, there is little coordination between public and private efforts and little information centrally available to measure the impact of the many efforts underway at the hospital or state levels. As a consequence, rural hospitals are engaging in similar types of activities with little knowledge of the existence or effectiveness of other efforts. Also, some rural hospitals are unaware of federal support efforts and report difficulty obtaining timely information about specific initiatives. To minimize these problems, a central source of information could be developed and funds allocated to systematically evaluate the more promising initiatives.

Given the complexity of the problems facing rural hospitals, how federal resources are spent is as important as the amount spent. Not all rural hospitals are financially distressed, nor would their closure invariably place an undue burden on community residents seeking care. Without a coordinated approach that targets at-risk essential hospitals, there is less assurance that hospitals most in need will receive federal support.

Recommendations to the Secretary of HHS

To realize the full potential of the only federal initiative that targets essential rural hospitals in all states, we recommend that the Secretary direct the Administrator of HCFA to

- develop instructions to guide potential SCHs through the application process;
- explore methods for refining current SCH eligibility criteria to better assure that hospitals providing essential services to their community are eligible for SCH designation;
- monitor financial information on SCHs to identify those in financial distress and assure that they are assisted, as warranted, in applying for special payment provisions, grants, and other HHS programs aimed at assisting rural hospitals; and
- when awarding grants, include an evaluation factor that considers whether the applicant is an SCH and if so, whether it is financially distressed.

implementation of the SCH provision and RHC act support this conclusion. We are not suggesting that HCFA generally has been inattentive to the individual payment provisions it implements; however, our discussions with HCFA regional and central office staff revealed that they did not have basic information needed to evaluate the implementation of the SCH or the RHC provision (see pp. 24, 27).

Our primary concern with respect to evaluation is that there is no HHS office monitoring the combined impact of the federal provisions for assisting rural hospitals (see p. 48). We found no evidence that such efforts were underway or that any office had responsibility for monitoring the overlapping effects of HHS provisions and programs. Without an assessment of the combined impact of federal initiatives, we do not know whether they work together to protect access to essential services in rural communities, or at least to alleviate the major problems of essential rural hospitals.

We recognize that several of the actions HHS cites as efforts to address rural hospitals' problems likely will improve the Medicare profitability of rural hospitals. These actions, while important, fail to assure that financially at-risk SCHs are assisted in taking advantage of the resources available to rural hospitals through HHS (for example, NHSC-state physician recruitment efforts, SCH volume adjustment, and the Rural Health Care Transition Grants).

Problems of Rural Hospitals

HHS believes that we oversimplified the categorization of rural hospitals' problems into four broad areas. Furthermore, HHS believes that the first three problem areas we identified are aspects of the same problem, low inpatient revenue. We agree that the problems of rural hospitals could have been grouped differently; however, we believe the categories we chose present the major problems we identified in a way appropriate for an overview of the problems. Also, we agree with HHS that the problems are related, and we stated this in our report (see p. 15). A more in-depth discussion of rural hospitals' problems based on multivariate and other analysis of hospital closures will be presented in a forthcoming report.

HHS said that we ignored the general problems of a shrinking population and declining economy faced by rural America. We did not identify shrinking population as a problem facing rural hospitals based on our analysis. Our comparison of distressed and successful small rural hospitals showed no evidence that hospitals in counties with shrinking populations fared worse than other hospitals. Further, the population of

financially secure hospitals should be ineligible for federal grants, only that if a grant is awarded to such a hospital, it should reflect a conscious decision and defined goal.

Also, HHS assumes that we are advocating use of “net financial loss” to measure a hospital’s financial need. We used this summary measure because it was available through a national data source and it is a summary measure of a hospital’s total profits and losses. However, we do not mean to imply that “net financial loss” should be the criterion used to evaluate need. We would encourage HHS to examine alternate ways of defining financial need before adopting a final measure.

SCH Designation

HHS believed we limited our analysis of SCHs to those with fewer than 100 beds, and therefore disagreed with our conclusions regarding this program. On the contrary, our analysis of the SCH provision included all sizes of SCHs, as shown by figure 3.1. Only our comparison of financially distressed and successful rural hospitals, used in chapter 2, was limited to those with fewer than 100 beds.

HHS disagreed with our position that the SCH eligibility criteria do not adequately identify rural hospitals whose closure could impair Medicare beneficiaries’ access to essential health care services. HHS cited three reasons why the proposal in our draft report to refine the current SCH criteria to consider hospitals providing an essential service would create problems: (1) it would be difficult to agree upon what services should be categorized as “essential”; (2) it would require that SCH status be conferred on any rural hospital that is the sole source of an essential service; and (3) it would create an incentive for hospitals to create a unique area of specialization, just to qualify for SCH status.

We agree with HHS that its current criteria generally identify hospitals that serve as the sole source of care, but believe that some essential hospitals cannot now take advantage of the SCH provision. Modifying the current criteria will have to be done carefully to avoid the problems HHS cites. Given the importance of identifying and assisting essential rural hospitals, however, we continue to believe that such modification is warranted.

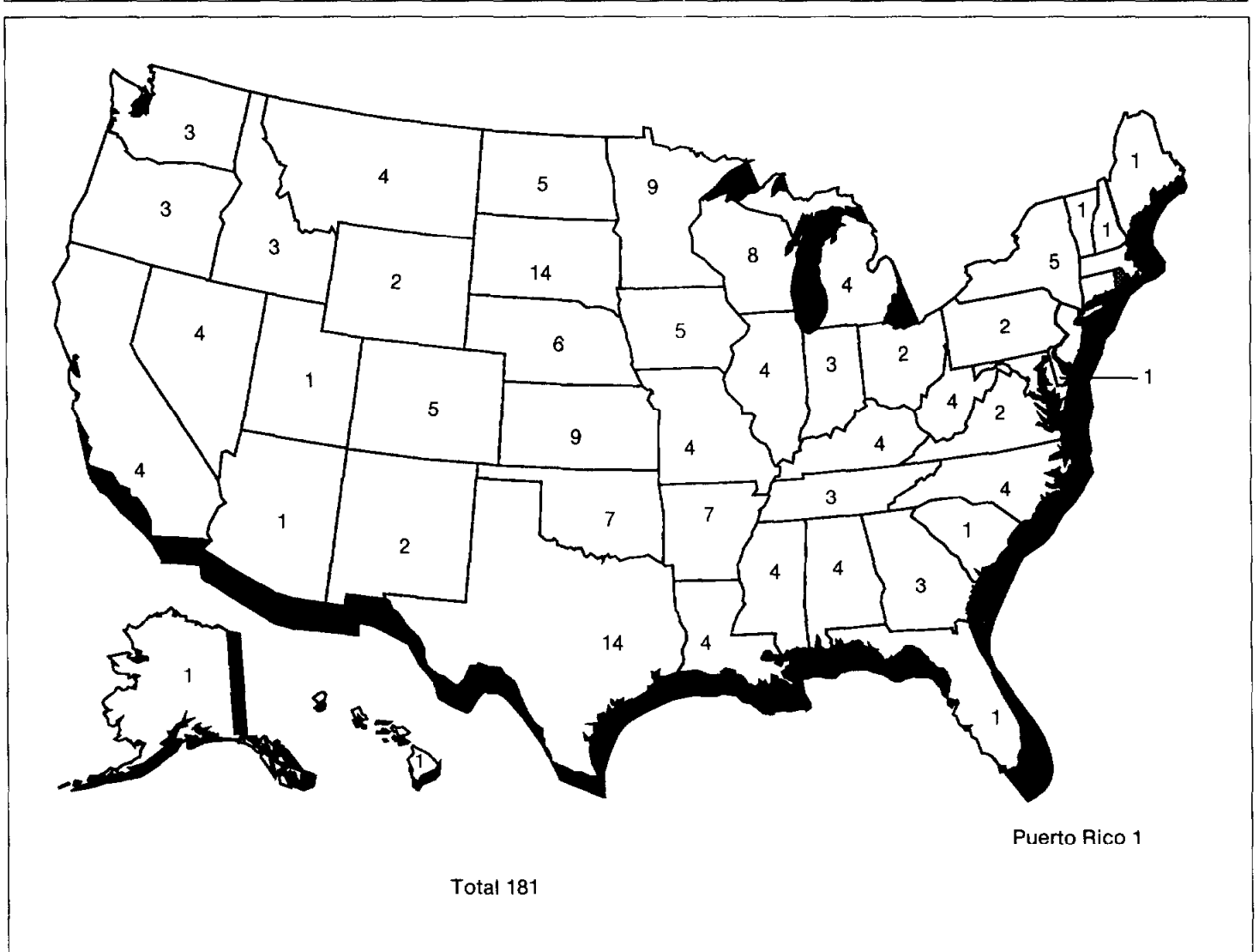
Our draft report recommended that HHS revise its SCH eligibility criteria to include hospitals that are sole providers of an essential service. Our intent is that the provision of an essential service, such as emergency care, be considered along with, but not exclusive of, other criteria, such

Rural Hospitals' Isolation and Financial Status (FY 1985-87)

State	No. of rural hospitals ^a	No. of rural hospitals with net losses ^b	Percent with net losses	No. of eligible SCHs with net losses ^c
Texas	172	91	53	7
Arkansas	65	34	52	1
Nevada	10	5	50	5
Wyoming	21	10	48	7
Mississippi	85	39	46	1
Alabama	50	22	44	0
Hawaii	7	3	43	1
Louisiana	63	27	43	3
Kansas	112	46	41	2
South Carolina	38	15	39	0
Washington	46	18	39	9
Alaska	13	5	38	5
West Virginia	45	17	38	1
New York	53	20	38	2
California	43	16	37	10
Arizona	20	7	35	4
Idaho	40	14	35	2
Utah	20	7	35	7
Tennessee	63	22	35	0
Oklahoma	78	27	35	3
Maine	24	8	33	3
Montana	52	17	33	9
Georgia	83	26	31	1
Florida	36	11	31	0
Colorado	43	13	30	5
Michigan	75	22	29	2
Indiana	55	16	29	0
Missouri	73	21	29	1
Maryland	7	2	29	2
Wisconsin	75	21	28	0
New Mexico	22	6	27	4
Oregon	37	10	27	5
Illinois	83	22	27	2
Nebraska	76	19	25	1
Kentucky	67	16	24	3
North Dakota	39	9	23	4
Minnesota	106	22	21	2
Iowa	87	18	21	0

(continued)

Distribution of Transition Grant Awards by State (1989)



Note: South Dakota had 9 awards at \$5,555, 3 at \$15,000, and 2 at 50,000.
Source Based on data provided by HCFA.

North Carolina

“I am concerned about the federal government’s attitude towards small and rural hospitals. A national policy dealing with questions of access in rural communities would go a long way in helping to clarify some of the issues.” (52 beds)

“I can gather little understanding for the concept that health care costs may be controlled/reduced by driving smaller, less costly providers out of the market... Given the inequity of our federal reimbursement system, the next decade will see rural America return to the environment of a century ago, no available health care... As a professional manager, all I ask is, place the rural hospital in an equal fair ballgame in terms of payment and let us compete in our market on equal terms.” (78 beds)

Tennessee

“Rural hospitals can survive if they are paid the cost of caring for Medicare patients. DRGs do not work well for small volume providers, especially in poorer counties. Medicare should pay actual costs to rural hospitals—with an inflation cap once costs have been set.” (40 beds)

“Almost two-thirds of our business is for Medicare patients. We will survive only if Medicare payments are adequate to cover our reasonable costs. This is not an appeal for special subsidies, but an appeal for a level playing field with respect to the urban/rural gap. It is not true that rural hospitals can deliver the same care for less money than urban hospitals. Many of our expenses are in fact higher than urban hospitals. For example, we must pay to recruit physicians whereas urban hospitals do not. We must also pay as much or more for supplies because of lower volume and greater travel distance for shipping. The DRG prospective payment system discriminates against rural hospitals. If this is allowed to continue, many more rural hospitals will close, including this one.” (39 beds)

Georgia

“Medicare is not paying its fair share of the business overhead costs. Administration of this prospective payment system...adds tremendously to the overall costs. We are shooting at flies with shotguns and cannons.” (45 beds)

California

“We need a plan for the permanent recovery of the rural health care delivery system.” (34 beds)

Kansas

“The rural/urban inequities must be alleviated... We are not asking for handouts. We are doing our best to keep costs down. We are trying but we need help. We lost \$116,000 last year, and this year may be worse. Also, we need to address the growing problem of the uninsured and underinsured.” (46 beds)

“Rural hospitals must receive the same reimbursement as urban hospitals. The regulations enforced on us by Medicare have turned into a time-consuming, costly issue which seems as though there is no answer—most are not relevant to patient care. The nursing staff is burdened by paperwork instead of doing the job they were trained for. The billing department grows weary of inconsistencies in obtaining reimbursement.” (24 beds)

Wisconsin

“Rural health care is an extremely critical issue. Cash payments from federal programs continue to go down and down. There is not adequate inflationary increases in Medicare and Medicare payment let alone enough to generate an operating margin. Equity, adequacy, and fairness are all we ask for. The health care system is in a sad state in terms of lacking a unified policy. If this country continues to place a high value on quality of health care, then a concentrated effort to review and evaluate the health system must take place. It must take place fairly and consistently.” (132 beds)

“Financing of rural health care—hospitals, physicians, nurses wages, etc., at the same level as urban hospitals—is the single item most essential to survival. Adequate facilities, equipment, technology, training all follow dollars. Urban-rural linkages, mergers, affiliations, shared services have been implemented all over the place and are inadequate as solutions with the current short-changed rate of reimbursement.” (22 beds)

Minnesota

“Congress must address rural America’s survival and future in a comprehensive well thought out bi-partisan plan... Rural America’s economy is a fully integrated, fragile network of interdependencies which must be addressed as such to be successful.” (136 beds)

“I believe that Congress is taking the wrong approach in trying to control health care costs. First of all, the hospitals that they are hurting by their legislation are the small hospitals. These small hospitals are not high-cost hospitals, it’s the large hospitals where the high costs are. I

Appendix IV
Opinions of Rural Hospital Administrators

trained personnel, etc.). The bottom line is that Medicare has conveniently eliminated these costs from both the inpatient and outpatient reimbursement formulas." (86 beds)

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report, "Rural
Hospitals: Federal Leadership and Targeted Programs Needed"

Overview

GAO believes that multiple, inter-related factors contribute to the financial distress of at-risk rural hospitals. Compared with successful rural hospitals, distressed hospitals have fewer patients on average per day, fewer specialty physicians, a more limited scope of services and higher costs per discharge.

GAO identified ten Federal initiatives that address problems facing rural hospitals either directly or indirectly. Despite these efforts, a number of rural hospitals that provide the sole source of care within a community are financially distressed and at risk of closure. Many others are financially distressed and have not fully benefited from Federal initiatives. GAO believes that problems remain, in part, because of shortcomings in program design, inadequate targeting, insufficient publicity, and a lack of effective monitoring.

GAO reports that many State governments and hospital administrators are engaged in efforts to address the problems of rural hospitals. The strategies vary considerably. While many of the efforts appear promising, GAO believes there is little information centrally available on their relative merit or impact. GAO also believes rural hospitals would benefit from the Federal government facilitating an exchange of information among States and hospital administrators.

There is no question but that many small rural hospitals are experiencing financial difficulties and we agree with some of the report's cited reasons for the causes of these difficulties. However, we do not agree that "HCFA placed relatively little emphasis on evaluating whether the Federal programs or provisions (designed to assist rural hospitals) are meeting their intended purpose." We monitor the status of all hospitals under the prospective payment system on an on-going basis and, over the past several years, have given particular attention to the deterioration in the fiscal condition of many rural hospitals. The actions we have taken to address the problems of rural hospitals include the following:

- o We have recommended higher update factors to rural hospitals for the last 2 years.

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In addition, it is apparent that GAO views the purpose of the EACH/RPCH program primarily as a vehicle to provide grant funds to shore up EACHs, or "essential access hospitals". We believe that the program is intended to accomplish much more than this and is in fact focused on the development of rural health care networks and rural primary care hospitals.

The EACH/RPCH program is intended to maintain access to cost-effective quality health care services in rural areas. It provides a means for small rural hospitals to remain financially viable by converting to "rural primary care hospitals" through the restructuring of their services to a less intensive level. These RPCHs will establish and maintain transfer, referral, and service agreements with Essential Access Community Hospitals, larger institutions which maintain a more comprehensive range of inpatient acute care services. We believe that the restructuring of the system and the development of such networks will ensure that the full range of health care services is available to rural Medicare beneficiaries.

The report notes that the changes enacted by OERA should alleviate large losses under Medicare for SCH-entitled hospitals. At the same time, the report also notes that even with the OERA legislation, many small rural hospitals under 50 beds will likely remain at risk due to losses on non-Medicare patients. It is also noted that even had Medicare paid under-50-bed SCHs their full costs in fiscal year 1987, many would still have experienced substantial losses. We believe these data further document that it is not inadequacies in the criteria to identify SCHs or the administration of the SCH provision that are causing financial distress for rural hospitals.

It is noteworthy that GAO limited its study to hospitals with fewer than 100 beds and thus did not consider the financial status of the 62 currently approved SCHs that have more than 99 beds. We cannot agree with generalized conclusions on the adequacy or the administration of any program in which nearly 17 percent of the largest and most likely financially successful hospitals are eliminated from the study.

We also disagree with the introductory statement referencing SCHs as ". . . the only Federal program which targets essential rural hospitals in all states." The SCH adjustment is not a Federal program; it is simply a Medicare payment adjustment targeted at certain hospitals which serve as the sole source of care reasonably available to Part A beneficiaries. There are other targeted payment adjustments, such as the one for rural referral centers, that the report did not address in depth.

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Second, we believe that the proposal would also establish an incentive for hospitals to create a unique area of specialization, just to qualify for SCH status. Considering small, rural hospitals' current difficulties in recruiting physicians and maintaining the equipment and staffing necessary to support even basic services, we believe that any unique incentives to add services would exacerbate an already critical problem.

Finally, although we recognize that the SCH criteria might be improved (and we solicited comment on this issue in the May 8, 1989 Federal Register), we believe our current qualifying criteria based on distance and market share generally do identify hospitals that serve as the sole source of inpatient care reasonably available to Part A beneficiaries. The criteria now in effect recognize that not all rural hospitals provide a full range of services. That is, within certain mileage limitations, we will classify an under 50-bed hospital as an SCH if it can demonstrate that it would have met the market share test except that some patients were forced to seek care outside its service area because it did not furnish the specialized care that the patients required.

For all of the reasons discussed above, we do not agree that SCH classification should be based on a hospital's provision of an "essential" service. The report identifies one instance in which GAO investigators found that a hospital was denied SCH status due to the proximity of another hospital, although the other hospital did not provide obstetrical care. The law specifically defines an SCH as a hospital that ". . . is the sole source of inpatient hospital services reasonably available to individuals in a geographical area who are entitled to benefits under Part A." The law does not define a SCH as a hospital furnishing a full range of services. In the example cited by GAO, we believe few Part A beneficiaries were disadvantaged because of their inability to obtain obstetrical services nearby. The recently released Prospective Payment Assessment Commission (PropAC) report titled, The Relationship Between Declining Use of Rural Hospitals and Access to Inpatient Services for Medicare Beneficiaries in Rural Areas, concludes that, "Access to care does not appear to have been impaired for Medicare beneficiaries who reside in rural areas in the five States (studied)."

In response to the GAO assertion that the SCH criteria are too narrow, we would note that if anything, the current SCH criteria are too broad. In yet another PropAC study it was found that the majority of current SCHs do not serve the majority of Medicare patients in their service area. That is, most Medicare patients seek hospital services at a more distant facility. This is not to say that access would not be impaired if the SCHs were to close, but it should be noted that the role SCHs play in delivering inpatient care appears to be declining.

Page 7

As discussed above, "net financial loss" is not a sound criterion for the awarding of grant funds and is often not a reliable measure of the complete financial position of a hospital. We believe that defining and operationalizing the meaning of the term "financial distress" is an extremely difficult and potentially futile task.

GAO Recommendation

To improve the coordination of Federal, State and hospital efforts and ensure that some entity with a broad perspective of the problems of rural hospitals can be held accountable, we recommend that the Secretary assure that a federal office is given the mandate, adequate resources, and the authority to:

- (1) coordinate Federal efforts that assist rural hospitals;
- (2) serve as a focal point of information on State and local initiatives; and
- (3) evaluate the impact of the various efforts to assist rural hospitals.

Department Comment

We agree with the GAO position that rural hospitals would benefit from the Federal Government facilitating an exchange of information among States and hospital administrators. However, we believe the Department already provides such an exchange through the efforts of the Office of Rural Health Policy (ORHP), Health Resources and Services Administration, PHS. The following are some of the recent actions by the Department in this area:

- o in FY 1989, ORHP awarded a contract to the National Governor's Association to describe the many innovative State programs that assist rural hospitals and communities;
- o recently, ORHP held a workshop to allow rural hospital and health representatives to assist the Department as it prepares to implement the Essential Access Community Hospital Program authorized by the Congress in 1989;
- o ORHP staff have participated in several seminars sponsored by the Department that bring together State legislators to exchange information on State rural health programs;
- o each year, the ORHP staff makes 10 to 20 presentations to State hospital associations and their rural hospital constituency groups to apprise them of Federal developments;

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Now on p. 34.

We have no knowledge of the source referenced on page 52, second paragraph, that "According to an ORHP official, the Office lacks the resources and the staff to carry out its responsibilities." Several ORHP officials had discussions with GAO officials regarding this report. For example, in one of the discussions ORHP indicated that work on the information clearinghouse was at a standstill because of the lack of an appropriation (a problem which no longer exists as previously discussed).

Now on p. 35.

The conclusion on page 53 that the value of the ORHP "has not been realized" on the basis of a "limited review" is difficult to reconcile with the progress in ORHP since 1987. The ORHP currently:

- o coordinates all rural research within the Department;
- o staffs the National Advisory Committee on Rural Health which issued a comprehensive set of recommendations to the Secretary of HHS; and
- o administers:
 - a) a grant program to rural health research centers,
 - b) a demonstration satellite telecommunications system in West Texas; and
 - c) has been a communication center linking States and the rural constituency in a coordinated effort to solve rural health problems.

Other Matters

HCFA has retained an independent research firm to perform an evaluation of the Rural Health Transition Grants Program. This evaluation includes ongoing monitoring of the program and a study of the effectiveness of the grant awards in addressing the hospital, community, and health care needs identified by the grantees. Such evaluations are common for HCFA programs and demonstrations and are contemplated for each of the rural health care programs addressed by GAO.

Now on pp. 28, 30

In the discussion of the Medical Assistance Facility (MAF) demonstration in Montana (pages 44 to 46), GAO states that HCFA needs to resolve outstanding reimbursement issues in order to move ahead on the project. HCFA has decided to use a cost-based reimbursement system for the MAFs. This is based on the EACH/RPCH legislation that calls for such a system for RPCHs in the early years of that program. In collaboration with the Montana Hospital Association, HCFA has made substantial progress in recent months in resolving not only payment issues, but matters related to quality assurance, utilization review, and certification and life safety standards.

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In addition, it should be noted that the first year of grant funding for the Montana MAF demonstration was intended as a planning and development grant. First year grant funds were used by the Montana Hospital Association to further develop the MAF concept in preparation for submitting a final and detailed program proposal. We believe that the MAF project is an excellent opportunity to assist beneficiaries in rural Montana to maintain access to needed medical services and, at the same time, to gain experience in the operation of facilities that can teach valuable lessons for the EACH/RFCH program.

Finally, we disagree with the comments from Rural Hospital Administrators to establish reimbursement based on actual cost. Actual cost reimbursement could be a serious detraction to the Prospective Payment System. Changing reimbursement rules for rural hospitals could establish a precedent for similar reimbursement changes for other types of providers as well.

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- o in May 1990, ORHP expects to issue an annotated compendium of over 600 rural health research projects undertaken during the 1980s; and
- o ORHP will establish an information clearinghouse on rural health programs which will include data on rural hospitals. It is expected that the clearinghouse will be in operation in October 1990.

We are concerned that the draft report does not recognize the role of the ORHP in coordinating Federal rural health policies and research. The programs that directly assist rural hospitals are very limited. These include the Rural Health Transition Program (RHTP), the SCH provisions in Medicare, and a few others. Contrary to the impression given in the draft report, HCFA programs have been evaluated or are currently under review. For example, HCFA has funded an extensive evaluation of the RHTP. The SCH provisions have been evaluated by HCFA and others with differing conclusions. The Swing Bed Program, has also been extensively evaluated and has been shown to be effective.

We are also concerned about the statement on page 29 that there are concerns about the capacity of ORHP to carry out the coordination and oversight duties. In this regard, we point to numerous initiatives for coordination that are well recognized and respected. For example, twice each year, ORHP brings together most of the key people involved in rural health research in the Department to work with rural health research centers and coordinate research efforts. Non-government representatives involved in rural health research and demonstration projects, such as the Robert Wood Johnson Foundation, often attend as well.

The ORHP has been extensively involved in the design and evaluation of the RHTP and continues to monitor and work with other HHS components in developing programs to improve access to rural health services. In that regard, ORHP has been working with HCFA and the hospital industry to monitor promising State programs aimed at ensuring that rural residents have access to essential services. The Department's focus, however, has not been on addressing the needs of all distressed hospitals, which in some instances do not provide essential access, but on the hospitals and services that are essential.

The comment on page 52, second paragraph, that characterizes the ORHP as being constrained in its operations because of the lack of a direct appropriation is not accurate. The increased FY 1990 appropriation has proved sufficient to support the ORHP operations and program management. The ORHP is now essentially self-supporting.

Now on p. 35.

Now on p. 34.

Page 6

GAO should recognize that the Medicare program was not intended to concern itself with the distribution of health resources. Access to care may be greatly affected by the lack of an obstetrical service, emergency department or even the lack of a hospital, but such problems are not within the domain of the Medicare program. FHS programs are as close as the Department comes to creating and supporting health infrastructure where it does not already exist. Congress will have to enact new legislation if the Federal Government is to be charged with the distribution of health resources on a national basis.

GAO Recommendation

- (3) monitor existing summary information on SCHs to identify those in financial distress and ensure that these hospitals are given preference and assisted, as warranted, in applying for special reimbursement provisions and grants administered by the agency.

Department Comment

Several points must be noted in discussing the issue of prioritizing grant awards. First, as GAO indicates, Congress did not include such preferences in the legislation. In implementing the program, HCFA was aware of the wide variety of problems in rural hospitals that Congress cited in the legislation and Committee report as reasons for the program. HCFA implemented the program in order to help rural hospitals with any of the cited problems. Thus, we believed that we were implementing congressional intent.

Second, GAO seems to assume that rural health problems will be solved simply by channelling grant funds to rural hospitals. However, the hospital's financial requirements may not always match the community's need. For example, a full-service hospital may no longer be needed in the community and it may not be cost-effective to maintain one. Therefore, simply awarding grant funds to a hospital in such a community will not address the basic problem. Also, using "net financial loss" of the hospital, as proposed by GAO, is not in and of itself a sound or reliable criterion for awarding grant funds. For this reason, grant awards were based in part on the applicant's ability to assess community needs and develop projects to address those needs. The purpose of the grants is to assist the transition of the hospital to provide alternative services that meet the more basic health care needs of its community.

Finally, HCFA is not aware of a wide-ranging consensus of indicators of community health care needs and does not have the resources to perform an independent assessment of these needs in every rural community. In FY 1989, more than 1,800 rural hospitals were eligible for grant awards and over 700 submitted applications for the program. Even if such needs could be agreed upon, a large body of data to measure these needs is not available. The grant awards were made, therefore, on the best information available to HCFA.

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Finally, the report does not mention other non-Federal rural health care grant programs. For example, the Robert Wood Johnson and W. K. Kellogg Foundations and the State of Colorado all sponsor grant programs designed to assist rural hospitals and the rural health care system. The report should make note of these programs.

GAO Recommendation

To realize the full potential of the only Federal program which targets essential rural hospitals in all states, we recommend that the Secretary direct the Administrator of HCFA to:

- (1) develop instructions to guide potential Sole Community Hospital applicants through the application process;

Department Comment

We have prepared an issuance for the Provider Reimbursement Manual that gives detailed instructions on all provisions regarding SCHs. The manual issuance should be printed and distributed shortly.

GAO Recommendation

- (2) revise current SCH eligibility criteria to include hospitals that are sole providers of an essential service (e.g. emergency, obstetrics); and

Department Comment

We do not agree with the report's conclusion that the SCH eligibility criteria do not adequately identify rural hospitals where closure could impair Medicare beneficiaries' access to essential health care services. GAO is critical of the current qualifying criteria because they depend on distance and market share to identify SCHs. In addition to the difficulty of identifying and agreeing upon what services should be categorized as "essential" we disagree with this recommendation for the following reasons.

First, the proposal would require that SCH status be conferred on any rural hospital that is the sole source of an essential service regardless of its proximity to other hospitals. That is, under the proposal, three rural hospitals, within 5 miles of each other, could all qualify as SCHs if each offered an essential service that the other two did not. We do not believe that any one of these hospitals truly represents the sole source of care reasonably available in its community regardless of any unique services it provides. No doubt, if one of the three hospitals in the example closed, the lost essential service would be added by either or both of the remaining hospitals if there is a sufficient market in the community for the service.

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- o On March 10, 1986, we issued proposed regulations to allow an adjustment to the hospital specific portion of the payment for SCHs that experienced a significant cost distortion because of new services added to meet community medical needs. This provision was subsequently enacted into law as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).
- o Effective October 1, 1989, we lowered the mileage criterion for SCH qualification and we liberalized the requalification standard for those hospitals that had previously given up SCH status. In addition, we streamlined the exception process for volume declines.
- o In the May 8, 1989 Federal Register we solicited public comment on a number of issues related to assuring "essential access" to hospital care for Medicare beneficiaries residing in rural areas.

Among the Federal programs administered by the Health Care Financing Administration (HCFA), the report concentrates attention on the SCH provision and concludes that the SCH qualifying criteria inadequately identify hospitals essential to their communities, that the payment policies have been ineffective in protecting these hospitals from large financial losses, and that insufficient administrative attention has been given to the SCH provision.

Now on p. 15.

Additionally, the report broadly categorizes the problems faced by rural hospitals into four areas (p. 4). HCFA believes that this categorization is much too narrow and simplistic and ignores the general problems of a shrinking population and declining economy faced by rural America as a whole. The first three issues identified by GAO are, in fact, aspects of the same problem, low inpatient revenue, attributable to multiple causes. These causes include low volume (due in part to the inability to recruit specialists) and high fixed costs per case (due to low volume). Table 3.1 on page 30, therefore, does not accurately portray the potential impact of the identified Federal initiatives.

Now on p. 21.

The report notes the existence of the new Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH program (pp. 37-38)) and lists concerns about factors that may limit its impact. As the report notes, funds have not yet been appropriated for this program. HCFA is currently developing program guidelines so that the program can be implemented when appropriations are available. The legislation authorized the program in up to seven States, and HCFA will be required to develop criteria for selecting these States. In developing the criteria used to select States and award grants to individual hospitals, special consideration will be given to those organizations that demonstrate need. We believe that it is appropriate to start the program in a limited number of States so that program experience can be gained before it is expanded to other sites. Although this will limit the impact of the program in the short term, we believe that the longer range workability of the program will be enhanced.

Now on pp. 25-26.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 6 1990

Mr. Mark Nadel
Associate Director
National and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Nadel:

Enclosed are the Department's comments on your draft report, "Rural Hospitals: Federal Leadership and Targeted Programs Needed." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "R. Kusserow".

Richard P. Kusserow
Inspector General

Enclosure

would agree that there is a lot of fat in the system but at this point in time it's not in the small rural hospitals. The current reimbursement system is making the fat get fatter and eliminating access to health care."
(47 beds)

Texas

"I'm not sure at this time that ALL hospitals should survive. Maybe, like the animal kingdom or even the "free market," this is the time for the survival of the fittest. I think we can survive and serve the community for at least the next 5 years, barring any unforeseen major setbacks. Setbacks that could affect us negatively... continued cutbacks in Medicare/Medicaid programs. Two years ago, we made a few thousand dollars on Medicare. In 1988, we lost \$28,000, so far this year we've lost \$57,000 to Medicare. Since we are a hospital district, we are totally responsible for footing the bills for the indigent care. In 1988, that amounted to \$35,000. It continues to grow." (16 beds)

New York

"Rural/urban reimbursement variance must be eliminated... recognition of the higher cost in rural areas due to lower volume and standby capabilities." (53 beds)

Colorado

"We are a sole provider. Since the start of PPS, this has been a disadvantage rather than an advantage. Our hospital-specific component and the National/Regional component are both below the national figure. If we could receive the 100 percent national rate instead of our current blended rate, our Medicare reimbursement would immediately increase 17 percent. To do this, we would have to give up our sole-provider status. If we did this, the gain would be offset by the fact that our capital pass-through would then be subject to reduction and we would no longer be eligible for PIP [periodic interim payments]. In addition to being penalized instead of helped on our blended rate, we are at a significant disadvantage with the way the wage index is handled. In the days of cost-based reimbursement, Medicare forced hospitals to allocate all costs for ancillary services evenly between inpatient and outpatient services. This shifted costs from the inpatient to the outpatient side. Our current DRG rates are based on these reduced inpatient costs. We are now being reimbursed for outpatient services based on averages from physicians' offices and freestanding providers that do not include these costs (24-hour coverage, low-volume/high-cost procedures, strict building codes,

Arizona

“Congress should recognize that there is a difference between small rural hospitals and large urban hospitals. Several months ago, I completed a grant for the Rural Healthcare Transition Grant Program...it took two weeks of my own time, plus additional time for others. It should be noted that a 99-bed hospital has capabilities well beyond that of a 22-bed rural and, in terms of grant writing, the rural hospital most likely to receive a grant is the one which needs it the least, i.e., the larger facility. The smallest hospitals should be given special consideration. Medicare intermediaries are in perfect position to represent both the interests of Medicare and rural hospitals but in fact represent Medicare’s interests only. Most rural hospitals do not have the staff who can become Medicare experts, but the intermediary does. Some 20 months ago, we filed for a specific payment (due if a decrease of greater than 5 percent of our Medicare discharges). Our intermediary placed the burden of proof on us, and to date we have spent almost \$2,000 just to fill out the paperwork. It seems very strange that a law enacted by Congress to provide semi-immediate relief to hospitals who have suffered utilization declines could be effectively ignored or side-stepped by both my intermediary and HCFA for over one-and-a-half years. (22 beds)

Nevada

“The business office must constantly train to be current in new regulations, laboratory and X-ray fee schedules, data collection for Medicare/Medicaid cost reports, new collection laws, indigent care claims submissions, Hill-Burton charity care regulations, prospective payment reimbursement... Every person on this staff entered health care to be of service and has become a procurer for the federal government, to obtain resources for the continuation of health care. The twin burdens of over-regulation and under-reimbursement will shortly force closure.” (20 beds)

Nebraska

“If HCFA would require less paperwork, we would need less office staff. If JCAHO [Joint Commission on Accreditation of Healthcare Organizations] was eliminated or became more realistic with requirements, less staff would need to be employed... If regulatory agencies would become more realistic with requirements, costs would be lower. We are also finding that hospitals are hiring more staff in nonpatient-care-related departments and less in patient-care-related departments. We need to go back to the basics of taking care of patients and eliminate the redundant documentation requirement!” (49 beds)

Opinions of Rural Hospital Administrators

The opinions of individual hospital administrators presented in part or whole in this appendix are for information only. They should not be interpreted as a consensus of all who responded to our survey or with whom we met. The number of beds at the facility of the responding administrator is indicated at the end of each statement.

Perceptions of Federal Programs and/or Initiatives

Mississippi

“Government must realize the costs for rural hospitals to provide health care to their communities are equal to, if not greater than, the costs incurred by urban hospitals.” (72 beds)

“The largest problem that affects small rural hospitals is the criteria used to determine the necessity for admission and length of stay. Because the public does not understand these regulations, the hospital and doctors are always the bad guy when they try to explain these regulations to their local communities... There are too many regulations that are in place, requiring too much paper work.” (59 beds)

“I find a mutual sentiment among my colleagues in three areas: (1) unfairness associated with the differential between urban and rural facilities, (2) inadequate DRG [diagnosis related group] rates to cover actual cost for services rendered, and (3) inadequate capital pass-through reimbursement. Other mutual concerns are: the admission criteria for Medicare recipients does not consider social circumstances, competition for physicians and nursing staff; and the increasing cost of supplies necessary to administer the quality of care which we are all dedicated to. Larger facilities can better utilize staff and allocate real cost over a broader range of services. The rural facility is required to maintain the same staffing patterns on a certified bed basis as the urban facility, and salaries are comparable. DRG #089 and #127 carry a reimbursement to urban facilities of \$5,300 and \$4,500, respectively, while reimbursement to a rural hospital is \$2,200 and \$1,900. I seriously doubt that salaries and supplies are 139 percent higher in the urban facility.” (57 beds)

Appendix II
Rural Hospitals' Isolation and Financial
Status (FY 1985-87)

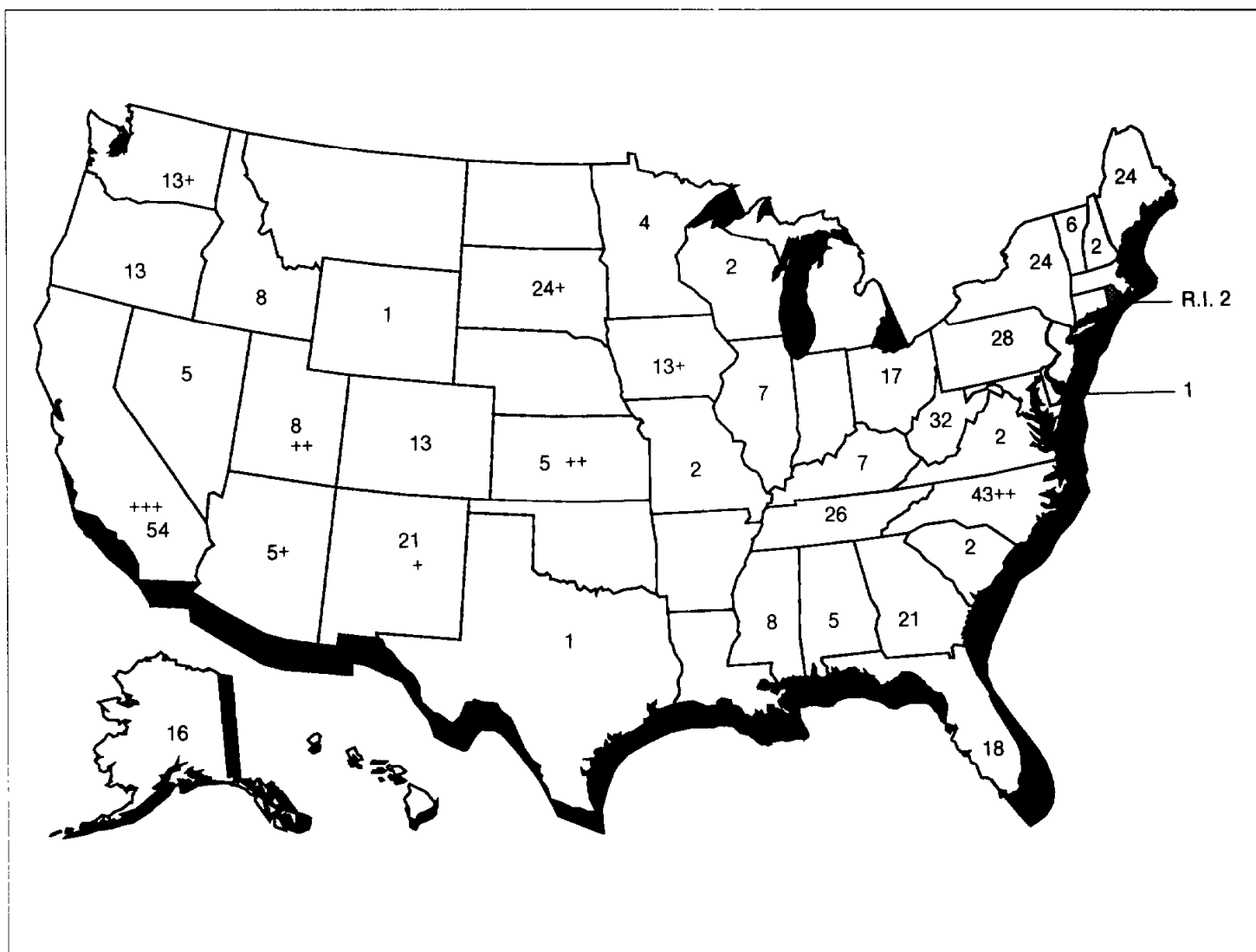
State	No. of rural hospitals^a	No. of rural hospitals with net losses^b	Percent with net losses	No. of eligible SCHs with net losses^c
Virginia	42	8	19	1
North Carolina	38	7	18	0
Ohio	65	11	17	0
Massachusetts	6	1	17	1
Pennsylvania	42	7	17	0
South Dakota	49	7	14	3
Vermont	14	1	7	0
Connecticut	2	0	0	0
Delaware	4	0	0	0
New Hampshire	15	0	0	0
Total	2,361	766	32	119

^aNumber of rural hospitals with good Medicare cost report data for at least 2 years between fiscal year 1985 and 1987.

^bHospitals' net total margin for the 3-year period fiscal year 1985-87. Hospitals with 2 years of profits and only 1 year of losses were excluded from the number with average losses.

^c"Eligible SCHs" refers to hospitals that (1) have been designated as SCHs at some point in time, (2) meet conservative distance or market share criteria, or (3) have been judged by the court to be eligible for SCH status but are not yet designated.

Distribution of Rural Health Clinics by State (1989)



Note. (+) Indicates a hospital-operated rural health clinic (total - 14)
 Source. Based on data provided by HCFA

as distance and patient travel time. HHS apparently interpreted our suggestion to mean that such hospitals should receive SCH designation regardless of these other criteria. Given HHS's concerns regarding the difficulties of implementing such criteria, we have revised our original recommendation. (See p. 49.)

HHS also stated that it believes existing criteria are too broad. To support its view, it cited a Prospective Payment Assessment Commission (ProPAC) study. HHS maintains the study found that the majority of current SCHs do not serve the majority of Medicare patients in their service area. We could not identify any recent ProPAC study that contained such a finding. HHS may have been referring to a recent ProPAC-commissioned study which made other findings related to the market share of isolated hospitals. The study acknowledges that its estimation procedures "underestimate, perhaps substantially, the number of small hospitals eligible under the predominant market share criteria."² Because of this limitation, this report should not be used to gauge whether current SCH criteria are too broad. However, our suggestion regarding essential services does not preclude HCFA from making other changes to improve the SCH designation.

Office of Rural Health Policy

HHS expressed concern that our report did not recognize ORHP's role in coordinating federal rural health policies and research. Because of HHS's concern, we expanded our discussion of ORHP to more fully reflect its contributions.

We continue to maintain that ORHP's full potential has not been realized. As the office with broad responsibility for rural health issues, it is in a unique position to influence federal policy if given the funding to investigate the operations and impact of federal initiatives, and directed to do so. While new funding for ORHP has been allocated since the time of our review, it is too early to assess the impact it will have. To the extent that the new funds are sufficient for ORHP to establish a national clearinghouse and to become more substantively involved in evaluating federal rural health initiatives, its capacity to perform oversight and advisory roles will be enhanced and our recommendations will have been implemented.

²Systemetrics/McGraw-Hill, *Small Isolated Rural Hospitals: Alternative Criteria for Identification in Comparison With Current Sole Community Hospitals*, Final Report to ProPAC, 1988, page 55.

rural America is not shrinking, although it is growing at a slower rate than urban America.¹ We do discuss the impact of a poor economy on distressed rural hospitals (see p. 18). We think this context for discussing the economy is appropriate, since comparing the overall rural economy with the overall urban economy does not explain why some rural hospitals thrive while others are financially distressed.

Prioritizing Funding and Defining Financial Need

HHS states that we assume that rural health problems will be solved simply by channeling grant funds to rural hospitals. This is not our position. We discuss the use of grant funds because the Congress authorized their use under the Rural Health Care Transition Grant Program.

HHS believes that we are proposing to use a measure of financial need as the sole criterion for targeting grants to rural hospitals. We do not intend to suggest such a position. Our report recommends that hospitals that are both financially distressed and essential be given greater consideration for funding (see pp. 49-50). We believe this criterion is appropriate whether the goal is (1) to assist the transition of the hospital to provide an alternate mix of services or (2) to assist the hospital in remaining a full-service acute-care institution.

Further, HHS's position on defining financially needy hospitals is unclear. HHS states that under the Essential Access Community Hospital/Rural Primary Care Hospital Program, "special consideration will be given to those organizations that demonstrate need." It is unclear from this statement whether, to receive special consideration, hospitals are supposed to demonstrate program need (for example, need for a new mix of services), financial need, or both. If HHS's statement refers in part to financial need, the agency will have to develop an objective, operational measure to assess need. Yet, in another section of its comments, HHS objects to "defining and operationalizing the meaning of the term financial distress" because it "is an extremely difficult and potentially futile task."

We believe that while any working definition of financial distress will be imperfect and incomplete in some way, the consequences of its imperfections will be less important than the consequences of refusing to adopt an objective measure of financial status. We are not suggesting that

¹Data from the 1989 Statistical Abstract show that between 1980 and 1987 the U.S. population of rural areas increased 4.1 percent, compared with an 8.4-percent increase in the population in urban areas. Data by state show rural area population declines in only nine midwestern states (MN, IA, NE, ND, SD, KS, IL, IN, and OH) and one southern state (WV).

To improve the coordination of federal, state, and hospital efforts and ensure that some entity with a broad perspective of the problems of rural hospitals can perform a substantive oversight and advisory role, we recommend that the Secretary assure that ORHP is given the resources to

- serve as a focal point of information on state and local initiatives and
- evaluate the individual and combined impact of federal efforts to assist rural hospitals.

Matter for Congressional Consideration

If congressional intent is to preserve rural residents' access to hospital care, the Congress should require that essential hospitals that are financially at risk be given priority when applying for federal grants designed to assist rural hospitals.

Agency Comments and Our Evaluation

HHS's comments on a draft of this report focused primarily on five areas: monitoring and evaluation efforts, the problems of rural hospitals, prioritizing funding efforts, the SCH designation, and the Office of Rural Health Policy (see app. V). Each of these areas is discussed below. Many of the technical comments suggested by HHS were incorporated into the text of the report.

Monitoring and Evaluating HHS Programs and Provisions

HHS expressed concern that our draft report characterized the SCH provision as a "program." HHS commented that "the SCH adjustment is not a Federal program; it is simply a Medicare payment adjustment targeted at certain hospitals which serve as the sole source of care..." We agree that the SCH provision is not a program, but believe it should be administered and monitored more like one. For example, in a program targeted at a group of hospitals, more concern likely would be placed on assuring that the target group is aware of the program, has a clear idea of how their applications will be judged, and faces a reasonable cost of applying (see pp. 24-25). Further, there would likely be a requirement for periodic regional reporting on application decisions, or some form of required record keeping, so that policymakers in the central office could better monitor the program and make adjustments as necessary (see p. 25).

HHS disagrees with our conclusion that "HCFA places relatively little emphasis on evaluating whether the federal programs or the provisions are meeting their intended purpose." Information we obtained on the

Conclusions, Recommendations, Matter for Congressional Consideration, and Agency Comments

Conclusions

Many rural hospitals find it increasingly difficult to keep pace with rapid changes in the health care industry and to address the multiple, interrelated problems affecting their financial viability. Federal, state, and hospital initiatives have been developed in response to many of these problems. In some cases, the efforts are modest; in others, substantial. For many of the efforts, however, it is either too soon or there is too little information to evaluate their impact.

A significant number of sole community hospitals are at risk of financial failure. Among rural hospitals, SCHs are of greatest concern because their closure may result in communities losing reasonable access to acute-care services. Improved reimbursement made possible by OBRA 89 should reduce future Medicare losses of SCHs. However, the overall low profitability of SCHs with fewer than 50 beds suggests that even with recent legislative changes, a number of essential rural hospitals will remain financially distressed and at significant risk of closure.

For SCHs, special efforts are needed to help assure communities' continued access to essential services. HCFA, however, does not systematically bring to bear the assistance available to rural hospitals under several other Medicare and HHS programs. For example, SCHs were not given assistance in obtaining transition grant funds, a potential source of financial assistance. Such assistance would be beneficial since at least 119 rural hospitals are financially at risk and appear to provide the sole source of care reasonably available to Medicare beneficiaries. Further, the eligibility criteria used by HCFA to designate SCHs does not consider all hospitals whose closure would create a problem of access to essential services. HCFA's greater attention to SCHs would better assure that they obtain the assistance currently available through a variety of federal programs.

Programs that can help SCHs avoid or recover from financial distress have administrative problems that mirror those that exist for rural hospitals in general. That is, there are several programs and provisions that could assist these hospitals, but they are not well linked or monitored to assess their combined impact, and there are few efforts to target funding so as to ensure assistance to hospitals most in need and essential to their communities. Improving the operations and monitoring of federal efforts to assist rural hospitals may require restructuring some of the initiatives. It may also require HHS to establish a more formalized system for monitoring and evaluating activities that have the potential to assist financially distressed, essential rural hospitals. This responsibility could

generally have more independence and flexibility to meet their individual needs. The structures of alliances vary, from informal to formal systems.

Memberships in the local networks we surveyed ranged from 4 to 28 hospitals. Forty-three percent of the hospitals had been members of their alliance for less than 5 years. All the alliances had formal structures that included a full-time salaried director.

Benefits of an alliance vary, depending on the organization's capabilities (see table 4.3). However, more than 65 percent of the hospital administrators reported moderate to great benefit from alliance activities in the areas of lobbying and drafting of legislation, management workshops, training in quality assurance methods, and rural health conferences.

Table 4.3: Benefits Reported by Rural Hospitals From Membership in an Alliance

Service accessed through alliance	Degree of benefit obtained (percent of hospitals reporting)		
	Great	Moderate	None
Board development	15	46	15
Dietary services	4	21	52
Financing arrangements	25	23	29
Grant funds	33	23	25
Laboratory services	6	21	50
Laundry services	4	8	64
Lobbying/drafting legislation	39	27	14
Management workshops	29	46	6
Physician recruitment	12	31	40
Quality assurance	25	46	8
Rural health conferences	35	31	14
Shared staffing arrangement	21	27	29
Referral/return agreements with tertiary hospitals and physician specialist	10	15	52
Transition/diversification	14	33	31

Note: Nonresponses result in total across lines of less than 100 percent

Alliances in Mississippi and Nevada provide good examples of the varying structures and benefits of rural alliances. Established in 1987, the Mississippi alliance includes a rural hospital with over 500 beds that is actively involved in developing a regional health care concept. Through linkage with this larger facility, smaller rural hospitals in northern Mississippi have accomplished tasks that probably would have been impossible, given their limited resources. For example, one small hospital, as a

**New Technology,
Management Programs
Found Useful**

Obtaining new technology and implementing a new management program was the third most frequently reported strategy of hospital administrators. Of all the activities reported, 13 percent were efforts to implement a new management program (for example, a quality assurance program) or acquire new or update existing technology (for example, CT scanners and ultrasound). Updating a hospital's technology or adding a new management program was a strategy considered to improve the quality of care and financial status of the institution.

**Group Purchasing
Arrangements Help Lower
Costs**

Concerned about the high cost of medical supplies and equipment, some rural hospitals have entered into group purchasing arrangements with hospital associations, local or national alliances, and other independent groups. Small hospitals are at a competitive disadvantage because they do not have the volume of services to purchase supplies in bulk or to negotiate favorable prices in procuring equipment or maintenance contracts.

As of 1987, at least 165 group purchasing organizations (GPOs) existed in the United States. Manufacturers give GPOs discounted prices because of high volume purchases. From a 1986 survey, the American Hospital Association estimates that hospitals with fewer than 50 beds used a GPO to make about one-half of their purchases. Hospitals with 50 to 99 beds reported that, on average, they made approximately one-third of their purchases through a GPO. Also, there are indications from a 1988 survey conducted by Group Purchasing News that smaller hospitals buy a larger portion of their supplies and equipment through GPOs.

Group purchasing arrangements are also offered through alliances (see p. 45). Alliances are attractive to rural hospitals because they offer group purchasing options as well as an opportunity for hospitals to pursue other common interests. The Voluntary Hospitals of America, a national alliance, reports that virtually all its member hospitals participate in its group purchasing program. This includes approximately 300 rural hospitals across the country. Several rural alliances we contacted reported becoming members of regional or national GPOs to increase their purchasing power.

Chapter 4
States and Hospitals Undertake Strategies to
Assist Rural Hospitals

Table 4.2: Recruitment and Retention Activities Reported by Rural Hospitals (1989)

Activity	Percent of hospitals reporting use by type of personnel					
	Physician	Nurse	Medical tech/ lab personnel	Physical therapist	Radiology technician	Respiratory therapist
Bonus program	9	20	8	12	7	7
Child care	3	8	8	8	8	8
Flexible work schedule	5	58	32	23	30	25
Housekeeping services	^a	1	1	1	1	1
Housing	5	5	2	2	2	1
Job placement for spouse	8	9	4	3	3	3
Loan forgiveness program	19	32	13	11	13	12
Loan program	24	30	19	15	17	14
Salary guarantee	53	12	12	11	10	9
Scholarship program	4	56	32	27	30	27
Reimbursement for professional conferences	26	73	67	55	65	57

^aFewer than 1 percent

A minimum income guarantee was the activity most commonly used to recruit and retain physicians. For nurses and other staff, reimbursement for professional conferences, scholarships, and flexible work schedules were the strategies most often used. One hospital developed a successful recruitment campaign in house after multiple attempts through a consulting firm failed. Using a "wanted-poster" that offered a \$5,000 reward for a family practice physician with obstetrical and surgical skills, the hospital conducted a nationwide search (see fig. 4.1).

Rural Hospitals' CEOs Respond to Challenges

Fifty-six percent of rural hospital CEOs reported that their hospitals were at risk of financial failure over the next 5 years. Many of these administrators were implementing strategies to improve their viability. Over two-thirds (69 percent) reported they were engaged in at least one activity designed to improve the hospital's financial status, community support, market share, or quality of care. The activities, which we classified into three areas, included (1) modifying services or staffing, or developing outreach programs; (2) recruiting and retaining health professionals; and (3) obtaining new technology or implementing a new management program. Also, many rural hospitals are joining together in local alliances and consortia in an effort to increase political influence and share resources, we were told by rural health experts.

Modifying Services, Staffing, or Outreach Help Improve Hospital Status

The majority (59 percent) of the activities² reported by hospital administrators involved modifying services or staffing or developing outreach programs, done to improve community support, market share, financial status, or quality of care. While modifying services usually included expanding the scope of services, modifying staffing usually meant reducing staff. Hospitals expanded such services as wellness and health promotion programs, outpatient clinic services, and services targeting the elderly (e.g., cafeteria meals served to elderly residents). Community fund-raising campaigns, focus groups, and health awareness programs are examples of outreach activities cited.

Some of the more innovative activities, as reported by the rural hospital administrators surveyed, were the following.

Hospital Slide Presentation/ Maternity Package

To increase community support for the hospital, the administrator gave slide presentations to civic leaders on the economic and regulatory constraints it faced. To increase the hospital's market share in obstetrics, the administrator appealed to two groups of patients: (1) privately insured women who were traveling to urban centers for care and (2) working uninsured women who had difficulty paying for care but were assumed to have the ability to pay. For both groups, the hospital created a package of benefits and services that included homelike birthing suites, birthing classes, home health visits following delivery, and a free dinner for two for the new parents. For the working uninsured women, the hospital also arranged to finance maternity packages through a local

²A total of 500 activities were reported under four separate categories in our questionnaire. In some cases the same activity was reported in more than one category. For example, health professional recruitment activities were reported as improving a hospital's financial status and its market share.

loan repayment and scholarship programs to place physicians in underserved areas. States provide technical assistance in such areas as identifying funding sources, writing grants, and analyzing data on hospital trends.

Additionally, we identified states attempting to reduce the impact of the rising cost of medical malpractice insurance. As malpractice costs have increased—particularly for such high-risk specialties as obstetrics—many physicians and hospitals have ceased to provide these services. In an effort to remedy this problem, 12 states (listed in table 4.1) have enacted laws to encourage providers in both rural and urban areas to continue delivering care to pregnant women. These provide (1) liability insurance premium subsidies for providers who locate in underserved areas or provide care to certain types of patients; (2) expanded liability protection to those who provide free, voluntary, and emergency delivery services; (3) state-funded indemnity for physicians who agree to provide free or minimally compensated health care services; and (4) no-fault liability for certain catastrophic, birth-related injuries. Of these four approaches, the premium subsidy has been the most widely used.

States and Hospitals Undertake Strategies to Assist Rural Hospitals

Some states and local communities are taking steps to address rural hospitals' problems of low patient volume, limited revenue, recruitment and retention of physicians, and regulatory constraints. State governments offer financial and technical assistance and have changed regulations to allow hospitals greater flexibility in developing a mix of services to meet the needs of area residents. Also, many rural hospital administrators are engaged in activities designed to improve their facilities' status. For example, hospitals are attracting patients by expanding outpatient clinic services and developing health promotion and outreach programs.

While many of the state and local efforts appear promising, little information is available centrally on the relative merit or impact of these efforts. As a consequence, many hospitals are engaged in similar activities with little knowledge of the experience of other communities.

States Use Various Strategies to Help Hospitals

Some states are pursuing a combination of strategies to assist rural hospitals that include regulatory reform, technical support, and financial assistance. Others have changed regulations and laws to permit rural and urban hospitals greater flexibility in modifying their service mix or diversifying their operations. Also, about half of the states have established an office of rural health as a focal point to coordinate regulatory and legislative activities affecting rural health care providers.

In Five States, a Comprehensive Approach to Problems of Rural Hospitals

Florida, Nevada, Oregon, Washington, and California are examples of states that have formulated comprehensive assistance programs targeting the needs of rural hospitals. Three of the states target their efforts toward a subset of rural hospitals. Each approach is unique.

- Florida targets assistance to rural hospitals with fewer than 85 beds that are sole providers in a county with low population density (fewer than 100 persons per square mile). These hospitals receive certain exemptions from CON review and have the option of being relicensed under a new category created for them. Health professionals affiliated with these hospitals are eligible for a loan repayment program.
- Nevada's legislature directed the state health department to develop separate regulations for the licensure of rural hospitals with 85 or fewer beds that are the sole institutional health care providers in low-populated areas. The Nevada Rural Hospital Project, an alliance of rural hospitals, received funding from the state to study and recommend proposed licensing regulations to the state. In addition, Nevada authorized

outreach or monitoring to assess whether the intent of the mechanism is accomplished. Selected hospital administrators' comments on some of the federal programs are included in appendix IV.

Recognizing problems in the coordination and monitoring of federal rural health efforts, HHS established ORHP within PHS in 1987. ORHP, authorized by the Congress in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), has responsibility for coordinating the work of federal agencies, state governments, and private sector organizations as they seek solutions to health care problems in rural communities. In particular, ORHP is charged with the following responsibilities:

- advising the Secretary on the effects of HCFA's Medicare and Medicaid policies on rural communities,
- coordinating rural health research within HHS and administering a grant program that supports the activities of the HHS-funded Rural Health Research Centers,
- providing staff support to the HHS National Advisory Committee on Rural Health, and
- developing a national clearinghouse for collecting and disseminating rural health information.

Since its inception, ORHP has worked to clarify federal policy and improve program administration relating to rural health care. For example, ORHP assisted the National Advisory Committee on Rural Health in preparing its 1989 annual report and recommendations to the Secretary of HHS. Recommendations were made on reforming Medicare hospital and physician payments, expanding federal programs to focus on rural health issues, increasing the quantity and quality of rural health research, and recruiting rural health personnel.

In addition to ORHP's federal advisory role, it provides local health officials and hospital administrators with information on federal rural health initiatives. In January 1990, for example, ORHP held a workshop to allow rural hospital and health representatives an opportunity to assist HHS as it prepares to implement the Essential Access Community Hospital Program authorized by the Congress in OBRA 89. At the time of our review, however, ORHP lacked adequate resources for operations and projects, including the development of a clearinghouse on rural health information. HHS has informed us that through its fiscal year 1990 appropriations, ORHP now has sufficient resources to support its operations.

The Congress authorized the establishment of an NHSC federal and also a state-administered loan repayment program in December 1987 (P.L. 100-177). The programs will pay up to \$20,000¹¹ per year toward a participant's outstanding educational loans if the recipient accepts an assignment in a designated medically underserved area. The federal loan repayment program is managed by PHS, and state programs operate through NHSC/state cooperative agreements. Of the 10 states applying for NHSC State Corps funding during fiscal year 1988, 7 were approved. These states were Florida, Maine, New Mexico, North Carolina, South Carolina, Texas, and West Virginia. According to PHS officials, 21 states submitted applications during fiscal year 1989, but because of funding constraints, only the original 7 were approved.

Because the NHSC loan repayment program has been available only since 1988, its effectiveness is difficult to assess. According to Corps officials, the program likely will have difficulty recruiting physicians because of increasing competition from providers such as health maintenance organizations.

With the gradual phaseout of the federal NHSC, rural areas must depend on state and local initiatives to attract health providers to their areas. OBRA 89 included provisions that may assist in this process. It established a national fee scale for services provided to Medicare beneficiaries and increased the incentive payment for physicians locating in underserved inner-city or rural areas. The fee scale is expected to reduce the imbalance in fees paid to medical versus specialty providers. However, compensation is only one of several issues that make physician practice in rural areas less attractive than in urban areas. Given that, it is unclear whether improved reimbursement alone will be a sufficient incentive to offset physician concerns about community amenities or the adequacy of physician support staff.

Other Medicare Provisions Increase Hospital Revenues

As discussed in chapter 2, rural hospital administrators are concerned that Medicare's prospective payment system places undue financial pressure on the operations of rural hospitals. To reduce the financial risk to rural hospitals, the Medicare program has, in addition to the SCH provision, three other special reimbursement mechanisms that provide additional sources of revenue to rural hospitals. Two of these, rural

¹¹\$25,000 for service in the Indian Health Service.

At the time of our review, the MAF project was delayed because of concerns about reimbursement and state licensure or certification. Nine Montana hospitals agreed to participate in the demonstration project, three as MAFs and six as a comparison group. Of the three demonstration MAFs, two are closed rural hospitals. Other Montana hospitals are reluctant to convert to a MAF since they will be required to relinquish their license for hospital beds. This would make it difficult and in some cases impossible for the facilities to revert back to full-service hospitals if the MAF proves unsuccessful.

Hospital licensure and certification is important for Medicare reimbursement. To qualify for such reimbursement, hospitals must meet a specific set of standards (that is, those of a state agency or the Joint Commission on Accreditation of Healthcare Organizations). The MAF, however, will lack the equipment and staff required for Medicare and Medicaid certification. HCFA has agreed to grant MAFs a waiver from these standards, allowing them to secure reimbursement, but as of April 1990, HCFA had not obtained the necessary approval from the Office of Management and Budget. Also, upon completion of the project, it is uncertain whether the new type of facility will be eligible for Medicare reimbursement.

The problems facing the MAF, as with use of mid-level practitioners, involve federal reimbursement policy and state licensure/certification laws. As such, satisfactorily resolving the issues is complicated by the varying interests and objectives of all the entities involved. However, the potential to learn whether a limited acute-care facility can fulfill a need and gain public confidence is important. Given the problems facing many small rural hospitals, HHS should attempt to expedite the implementation of demonstration projects of this type.

NHSC: No Longer a Source of Physician Supply for Rural Communities

The major federal program designed to help rural communities attract physicians to their area is the National Health Service Corps. It was established by the Congress within the Public Health Service in 1970 (P.L. 91-623). NHSC's mission is to provide health personnel to areas, populations, and facilities of greatest need, whether urban or rural. Although Corps assignments are not made directly to rural hospitals, NHSC physicians provide patient care in rural areas and thus are a potential source of patient referrals for a rural hospital.

Currently about 60 percent of all Corps physicians have been placed in rural areas. However, between 1986 and 1988, the number of Corps assignees to rural areas dropped by nearly 400 to approximately 1,450.

Programs to Help Hospitals Modify Service Mix and Recruit Health Providers Deserve Attention

To remain viable institutions, some rural hospitals may need to alter significantly their mix of services. Two federal initiatives that help rural hospitals develop a service mix that reflects local needs are the Rural Health Care Transition Grant program and the Medical Assistance Facility (MAF) demonstration project. Our review of the programs found that (1) the transition grant program did not target at-risk hospitals that are essential to their communities and (2) as of April 1990, MAF certification issues were not yet fully resolved.

Also, funding for the National Health Service Corps (NHSC), the major federal program designed to improve the supply and distribution of health providers in rural and urban communities, has been significantly reduced in the past decade. Thus, NHSC can no longer be relied upon to supply physicians to rural areas.

Grant Program Needs Additional Review Criteria

To increase patient volume and adapt to changes in the health care environment, some hospitals have introduced or expanded their outpatient and long-term care services. Other hospitals have converted into an alternate type of health resource, such as an ambulatory care or long-term care facility. The Rural Health Care Transition Grants, authorized by the Omnibus Budget Reconciliation Act of 1987, were to assist rural hospitals in planning and implementing projects to modify the hospitals' type and extent of services. The legislation gave HCFA broad authority to make grants for a variety of activities, including recruiting physicians, diversifying into new services, and developing cooperative efforts with other health providers.

For fiscal year 1989, \$8.9 million in appropriated funds was available for the transition grant program and its evaluation. Not-for-profit rural hospitals with fewer than 100 beds were eligible for up to \$50,000 per year for 2 years. In September 1989, HCFA awarded 181 grants under this program (see app. III). The criteria for selecting transition grant recipients are of particular concern, we believe. The review criteria presented in the HCFA grant announcement had little focus on either at-risk hospitals that have the potential to be viable or hospitals considered essential to the delivery of health care in a community (for example, SCHS).⁹ Although the Congress did not require HCFA to focus on at-

⁹Reviewers scored hospital applications according to (1) the applicant's ability to present the problem and needs of the community; (2) the likelihood of successful impact; (3) the extent to which the project would improve access to care; (4) the proposed degree of coordination among the hospital, government and community leaders, and other providers; and (5) the project's effect on reducing Medicare expenditures

addresses the problem of low patient volume directly by encouraging patient transfers and referrals to essential access hospitals. But several characteristics of the program may limit its impact. First, it will assist essential access hospitals in only seven states. Although isolated hospitals that are also financially distressed are relatively few (see app. II), they appear scattered through at least 32 states. Second, no criteria are specified for selecting states to receive grants. Consequently, states with a relatively large number of distressed and isolated rural hospitals could be rejected, while less needy states are funded. Finally, although the designated essential access facilities will receive the same Medicare payment as SCHS, they are not otherwise targeted for special consideration under other federal efforts, as discussed below.

The Potential of the Rural Health Clinic Act Not Fully Realized

The Rural Health Clinic Services Act of 1977 (P.L. 95-210) includes provisions that assist clinics in using mid-level practitioners (for example, nurse-practitioners and physician assistants) in areas that have a shortage of physicians. The RHC act allows a clinic to bill Medicare and Medicaid directly for services provided to beneficiaries by mid-level practitioners. RHCs can be either provider-based facilities (that is, operated by a hospital, skilled nursing facility, or home health agency) or independent clinics. To qualify for the reimbursement, an RHC must be located in a medically underserved rural area and staffed with mid-level practitioners at least 50 percent⁶ of the time. Hospital-operated clinics are reimbursed on a cost-related basis, at the same rate paid for outpatient services under Medicare.

Some rural health experts believe that RHCs can assist rural hospitals with problems of declining patient base and physician coverage. For example, a hospital closing its emergency room or entire facility could convert the emergency room to an RHC. The services of the clinic could be provided at lower cost, and otherwise idle space could be used to maintain some level of services. With the assistance of a physician on staff, the clinic could function as a full-service, 24-hour emergency room or an urgent care facility open only during specified hours.

When a hospital operates an RHC, it may be collocated with the hospital or free-standing. Because payment is cost based, the RHC could help a hospital cover its fixed costs. Despite this financial advantage, only 14 of the 483 currently designated RHCs are operated by a hospital (see

⁶OBRA 89 lowered the requirement from 60 to 50 percent.

Over 40 percent (61 hospitals) of SCHs with fewer than 50 beds experienced losses in at least 2 years during fiscal years 1985-87.⁴ Our analysis showed that Medicare losses are not the major force driving these hospitals' financial distress. Even if Medicare had paid under-50-bed SCHs their full costs in fiscal year 1987, many still would have experienced substantial losses.⁵ Thus, some of these hospitals and communities will need more than increased Medicare payment to maintain rural residents' access to hospital care.

**SCH Designation Currently
Not a Good Indicator of
Hospitals' Importance to
Community Access**

Not all hospitals that are essential to their communities are eligible under the current criteria. Criteria for SCH eligibility are based on distance and other factors related to the accessibility of alternative hospitals or the community's dependence on the hospitals. Designation is contingent on a minimum distance to the nearest "like" hospital, but like is defined in the regulations as any short-term acute-care hospital, regardless of the services provided.

Given the current definition of "like," a hospital may be excluded from designation even though it is an area's sole provider of essential services. For example, a 153-bed hospital that provided obstetrical care was denied SCH status because of the presence of a 23-bed hospital within 25 miles, although the other hospital did not provide obstetrical care. A similar situation could occur with respect to the provision of emergency services. Because of situations like these and to better assure that all hospitals providing essential services to their communities are eligible for SCH designation, we believe HCFA should examine its SCH eligibility criteria.

**SCH Provision Needs
Greater Administrative
Attention**

Our review of SCH applications at two regional offices and telephone conversations with officials of some designated and potentially eligible hospitals suggest that potential applicants for SCH status lack sufficient information about the application process. Currently, not all potential

⁴If the group is expanded to include all under-50-bed hospitals that (1) were ever designated SCHs, (2) meet criteria for designation, or (3) were judged to be eligible by the court but that are not yet designated, we estimate there are at least 91 that lost money in 2 or more years during fiscal years 1985-87.

⁵Of SCHs under 50 beds, 25 percent had negative total margins (expenses exceeding revenues) of 9 percent or more in fiscal year 1987. Had Medicare paid these hospitals their full Medicare costs, these hospitals still would have had negative total margins of 7 percent or more, indicative of continuing financial problems.

This payment mechanism was designed to recognize the special circumstances of sole community hospitals by considering their hospital-specific costs. The mechanism used to pay SCHs, like all hospitals under PPS, uses predetermined rates. Instead of being based on the average costs of all rural hospitals in 1981 (and updated annually), however, SCH rates are based largely on the individual hospital's 1982 costs.² At the time of our review, 372 hospitals were designated SCHs.

Many SCHs have experienced financial losses on their Medicare patients because their costs increased at rates higher than the adjustment factors used to update 1982 costs. For example, in fiscal year 1987 one-quarter of SCHs had Medicare operating costs that exceeded their PPS revenues by 16 percent or more.³ One explanation for this is that SCHs on average have had significant declines in inpatient volume, which tend to increase their per case costs. To correct this payment rate problem, OBRA 89 increased reimbursement to designated SCHs by allowing them to receive payment based on the highest of either (1) their updated 1982 costs, (2) their updated 1987 costs, or (3) the rural hospital PPS rate.

While OBRA 89 increased Medicare payment rates by allowing a hospital to receive the highest of three rates, losses on Medicare patients will still occur for SCHs whose costs continue to increase faster than the adjustment factor that will be used to update the base year costs. There is a safeguard, however, to protect hospitals experiencing per-case cost increases that result from declines in volume. Specifically, if such volume declines are more than 5 percent and are due to circumstances beyond the hospitals' control, SCH-eligible hospitals may apply for additional reimbursement, referred to as a volume adjustment. This provision has been available to hospitals since fiscal year 1984, but is seldom used. Only 8 hospitals received a payment and only 23 applied to HCFA for the adjustment between April 1985 and February 1989. However, at least 114 designated SCHs experienced declines of 5 percent or more in discharges during fiscal year 1987 alone.

HCFA has not investigated why so few hospitals have applied for the volume adjustment. We telephoned officials of some hospitals that might be eligible for SCH status and found that many were unaware of or misunderstood the volume adjustment provision. Effective October 1989, however, HCFA attempted to streamline and expedite the application process

²Before OBRA 89, payment was based on the sum of 75 percent of the hospital's 1982 cost and 25 percent of the regional payment rate

³Data set includes 271 SCHs designated during 1983-87.

Federal Programs Need Targeted Approach to Help At-Risk Rural Hospitals

A number of federal initiatives are available to help rural hospitals increase their revenues, attract patients, and recruit health professionals. To date, little attention has been given to determining the overall impact of these initiatives. In addition, the one federal provision designed to help rural hospitals that provide the sole source of care to Medicare beneficiaries has not adequately protected these hospitals from large losses on Medicare patients.

Also, some rural hospital administrators have considerable difficulty getting information they need to apply to federal programs. In two instances, hospital administrators spent about \$10,000 each for consultants to help them apply for SCH status.

Most federal efforts that assist rural hospitals are administered by HCFA and structured to provide additional Medicare payment to hospitals that meet eligibility criteria. As a consequence, HCFA's main administrative effort is to determine which hospitals are eligible for payment. Of course, accurate payments are an essential element of any federal program. However, with the SCH and rural health clinic (RHC) provisions, HCFA places relatively little emphasis on such activities as outreach, technical assistance, or evaluation of whether the provisions are meeting their intended purpose. Moreover, there is no office monitoring the combined impact of federal provisions assisting rural hospitals.

Recognizing problems in the coordination and monitoring of federal rural health efforts, the Department of Health and Human Services (HHS) established the Office of Rural Health Policy (ORHP) in August 1987.¹ Our review suggests that HHS could better use ORHP in monitoring and evaluating federal rural health initiatives.

Ten Federal Initiatives Assist Rural Hospitals

We identified 10 initiatives within HHS that address rural hospitals' problems by (1) providing ways for them to lower their costs per patient, (2) recruiting federally sponsored health providers to underserved areas, (3) increasing their Medicare payment, or (4) providing grant funding, information, or technical assistance. The specific efforts are listed in table 3.1 with a notation identifying the major problems they address. The initiatives do not represent an exhaustive list of federal efforts that are available to assist rural hospitals, but they are the major efforts that specifically target rural hospitals.

¹ Authorized by the Congress in Dec. 1987, P.L. 100-203.

Medicare's Prospective Payment System Limits Hospital Revenue

PPS sets payment at a predetermined amount, based on the 1981 average cost of treatment for each patient diagnosis, adjusted for certain hospital characteristics and updated annually. Hospitals with costs below this amount make a profit from the system; those with costs above, lose. In general, rural hospitals with fewer than 100 beds have not fared as well as larger hospitals under this system.

Urban and rural hospitals are paid based on standardized amounts that represent the average adjusted cost of treating Medicare patients in urban and rural hospitals, respectively. Because rural hospitals have had lower average costs than urban hospitals, their payment is based on a standardized amount that is about 11 percent lower (in fiscal year 1989) than the standardized amount used to pay urban hospitals.

This disparity in payment rates was the focus of much concern by rural hospital administrators we surveyed. They contend they must pay the same prices for supplies and equipment as their urban counterparts, and sometimes offer at least equal wages to attract personnel, yet are paid at a lower rate. Several administrators expressed concern that current payment rates perpetuate inequalities in the resources (i.e., human and technological) available in rural hospitals relative to urban facilities.

For the distressed hospitals, PPS operating costs exceeded PPS revenues, resulting in a median loss for fiscal year 1987 of 12 percent. This compares with a median profit of 4 percent for the successful hospitals. While losses on the hospitals' Medicare patients were significant for the distressed hospitals, their average losses on other patients were considerably larger. Consequently, increases in Medicare payment alone are not likely to result in profits for the most distressed hospitals.⁶

Economic Environment Affects Hospital Revenues

Most hospitals, and particularly small ones, depend on nonpatient revenue (that is, public or private funds) to make up for financial losses on patient care.⁷ Two factors that affect the availability of nonpatient revenue are the community's economic environment and the hospital's ability to secure public or private grants or donations.

⁶For example, if Medicare paid the distressed hospitals for their full Medicare costs in fiscal year 1987, overall costs still would have exceeded revenues by 7 percent or more in half of these hospitals, indicating continuing financial distress.

⁷This is evident from a comparison of hospitals' operating margins (a measure of profitability on patient care) with their total margins (a measure of their overall profitability). In general, hospitals' operating margins are lower than their total margins, and the difference is greatest for those with fewer than 50 beds.

allowing the hospital to decrease its costs per patient and improve financially.

Hospitals are ultimately dependent on physicians to maintain or increase their patient volume; in a small rural hospital, the loss of a single doctor can cause a serious volume decline. Therefore, problems in recruiting and retaining physicians likely contribute to low patient volume in many hospitals. Hospital administrators (CEOs) we surveyed cited recruitment and retention of physicians as a major challenge; about one-third reported spending at least 20 percent of their time on physician recruitment activities.

Recent survey research² indicates that low patient volume is in part a result of patient preferences and need to seek care elsewhere. Smaller hospitals, more than others, must combat the consumer belief that “the bigger the hospital, the better” in order to attract patients. A more limited scope of services (discussed below) also works against these facilities in competing for patients.

Limited Services and Technology Reduce Ability to Compete

Distressed rural hospitals³ maintain a more limited scope of services and fewer technological resources than successful hospitals. Both factors make it difficult for a distressed hospital to attract patients, physicians, and physician referrals. In addition to lower patient volume, distressed hospitals had, on average, fewer doctors on their medical staff and were less likely to provide inpatient obstetrical care or intensive care or to have available ultrasound or CT scanner technologies.

Often, as with low patient volume, limited scope of services and fewer technological resources are the result of some problems and the cause of others. For example, a limited scope of services may stem from an inability to recruit or retain a mix of specialist physicians, less technology from an inability to obtain capital needed to modernize or acquire expensive equipment. Both problems may cause a hospital’s loss of patients.

²Illinois Farm Bureau, *Health Care in Rural Illinois*, 1989, p. 45, and Community Health Services Development Project, unpublished data from 18 rural community surveys conducted between 1985 and 1990.

³We defined distressed rural hospitals as those with a 3-year average total margin in the bottom 25 percentile of rural hospitals with fewer than 100 beds.

To identify state policies that have the potential to affect rural hospitals positively, we used primarily the results of a recently completed survey of all state health agencies conducted by the National Governors' Association. Along with this survey, we used supporting evidence identified through a search of the literature. In addition, we interviewed health officials in 27 states by telephone. Our work was performed from July through December 1989 in accordance with generally accepted government auditing standards.

potential to address major problems (for example, recruitment and retention of physicians) for rural hospitals. Although it was beyond the scope of this study to completely evaluate each program described, we identified problems that were the most evident.

By making suggestions on how to improve the operations and impact of federal programs, we did not intend to imply that every rural hospital should remain open as a full-service, acute-care facility. In some instances, the closure of a hospital located near another hospital offering a comparable range of services can strengthen the viability of the remaining facility. But, in other cases, a hospital's closure may jeopardize access to care, and efforts to assist the facility or community may be warranted.

Methodology

To identify the major problems of rural hospitals considered at risk of failure, we compared the characteristics of successful hospitals with those of financially distressed hospitals. In addition, we reviewed related literature. To obtain information on rural hospitals from the perspective of residents of rural communities, we made site visits to several rural hospitals and surveyed rural hospital chief executive officers (CEOs).

Our comparison of successful and distressed rural hospitals was limited to those with fewer than 100 beds because of the greater likelihood of financial distress and closure in this group. Using Medicare automated cost report data averaged over a 3-year period, we defined successful hospitals as those with total profit margins⁵ in the "top" 25 percentile of all rural hospitals with fewer than 100 beds (N=406). We defined financially distressed hospitals as those in the "bottom" 25 percentile (N=392).⁶

To identify the distinguishing characteristics of successful and distressed hospitals, we compared data on patient mix, bed size, patient volume, economic environment, geographic location, services, and physicians. For this analysis, we used data from the American Hospital Association's (AHA) Annual Survey, the Health Resources and Services

⁵The total margin is a commonly used measure of overall profitability. It is calculated as follows: (total revenue – total costs)/total revenue. Each hospital's total margin was averaged over a 3-year period to provide a more stable measure of profitability than a 1-year figure.

⁶Hospitals were then excluded from the successful group if they had 2 years of negative margins, and were excluded from the distressed group if they had 2 years of positive margins.

Introduction

Faced with troubled rural economies, fewer resources, and a competitive health care environment, rural hospitals are experiencing increasing financial distress. As a consequence, many rural hospitals have closed since 1980, and others are considered at risk of closure over the next few years. The Chairman of the House Appropriations Committee asked that we identify strategies and programs that could assist rural hospitals considered to be “at risk.” There is concern that rural hospital closures may jeopardize access to health care services, particularly for elderly and low-income residents who may have greater difficulty traveling to a neighboring health care facility.

Background

Rural hospitals are operating in a health care environment that has changed dramatically in the last 2 decades. Scientific and technological advances, as well as changes in reimbursement policies, have greatly altered medical practice patterns. New technologies have shifted treatment for certain conditions from inpatient to outpatient settings, reducing inpatient volume. Although overall use of inpatient services has declined, the patients who are hospitalized tend to be more severely ill than patients in prior years and require a more complex range of services. Further, modern roadways and public transportation systems have reduced the isolation of many rural communities. Residents of rural areas now have greater mobility and, therefore, can obtain health services from more distant areas. All of these factors contribute to rural hospitals now facing a more competitive environment than when they were built.

Many rural hospitals were built in the 1950s with federal matching funds made available through the Hill-Burton Act of 1946.¹ But the need for hospital beds has declined due to changes in the health care industry. By the mid-1970s, concern about the growth in the number of hospital beds, services, and costly technology led to passage of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). The act required hospitals to obtain a certificate-of-need (CON) for capital expenditures on physical plant, equipment, and services. Although federal CON requirements were discontinued in 1987, many states continue to regulate the growth in hospital equipment and services. Federal and state regulatory efforts have attempted to control health care costs by limiting large capital investments to those considered needed.

¹The Hospital Survey and Construction Act of 1946 (P.L. 96-499).

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Abbreviations

AHA	American Hospital Association
CEO	chief executive officer
CON	certificate-of-need
GPO	group purchasing organization
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MAF	medical assistance facility
NHSC	National Health Service Corps
OBRA 89	Omnibus Budget Reconciliation Act of 1989
ORHP	Office of Rural Health Policy
PHS	Public Health Service
PPS	prospective payment system
ProPAC	Prospective Payment Assessment Commission
RHC	rural health clinic
SCH	sole community hospital

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Medicare's sole community hospital (SCH) provision is a major federal effort that assists rural hospitals that are the only source of care for Medicare beneficiaries. However, it has not adequately protected them from large losses on Medicare patients. Although improved reimbursement under the Omnibus Budget Reconciliation Act of 1989 should alleviate large Medicare losses, many SCHs likely will still experience problems as a result of losses on other patients. Also, current SCH eligibility criteria do not consider all hospitals whose closure would cut off access to essential hospital services.

Another federal provision, the Rural Health Clinic (RHC) Services Act, could help rural hospitals to develop outpatient clinic services and use mid-level practitioners (e.g., physician assistants). RHCs are reimbursed on a cost-related basis for services provided to Medicare and Medicaid beneficiaries. However, despite the financial advantages, only 14 of the 483 RHCs are operated by a hospital. Reported barriers to the growth of RHCs include a lack of information disseminated on the program and restrictive state certification procedures for mid-level practitioners.

The Congress, through the Rural Health Care Transition Grant Program, made grants available to help rural hospitals develop a mix of services that reflect the needs of their areas. However, criteria for selection of grant recipients did not focus on financially at-risk hospitals that are essential to a community. Without more effort by the Congress and the Health Care Financing Administration to target funding, financially secure hospitals may receive federal support at the expense of at-risk, essential hospitals.

Federal efforts that assist rural hospitals are not well linked or evaluated for their combined impact. In addition, the SCH and RHC provisions are not sufficiently monitored. Recognizing problems in the coordination and monitoring of federal rural health efforts, the Department of Health and Human Services (HHS) established the Office of Rural Health Policy (ORHP). Although ORHP is in a unique position to independently assess the operations and combined impact of federal initiatives, it has not been directed to do so.

States and Hospitals Initiate Efforts to Help Rural Hospitals

Most states provide some assistance to rural hospitals. About half of the states have an office of rural health, and some states have changed laws and regulations to permit hospitals greater flexibility in licensing new combinations of services. Additionally, a few states have a broad range of planning and technical support efforts to assist rural hospitals.

Executive Summary

Purpose

As a consequence of increasing financial pressures, a number of rural hospitals have closed in recent years and many more are considered at risk of closure. There is widespread congressional concern that these closures may jeopardize access to medical care, particularly for elderly and low-income residents who may have difficulty traveling to another facility. In light of these concerns, the Chairman of the House Appropriations Committee asked GAO to identify strategies and programs that could help at-risk rural hospitals.

This report identifies programmatic efforts that attempt to address major problems confronting at-risk rural hospitals. The Omnibus Budget Reconciliation Act of 1989 established new federal initiatives and refined existing efforts. If funding is appropriated, the new initiatives will significantly increase assistance to rural hospitals. Many problems, however, remain unresolved.

Background

Rural hospitals are operating in a health care environment that has changed dramatically in the last 2 decades. Changes include growth in costly technology, shifting of services from inpatient to outpatient settings, and establishment of Medicare's fixed-price prospective payment system for inpatient services. In addition, due to improved roadways and public transportation systems, rural residents are considerably more mobile and have greater choice in where they obtain health care services.

Although the majority of rural hospitals have maintained their financial viability in this dynamic environment, some have not. From 1980 to 1988, 408 U.S. hospitals closed—half in rural areas. For an initial assessment of the problems of at-risk rural hospitals, GAO compared the characteristics of successful and distressed small rural hospitals and interviewed a number of rural hospital administrators. To identify programs and strategies that address the problems of rural hospitals, GAO interviewed federal health officials, reviewed findings from a nationwide survey of state health agencies, and surveyed rural hospital administrators. Another GAO report, soon to be issued, will present findings from an in-depth study of the causes and consequences of rural hospital closures.

