THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

*Op-Ed*

# Global Budgets for Rural Hospitals

JOSHUA M. SHARFSTEIN

Are rural hospitals an endangered species? Since 2005, more than one hundred have closed, with about one in four of the roughly two thousand remaining at high risk or mid-high risk for going out of business.[1] A website exists to track their demise (http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/). Bipartisan legislation in the US House of Representatives is known as the Save Rural Hospitals Act, and there is a Twitter campaign with the hashtag #SaveRural.

What most needs saving in rural America, however, are the lives of those who reside there. According to the Agency for Healthcare Research and Quality, life expectancy is several years lower in rural America than elsewhere in the United States, with the gap growing larger. Key contributors to this disparity include heart disease, chronic obstructive pulmonary disease, lung cancer, stroke, diabetes, drug addiction, and suicide.

The most popular proposals to stem the tide of rural hospital closures would have little to no impact on the underlying health crisis, and some would actually widen disparities. But an emerging innovation—global hospital budgeting—could be a lifeline both for vital facilities and for their communities.

The central cause of financial distress among rural hospitals is declining patient admissions. Smaller hospitals, with a greater percentage of fixed costs, have had serious difficulties coping with population declines, shifts in certain types of care to larger hospital centers, and general trends favoring outpatient treatment. The Affordable Care Act ended a few special support programs for rural hospitals on the presumption that Medicaid expansion would more than cover the shortfall. It is no surprise, then, that rural hospitals in states that failed to expand Medicaid are particularly distressed.[2]

The Milbank Quarterly, Vol. 94, No. 2, 2016 (pp. 255-259)

## Responses to Declining Admissions

Rural hospitals are responding to seeing fewer patients in some combination of 3 ways: (1) finding more patients, (2) seeking greater reimbursement for each patient, and (3) cutting back on services. But the most promising option may be none of the above: shifting the basis of payment away from fee-for-service reimbursement for rural hospitals.

### *Find More Patients*

In December, the *Wall Street Journal* reported that rural hospitals are increasingly filling beds with patients undergoing elective surgery. For example, the number of knee and hip replacements at small rural hospitals increased 42% between 2008 and 2013, compared to just 9% at other hospitals.[3] Unfortunately, because surgeons at these facilities operate infrequently, their complication rates are greater, with nearly a doubling of risk-adjusted 30-day mortality. The reliance on more risky elective surgeries to bolster rural hospitals for the good of their communities recalls the old saying that the operation was a success, but the patient died.

### *Seek Greater Reimbursement for Each Patient*

The Save Rural Hospitals Act seeks to enhance multiple kinds of reimbursements for rural hospitals in the Medicare and Medicaid programs. However, paying all rural hospitals more is expensive and inefficient, as the majority of these facilities are not facing grave financial challenges. Moreover, this approach does not confront the underlying trend in fewer admissions, and so, at best, for many hospitals it just postpones the day of reckoning.

### *Cut Back on Services*

Many hospitals are cutting back on services, and another bill, known as the Rural Emergency Acute Care Hospital Act, would smooth the path for doing so. The legislation would allow rural hospitals to close all inpatient services and transition into emergency departments with outpatient services, and qualify for reimbursement from Medicare at

110% of costs. Because of the emphasis on emergency care, however, the legislation might leave the facilities dependent on high volumes of acute care visits, a situation that is not necessarily aligned with community interests in better health and prevention.

### *Leave Fee-for-Service Reimbursement Behind*

This is a new option, not like the others. A global budget for a hospital across all payers provides a guarantee of revenue in advance, no matter the volume of admissions and other hospital services. This financial model flips the traditional fee-for-service incentive structure and encourages hospitals to take steps to reduce preventable admissions by implementing strategies that improve health. The more a hospital improves the health of its community, the greater its financial gain.

In Maryland, 10 rural hospitals have operated on all-payer global budgets under the state's unique rate-setting authority since 2010. These hospitals have changed the way they do business, emphasizing care coordination, primary care follow-up, and community health partnerships. Western Maryland Regional Medical Center, for example, provides 30 days of free medications to discharged patients; embeds care coordinators and navigators in local practices; places doctors and nurse practitioners in skilled nursing homes; uses telemonitoring for blood glucose, blood pressure, and weight; and works to meet the social needs of its patients, including food security and transportation access.[4]

A global budget does not guarantee a hospital solvency, but it does provide a path to sustainability that is independent of inpatient volume. It ends the perpetual search for more patients and allows the hospital to do well by doing right by its community. In the words of Barry Ronan, CEO of Western Maryland Regional Medical Center, having a global budget "reminds us why we chose this field."[5]

Global hospital budgets can appeal to payers, especially those weary of the tug-of-war over patient volume, in which prior approval and other utilization review tactics square off against new hospital service lines and aggressive marketing. Even if payers find themselves paying higher rates per admission, a decline in preventable admissions will mean net cost savings. Payers with a long view will also appreciate that improved community health will pay dividends over time.

Global budgeting for rural hospitals is possible in the 49 states without Maryland's rate-setting system. Local payers would need to agree

to pay a share of a predetermined budget for a rural hospital based on such factors as their negotiated rates and their respective shares of actual patient volume. With a waiver from the Centers for Medicare and Medicaid Services (CMS), Medicare could participate, and with the support from the state, so could Medicaid. An independent authority could be designated to negotiate budgets and oversee a mechanism to arrange for payment. The authority could also assure that hospitals are taking appropriate steps to improve the health of their communities and are not seeking to take advantage of new incentives by referring appropriate patients elsewhere. CMS, in consultation with the Office of Rural Health Policy at the Health Resources and Services Administration and the National Rural Health Association, could accelerate the process of establishing global budgets for rural hospitals by developing a model pathway.

Karen Murphy, who helped design Maryland's global budgeting model at CMS and who is now the secretary of health in Pennsylvania, told me, "It is imperative that we develop a sustainable model for rural health, not just for rural hospitals. Rural communities face different challenges than urban counterparts, and our policies should support local innovation in meeting these needs. Global hospital budgeting offers the potential to reform rural health care in alignment with better population health."

In other words, the best way to #SaveRural hospitals may turn out to be a great way to #SaveRural lives.

## References

1. Kaufman B, Pink G, Holmes M. Prediction of financial distress among rural hospitals. NC Rural Health Research Program. January 2016. http://www.shepscenter.unc.edu/download/12524/. Accessed February 29, 2016.
2. Callow A. Medicaid expansion and rural hospital closures. Families USA. December 2014. http://familiesusa.org/product/medicaid-expansion-and-rural-hospital-closures. Accessed March 1, 2016.
3. Weaver C, Mathews AW, McGinty T. New risks at rural hospitals. *Wall Street Journal*. December 25, 2015.
4. Ronan B. Thinking out of the box. The Ronan Report. December 28, 2015. http://theronanreport.blogspot.com/2015/12/thinking-out-of-box.html. Accessed March 1, 2016.

5. Ronan B. Total patient revenue. The Ronan Report. April 27, 2011. http://theronanreport.blogspot.com/2011/04/total-patient-revenue.html. Accessed March 1, 2016.

---

*Address Correspondence to*: Joshua M. Sharfstein, Johns Hopkins Bloomberg School of Public Health, 615 N Wolfe St, Ste W1033D, Baltimore, MD 21205 (email: Joshua.Sharfstein@jhu.edu).