Small Rural Hospitals: A Decade of Progress, an Uncertain Future

Final Report on the Grant Program for Rural Health Care Transition

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WHY CONGRESS ESTABLISHED THE RURAL HEALTH CARE TRANSITION
GRANTS PROGRAM

Congressional concerns about both the financial viability of rural hospitals and the access of
rural residents to health care led to the introduction of the Grant Program for Rural Health Care
Transition (RHCT) in 1989. During the 1980s, a convergence of forces caused the financial
condition of many small rural hospitals to decline drastically. These forces included unfavorable
demographic and economic trends, changing health care practice patterns, shortages of health care
practitioners willing to practice in rural areas, and the introduction of prospective payment for acute
inpatient care. More than 10 percent of rural hospitals closed during the decade. To ensure
continued access to health care in rural America, Congress responded by establishing the RHCT
Grants Program (under the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239,
Section 6003[g]) and other programs.

The RHCT Grants Program was designed to give small hospitals the flexibility needed to
address their diverse problems. Thus, grantees designed their own projects, the purpose of which
was to improve hospital management or finances, and projects that involved consortia of small rural
hospitals were encouraged. Eligibility for the grant program was restricted to non Federal, not-for-
profit rural hospitals with fewer than 100 beds. Grants were awarded for as long as 3 years, with
maximum funding of $50,000 per year. Congress specified only two restrictions on the grant
expenditures: (1) grants could not be used to retire debt incurred for capital expenditures made
before the beginning of grant period, and (2) the maximum expenditure for capital items was one-
third of the grant amount.
WHAT HAS HAPPENED TO THE FINANCES OF SMALL RURAL HOSPITALS SINCE THE RHCT PROGRAM BEGAN?

In 1989, when Congress initiated the RHCT program, small rural hospitals faced difficult financial circumstances. What has happened since then? Has the outlook improved, or has the situation remained the same?

Small rural hospitals are being used more. Although inpatient care has continued to decline since the grant program was implemented, this decrease has been offset by a substantial increase in outpatient use (see Table 1). Occupancy rates have fallen slightly—from 37 percent to 32 percent. However, at all small community hospitals nationwide, outpatient visits skyrocketed 56 percent from 1992 to 1996, and outpatient emergency room visits rose 10 percent. As a result, outpatient revenue as a percentage of all patient revenue increased from 30 percent in 1990 to 46 percent in 1996.

Because of this increase in outpatient utilization, the short-term financial outlook of small rural hospitals improved substantially. In 1989, the median small rural hospital was losing money on operations; it had an operating margin of −0.04 percent. By 1996, however, this margin had increased to 3.2 percent (see Table 2). Furthermore, two measures of financial efficiency—the total asset turnover ratio and the number of days in net accounts receivable—also had improved. The total asset turnover ratio (which indicates how much revenue a hospital is generating relative to the amount of assets the hospital owns) increased slightly, from 0.99 in 1990 to 1.03 in 1996. During this period, the days in net accounts receivable (a measure of how long it takes a hospital to collect money owed) declined from slightly more than 76 days to 69 days. These improvements in the short-term financial indicators strongly suggest that as a group, small rural hospitals were in better financial shape in 1996 than they were in 1989.¹

¹Although some hospitals closed during the period, the number of closures was too small to explain this change in financial condition.
### TABLE 1

**TRENDS IN SMALL RURAL HOSPITAL UTILIZATION**

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Acute Care Occupancy Rate&lt;sup&gt;a&lt;/sup&gt; (Percent; median)</td>
<td>36.60</td>
<td>35.42</td>
<td>35.49</td>
<td>34.56</td>
<td>33.29</td>
<td>31.96</td>
<td>32.03</td>
</tr>
<tr>
<td>Average Number of Outpatient Visits&lt;sup&gt;b&lt;/sup&gt; (Average)</td>
<td>--</td>
<td>--</td>
<td>14,135</td>
<td>14,169</td>
<td>16,161</td>
<td>18,102</td>
<td>22,032</td>
</tr>
<tr>
<td>Average Number of Emergency Room Visits&lt;sup&gt;b&lt;/sup&gt; (Average)</td>
<td>--</td>
<td>--</td>
<td>5,942</td>
<td>5,746</td>
<td>5,618</td>
<td>6,002</td>
<td>6,532</td>
</tr>
<tr>
<td>Outpatient Revenue as a Percentage of All Patient Revenue&lt;sup&gt;a&lt;/sup&gt; (Median)</td>
<td>30.19</td>
<td>32.97</td>
<td>35.99</td>
<td>38.22</td>
<td>42.67</td>
<td>43.76</td>
<td>45.7</td>
</tr>
</tbody>
</table>


<sup>a</sup>Includes hospitals with 25 to 99 beds.

<sup>b</sup>Includes hospitals with 1 to 100 beds.
TABLE 2
TRENDS IN SHORT-TERM FINANCIAL INDICATORS OF SMALL RURAL HOSPITALS

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin (Median)</td>
<td>-0.04</td>
<td>0.87</td>
<td>1.54</td>
<td>2.36</td>
<td>2.67</td>
<td>2.81</td>
<td>3.27</td>
<td>3.20</td>
</tr>
<tr>
<td>Total Asset Turnover Ratio (Median)</td>
<td>--</td>
<td>0.99</td>
<td>1.03</td>
<td>1.06</td>
<td>1.07</td>
<td>1.04</td>
<td>1.05</td>
<td>1.03</td>
</tr>
<tr>
<td>Days in Net Accounts Receivable (Median)</td>
<td>--</td>
<td>76.16</td>
<td>75.84</td>
<td>72.58</td>
<td>70.23</td>
<td>70.36</td>
<td>68.95</td>
<td>68.54</td>
</tr>
</tbody>
</table>


NOTE: Operating Margin: Total operating revenues minus total operating expense, divided by total operating revenue.

Total Asset Turnover: Net patient revenue divided by total assets.

Days in Net Accounts Receivable: Net patient accounts receivable divided by net patient revenue times 365.
Examining long-term financial indicators reveals a different picture. The average age of plant (an accounting measure of the financial age of a hospital’s property, plant, and equipment) increased 7 percent between 1989 and 1996, suggesting that small rural hospitals were not investing in new capital equipment (see Table 3). Indeed, a decrease occurred in the ratio of long-term liabilities to total assets (a measure that indicates the degree to which long-term financing is used to fund a hospital’s assets), suggesting that small rural hospitals either did not attempt to obtain, or could not obtain, capital financing. At the same time, however, the average amount of dept per bed grew, indicating that these hospitals were increasing their debt relative to their size, either by borrowing from short-term sources or by decreasing the size of their inpatient operations without proportional retirement of debt.

The combination of improving utilization and short-term financial measures and deteriorating long-term measures suggests that small rural hospitals have made gains in addressing their financial problems but continue to face substantial financial difficulties. The typical rural hospital is not losing money by merely existing, as it was in 1989; however, it is struggling to keep its facilities up-to-date.

The improved financial status has led to a gradual decline in the rate of hospital closures. More than 10 percent of all rural hospitals closed during the 1980s. During the early 1990s, the rate remained high, with 5 percent of rural hospitals closing between 1990 and 1994. However, the annual number of closures declined during this period, dropping sharply in 1994 (see Figure 1). This change suggests that the total number of closures occurring during the 1990s is unlikely to reach the

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2 The average age of plant has decreased slightly since 1994, suggesting that the improving operating margins may be starting to have a favorable impact on long-term finances. However, the accumulation of reserves from the increased profitability has not yet overcome the depletion of the previous decade.
TABLE 3

TRENDS IN LONG-TERM FINANCIAL INDICATORS

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age of Plant</td>
<td>8.89</td>
<td>9.03</td>
<td>9.72</td>
<td>9.76</td>
<td>9.85</td>
<td>9.82</td>
<td>9.56</td>
<td>9.51</td>
</tr>
<tr>
<td>(Years; median)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of Long-Term</td>
<td>0.24</td>
<td>0.24</td>
<td>0.25</td>
<td>0.24</td>
<td>0.24</td>
<td>0.23</td>
<td>0.22</td>
<td>0.21</td>
</tr>
<tr>
<td>Liabilities to Total Assets (Median)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt per Bed, Total Facility (Dollars; median)</td>
<td>--</td>
<td>26,711</td>
<td>29,963</td>
<td>30,059</td>
<td>31,657</td>
<td>34,396</td>
<td>38,863</td>
<td>44,070</td>
</tr>
</tbody>
</table>


NOTE: Average Age of Plant: Total accumulated depreciation on all hospital plant, property, and equipment divided by current depreciation.

Long-Term Liabilities to Total Assets: Long-term liabilities divided by total assets.

Debt per Bed, Total Facility: Ratio of total liabilities to total number of beds in service.
same level it did during the 1980s. Although hospital closure might be a critical problem for the local community, the decrease in the number of closures has erased the issue from the national consciousness (DesHarnais et al. 1998).

DID THE RHCT GRANTS PROGRAM ACCOUNT FOR THESE IMPROVEMENTS?

The RHCT Grants Program made 1,224 awards between 1989 and 1996. A total of $149 million was appropriated for the program, and 932 small rural hospitals (approximately 48 percent of all eligible hospitals) received at least one award. Given that nearly half the rural hospitals received an average of $160,000 from the program, the question naturally arises: could the recovery of small rural hospitals be attributed to this program?

The evaluation of the RHCT program found the same results year after year: the finances of small rural hospitals improved during their grant period, but small hospitals that had not received grants improved just as much as did those with grants (Cheh and Wooldridge 1993; Wooldridge et
al. 1994; Cheh and Wooldridge 1995; Cheh et al. 1996; Bergeron et al. 1997; and Bergeron and Kabir 1998). The evaluation showed that some RHCT projects were successful and helped the grantees to become financially viable. All too often, however, the grant projects were poorly planned or poorly executed, resulting in no financial improvements or even additional financial strain.

The RHCT program was not an effective one that could account for the resurgence of the small rural hospital, nor was it a major factor in the improvement in the hospitals' finances. However, it did allow for data to be collected from many small institutions over time, so that the factors that might account for the resurgence in operating margins could be identified.

WHAT CAUSED THE FINANCES OF RURAL HOSPITALS TO IMPROVE?

Just as a convergence of forces led to the demise of rural hospitals, another set of forces has been responsible for their resurgence. The combination of favorable economic trends, beneficial Federal regulatory changes, and improved rural hospital management that communicates better and offers a broader scope of services has brought about the rebirth of the small rural hospital.

What Did Small Rural Hospitals Do to Improve Their Finances?

A key factor explaining the survival of small rural hospitals is their implementation of significant operational changes during the 1990s. In particular, small rural hospitals expanded their scope of services to meet local residential needs in ways that increased revenues for the institutions. They also changed their ways of doing business, by communicating more, adding visiting physician clinics, and employing more advanced practice nurses and physician assistants.

Small Rural Hospitals Added Services

One of the biggest changes that small rural hospitals made was to provide a number of different services, most importantly, outpatient services. Only 56 percent of rural hospitals had organized
outpatient departments in 1987 (Office of Technology Assessment 1990). By 1998, 91 percent of small rural hospitals reported that they offered outpatient services.³

Small rural hospitals added two types of outpatient institutions that improved outpatient revenue: (1) rural health clinics, and (2) home health agencies. The greatest growth was in rural health clinics. In 1989, the year the RHCT Grants Program was implemented, only 7 of the 1,615 small rural hospitals eligible for the program operated rural health clinics (see Figure 2). By 1997, 457 were doing so—an increase of more than 6,000 percent. Of these hospitals, 173 added more than one rural health clinic. One hospital operated 10 clinics.

FIGURE 2
GROWTH IN RURAL HEALTH CLINIC OWNERSHIP AMONG SMALL RURAL HOSPITALS

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>1,615</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>7</td>
</tr>
<tr>
<td>1990</td>
<td>19</td>
</tr>
<tr>
<td>1991</td>
<td>35</td>
</tr>
<tr>
<td>1992</td>
<td>70</td>
</tr>
<tr>
<td>1993</td>
<td>134</td>
</tr>
<tr>
<td>1994</td>
<td>231</td>
</tr>
<tr>
<td>1995</td>
<td>315</td>
</tr>
<tr>
<td>1996</td>
<td>408</td>
</tr>
<tr>
<td>1997</td>
<td>457</td>
</tr>
</tbody>
</table>

Note: 1,615 is the number of small, nonfederal, community hospitals operating between 1989 and 1997.

The financial advantages to small rural hospitals of operating rural health clinics primarily arise from Medicare and Medicaid reimbursement policies. Until the Balanced Budget Act of 1997 was passed, rural health clinics were reimbursed for their costs by both the Medicare and Medicaid programs, which resulted in payments that were, respectively, 115 and 62 percent more than was paid under prevailing reimbursement systems (Cheh and Thompson 1997).\textsuperscript{4} Despite this financial incentive, grantees found it difficult to start rural clinics during the early years of the RHCT program, primarily because of lack of physician support (physicians did not want to supervise advanced practice nurses and physicians assistants); difficulties recruiting physicians, advanced practice nurses, and physician assistants; and administrators’ difficulties understanding the regulations (Cheh and Wooldridge 1993). These barriers still exist; studies of later grantees found that physicians were very concerned about supervisory issues, such as physician liability and increasing physician burden (Bergeron et al. 1998). For many small rural hospitals, however, the benefits of operating rural health clinics outweigh the negative aspects, and the clinics are a key component of many small hospitals’ plans to remain financially stable.

To improve their financial stability, small rural hospitals also added home health agencies. In 1989, only 31 percent of these hospitals had established home health agencies, but, by 1997, 56 percent had done so (see Figure 3). However, in contrast to the number of rural health clinics opened, most small rural hospitals added only a single agency.

\textsuperscript{4}Medicaid estimates use data from California and Texas only.
FIGURE 3

GROWTH IN HOME HEALTH AGENCY OWNERSHIP AMONG SMALL RURAL HOSPITALS

Number of Hospitals
1,615

<table>
<thead>
<tr>
<th>Year</th>
<th>Had home health agency</th>
<th>Did not have home health agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>501</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>528</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>559</td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>627</td>
<td></td>
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<tr>
<td>1993</td>
<td>695</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>764</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>831</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>880</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>906</td>
<td></td>
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</tbody>
</table>


Note: 1,615 is the number of small, nonfederal, community hospitals operating between 1989 and 1997.

The financial benefits accruing from the home health agencies are due primarily to Medicare's cost-reimbursement method. Hospitals can shift a proportion of overhead costs to the home health agency, and those costs will be reimbursed up to a prescribed cost limit. The absence of significant controversy about opening them was another key benefit of the home health agencies. Many grantees who successfully opened home health programs described their programs as "a godsend" and "our pride and joy" (Wooldridge et al. 1994). Some hospitals failed to open their agencies because a longstanding provider already was servicing the community, and the potential loss in community relations was greater than any expected gain. With this exception, home health services were perceived as real attributes to the community, as well as a means of increasing hospital revenues.
Many small rural hospitals increased their diagnostic capacity during the 1990s, which helped both inpatient and outpatient revenues to grow. In each year of the grant evaluations, the RHCT grantees improved their diagnostic capacity, most measurably by offering computerized axial tomography and magnetic resonance imaging services (Cheh and Wooldridge 1993; Wooldridge et al. 1994; Cheh and Wooldridge 1995; Cheh et al. 1996; Bergeron et al. 1997; and Neuman and Bergeron 1998). Some of the improvement can be attributed to technological advances that allow this equipment to be used in mobile units, thus giving small hospitals access to the equipment part time, and at a fraction of the cost of non-mobile units. In addition, these services have allowed local hospitals to keep patients who otherwise would have gone to other institutions and have enhanced the hospitals’ images in their communities.

Long-term care was less popular than the other new services. Nevertheless, hospitals successfully added this service, which provided additional revenue. In 1987, 47 percent of eligible hospitals participated in the national swing-bed program (Office of Technology Assessment 1990). Since then, Public Law 100-203 has made it easier for all rural hospitals with fewer than 100 beds to participate. By 1997, 69 percent of the small community rural hospitals were participating.\superscript{5} A much smaller percentage chose to add a Medicare-certified skilled nursing facility. In 1989, 303 of the small rural hospitals had skilled nursing facilities; that number grew to 434 in 1997 (see Figure 4). These long-term care services helped small hospitals financially by allowing them to (1) generate revenue from unused beds at little marginal cost, and (2) use both staff and space more efficiently. In addition, skilled nursing facilities are cost-reimbursed by Medicare, allowing hospitals to shift a portion of their overhead cost to this program.

\superscript{5}Tabulations from the HCFA Online Survey Certification and Reporting System (1998).
Small Rural Hospitals Changed Their Ways of Doing Business

Many small rural hospitals aided in their own recovery by ceasing to do business as usual. For years, many of these hospitals had operated in a traditional manner, functioning independently and using only local physicians to provide care. During the years of the grant program, however, we observed three distinct changes. First, grantees were more likely to be part of a management organization, consortium, or hospital system. Second, grantees hired more advanced practice nurses and physician assistants to work at their facilities. Third, grantees established clinics for visiting specialists to provide care locally on a regular basis.

The growth in consortia and hospital systems suggests that small rural hospitals have increased their communications with each other in ways that may help to increase profits. It is unlikely that the consortium projects themselves are increasing profits; evaluations of the RHCT-funded and
Robert Wood Johnson-funded consortium projects consistently found that the projects themselves had minimal impacts on the bottom line (Cheh and Wooldridge 1993; Bergeron and Neuman 1988; and Moscovice et al. 1995). A few consortia do well and improve a hospital’s financial situation; however, many are ineffective. Indeed, evaluations of very early RHCT consortia found that many “fell apart and the participants simply ignored each other” (Cheh and Wooldridge 1993). Despite the fact that many consortia ultimately achieve little, grantees still continued to propose consortium projects. Many hospital administrators and staff believe they benefit from participation, even if the projects do not help financially (Bergeron and Neuman 1998). Perhaps the communication these projects fosters provides the real benefit.

Small rural hospitals now are much more receptive to the employment of advanced practice nurses and physician assistants than they were in the past. This change is due in part to the increased use of rural health clinics, as a clinic must employ one of these practitioners at least half time to receive enhanced reimbursement. In addition, hospitals nationwide have been increasing their employment of advanced practice nurses and physician assistants (Green 1995). However, continued physician opposition to the use of these practitioners makes it impossible for some hospitals to avail themselves of this option.

The employment of these health professionals has helped to improve the financial status of small rural hospitals in a number of ways. In addition to making the hospitals eligible to receive enhanced reimbursement through the rural health clinics program, these health professionals relieved overburdened physicians; increased the hospitals’ service volume; and lowered the cost of staffing clinics, emergency rooms, and other departments (Bergeron et al. 1998). More rural hospitals may

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6Certified Registered Nurse Anesthetists are the sole anesthesia providers in more than 70 percent of rural hospitals (American Academy of Nurse Anesthetists 1998).
be able to benefit from using these practitioners in the future; currently, a nationwide shortage has precluded their full use.

The final change we observed among the grantees was the use of visiting physician clinics in local hospitals. Small rural hospitals have used the services of visiting physicians (especially itinerant surgeons) for many years. More recently, increasing numbers of specialist physicians have been willing to travel to small rural hospitals and operate clinics. This increase is attributable to oversupplies of specialty physicians in urban areas, decreases in the use of specialists due to managed care, and the competition among urban hospitals to secure referral sources (forthcoming report by Mathematica Policy Research, Inc. [MPR]).

Visiting physician clinics help to improve hospital finances because some visiting specialists pay a fee directly to the hospital to use its facilities. This source of revenue is a new one for the institutions. In addition, the visiting physicians order ancillary tests or perform procedures at the local hospitals, generating laboratory, x-ray, and operating room revenues. Finally, many local hospital administrators report that visiting specialists enhance the local hospital’s reputation in the local community, resulting in greater community support for the institution.

**What Other Factors Contributed to the Improvement?**

Rural hospitals have worked hard to make the transition from empty, inpatient institutions to solvent, multiservice care facilities. However, the evidence strongly suggests that the financial gains are not solely the result of the hospitals’ efforts. Although almost all have added outpatient services, and 50 percent now provide home health services, the majority do not operate rural health clinics or skilled nursing facilities. Moreover, many of these hospitals do not employ advanced
practice nurses and physician assistants or do not have visiting specialists. These findings suggest that other forces are contributing to the improvements in financial stability.

**Rural Areas Revitalized During the Decade**

During the 1990s, rural areas gained residents and increased financial resources—conditions that were likely to improve the revenues and financial status of small rural hospitals. From 1990 to 1996, rural populations grew by 6 percent (see Table 4). This increase was just slightly less than the 7 percent increase in urban populations. In contrast, during the 1980s, the rural population grew just 3 percent, whereas the urban population grew 12 percent (Hamrick 1997). Rural population growth was robust, with more than three-fourths of rural counties experiencing population growth during 1990s. Despite an increase in the number of rural retirement areas, the rural elderly population increased at a slower rate than did the nonelderly population, resulting in a higher proportion of younger, working-age rural residents. This growth in population gave the rural hospital a larger local market from which to attract patients.

Accompanying this population increase was a growth in employment and income. Rural employment grew an average of 1.5 percent per year from 1990 to 1996, and average weekly earnings grew 1.8 percent (see Table 4). Between 1990 and 1995, personal income (a combination of earnings and other income sources) grew 4.3 percent (after adjusting for inflation). These changes in employment and income likely contributed to the small rural hospitals' recovery by increasing
<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1996</th>
<th>Percent Change</th>
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<tbody>
<tr>
<td>Population (in Thousands)</td>
<td>50,903</td>
<td>53,904</td>
<td>5.9</td>
</tr>
<tr>
<td>Average Weekly Earning (Constant Dollars)</td>
<td>413</td>
<td>420</td>
<td>1.8</td>
</tr>
<tr>
<td>Median Personal Income (Constant Dollars)</td>
<td>17,200</td>
<td>17,933(^a)</td>
<td>4.3</td>
</tr>
</tbody>
</table>

**SOURCE:** Hamrick (1997).

\(^a\)1995 figure.
both the demand for health care services in the community and the ability of residents to pay for the services.  

**Federal Government Increased Resources**

During this decade, the Federal government implemented new programs and regulations that offered rural hospitals better financial opportunities. One major group of initiatives focused on Medicare program payment policies. Because Medicare is a major revenue source for small rural hospitals, improving Medicare payments increases the revenues and operating margins of these institutions. The other major Federal initiatives focused primarily on reducing the other problems that rural hospitals face, such as shortages in the number of health care providers.  

**Medicare Reimbursements Were Enhanced.** A number of Medicare reimbursement changes affected the small hospitals’ ability to improve their finances. The most encompassing change was initiated on October 1, 1994, when Medicare first paid the same standard diagnosis related group (DRG) amount for rural hospitals that it paid for urban areas. This change in the regulation, which affected all small hospitals, provided more revenue for each hospital proportionate to its number of Medicare-reimbursed admissions. Another change that enhanced Medicare hospital reimbursement for some rural hospitals was the development of a special payment status for Medicare Dependent hospitals. For cost-reporting periods beginning on or after April 1, 1990, and

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7Although employment and income in rural areas rose during this period, the percentage living below the poverty level also increased. Thus, not all residents were enjoying the benefits of increased economic activity, thereby possibly increasing the financial pressure on small rural hospitals that defined their missions as that of providing care for their communities. To the extent that the Medicaid program helped to pay for the health care needs of these residents, the hospitals felt less financial strain.

8A number of state initiatives also have contributed to the financial solvency of small rural hospitals. However, they are beyond the scope of this report.
ending before October 1, 1994, and beginning on or after October 1, 1997, and ending before October 1, 2001, the Medicare program designated hospitals as Medicare Dependent hospitals if they (1) were located in rural areas, (2) had fewer than 100 beds, and (3) had at least 60 percent of the hospital’s inpatient days or discharges attributable to individuals receiving Medicare Part A. Hospitals that meet these criteria receive either the regular DRG payment rate or a hospital-specific payment rate, whichever is greater.

Status as a sole community hospital also enhances a hospital’s Medicare revenue. As with Medicare Dependent hospitals, sole community hospitals are paid the greater amount of either the regular DRG rate or a hospital-specific rate. In addition, they may qualify to receive a payment adjustment to take into account a significant decrease in admissions or a significant increase in operating costs, if these changes result from circumstances beyond their control. Although sole community hospital status was available throughout the 1980s, the law was modified several times to allow more facilities to qualify. In 1989, for example, a modification reduced the minimum distance separating a sole community hospital from another hospital, from 50 to 35 miles (Public Law 101-239). As a result of this and other legislative changes, the number of hospitals paid as sole community providers increased from 375 in 1990 to 678 in 1998 (Office of Technology Assessment 1990; and personal communication from S. Mazumdar, Health Care Financing Administration, October 21, 1998).

HCFA introduced two limited-service hospital programs during the 1990s that allowed some of the weakest hospitals to convert to a different type of health care institution. These limited-service hospitals were exempt from key requirements of the Medicare conditions of participation and were offered enhanced reimbursement; in turn, they were required to limit the type of care they provided. The first program, the Medical Assistance Facility (MAF) program, operates solely in
Montana. Under the program, 12 MAFs, most of which were conversions from financially
distressed, small hospitals, have opened (Wright et al. 1995). The second program, the Essential
Access Community Hospital/Rural Primary Care Hospital Program, was implemented in seven
states. As of August 1997, 38 small rural hospitals converted to rural primary care hospitals (U.S.
General Accounting Office 1998). Most of these 38 institutions had been financially distressed
hospitals before their conversions (Wright et al. 1995).

Physicians Available for Underserved Areas Increased. One problem that continuously has
plagued small rural hospitals is the undersupply of physicians. Physicians are a hospital’s lifeblood—
without physicians, there are no patients; without patients, there are no revenues. Two trends have
served to increase the supply of health care practitioners in underserved rural areas: (1) an increase
in the number of National Health Service Corps providers, and (2) an increase in visa waivers
provided to foreign physicians to practice in this country. These trends have increased substantially
the supply of physicians willing to work in small rural hospitals.

The National Health Service Corps places health care professionals in underserved areas,
primarily by providing funding to pay for professional education in return for years of service.
During the early 1980s, Congress cut the number of scholarships in the program (from 1,700 in 1980
to 162 in 1981) in response to a prediction that, starting in the late 1980s, the health provider
shortage would be alleviated by an oversupply of physicians (Martinez, internal MPR report). In
1990, Congress revitalized the program when it became apparent that the shortage had persisted
(Public Law 101-597). Funding from the program grew from $47 million in 1989 to $90 million in
1990, and this increase translated into growth in the number of providers to be placed in underserved
areas, from 1,000 in 1990 to 2,200 in 1998 (National Health Service Corps 1998).
The second trend that has increased the supply of physicians to underserved areas is the rise in the number of waivers for physicians with J-1 visas. A foreign physician who enters the country to seek further graduate medical education under an exchange program typically is given a J-1 visa, which requires the physician to leave the country after training has been completed. However, this requirement can be waived at the request of a Federal agency or state, which requires that the physician practice for a specified period of time in an underserved area. In 1990, only 70 waivers were given to physicians under these circumstances; this number grew to 1,374 in 1995 (U.S. General Accounting Office 1996).

The net result of these two trends has been a substantial increase in physician supply in underserved areas. In 1988, an estimated 3,875 additional physicians were needed to remove the nation’s health shortage area designations (Office of Technology Assessment 1990). The increase of 1,200 National Health Service Corps providers and 1,300 physicians with J-1 visa waivers suggests that 2,500—or 64 percent—of these physicians have been added. Little progress toward this goal had occurred during the 1980s (Office of Technology Assessment 1990). Thus, these trends have made the physician recruitment situation for small rural hospitals stronger than it had been in many years.

Other New Programs Provide Additional Resources. During the 1990s, other Federal agencies have added to the stream of financial resources directed to rural health care delivery systems. For example, the Office of Rural Health operates the Rural Health Outreach Grant program, the goal of which is "...to expand access to, coordinate, restrain the cost of, and improve

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9The 1988 estimates are for physicians only; the National Health Service Corps figures reflect the number of physicians, advanced practice nurses, physician assistants, and dentists. However, the majority of the National Health Service Corps providers are physicians.
the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions” (Public Health Service Act, Section 330A). To date, close to $150 million dollars has been allocated under this program. In addition, in 1996, Congress authorized funding for the Rural Network Development grants, which have the same purpose as the Rural Health Outreach Grants, but which fund different types of projects. The Office of Rural Health also provided rural telemedicine grants during the early 1990s, which continue to be funded through the Rural Outreach/Rural Network development programs. Although these programs were not directed specifically at small rural hospitals, a number of these institutions have benefitted from the grants.

WHAT IS THE FUTURE FOR SMALL RURAL HOSPITALS?

Small rural hospitals are experiencing much better circumstances than they were a decade ago. The combination of changes in the services they offer, improvements in local economic and demographic trends, and increases in Federal resources has stabilized this type of hospital. Nevertheless, they are financially vulnerable and have yet to rebuild their resources to the levels of their urban counterparts.

Remaining financially stable will be difficult. Small rural hospitals are being paid the same DRG rate as are urban hospitals; however, in the Balanced Budget Agreement of 1997, Congress elected to increase DRG payments at a rate less than the rate of inflation, and to maintain reductions made earlier in hospital capital payments. These reductions apply to all hospitals, making it more difficult for them to maintain positive operating margins.

Small rural hospitals face a greater challenge--maintaining the financial solvency of their new services. The Balanced Budget Act of 1997 mandates that HCFA implement prospective payment systems for outpatient, home health, and skilled nursing services--the very services that rural
hospitals added to improve their finances. Prospective payment is a challenge for these small facilities to manage because their low volume makes it difficult to control service use. Results from the Evaluation of the National Home Health Prospective Payment Demonstration found that small home health agencies failed to reduce costs per episode because their small size made it difficult to reduce their visits and, at the same time, caused their cost per visit to increase by more than the corresponding increase in large agencies (Cheh and Trenholm 1998). Operating these new services profitably without the benefits of cost reimbursement may prove to be too difficult for many administrators of small hospitals.

The Balanced Budget Act of 1997 also changed payment regulations for rural health clinics. Rural hospitals with more than 50 beds no longer receive unlimited Medicare cost reimbursement for rural health clinic visits—a change that probably will have little impact on clinic revenues (Cheh and Thompson 1997). However, the act also ends the mandate for cost-based reimbursement for Medicaid patients, which could seriously cut rural health clinic revenues. Whether small hospitals will be able to operate rural clinics profitably without cost-based reimbursement from Medicaid remains to be seen.

Other potential problems loom for small rural hospitals. To date, most rural hospitals have avoided the impacts of managed care, primarily because managed care in rural areas had very low enrollments (Moseovice et al. 1997). However, recent increases in capitated Medicaid managed care in rural areas, combined with the potential for low negotiated payment rates, raises the specter of real future challenges (Slifkin et al. forthcoming). Although the RHCT grantees have made some efforts to prepare for managed care, in particular, to create provider-hospital organizations, the way in which anti-trust laws will be applied in rural areas is a potential problem. If anti-trust regulations
are applied stringently, then rural hospitals will have difficulty forming the types of organizations that can help them to negotiate with managed care organizations in the future.

The financial future is not all grim. Congress continues to support two rural health care initiatives. First, with the implementation of the Critical Access Hospital Program, the limited service hospital concept that HCFA introduced during the 1990s has been expanded to all 50 states, enabling more small hospitals to convert to this new type of institution, and to receive enhanced reimbursement. Second, telemedicine initiatives in rural areas have received increased support. The Federal Communication Commission has designated the Rural Health Care Corporation to provide as much as $400 million annually to rural health providers so that they will pay no more for telecommunication services than do urban providers. In addition, Congress mandated in the Balanced Budget Act of 1997 that HCFA pay for professional consultations via telecommunications for Medicare beneficiaries residing in health professional shortage areas.

Nevertheless, these initiatives will not keep small rural hospitals solvent. Only some small hospitals can appropriately convert to a Critical Access Hospital. Moreover, telemedicine services are not a major source of hospital revenues.

In 1989, Congress provided RHCT grants to help small rural hospitals make the transition to outpatient institutions. Many small rural hospitals have done so, some with the help of the grants. Now, Congress is reducing Medicare reimbursement for the very same services that, only a decade earlier, it had encouraged hospitals to expand to improve their viability. History teaches us that these reimbursement changes will make it very difficult for small rural hospitals to remain financially viable. If these hospitals perform as poorly in the 21st century as they did during the 1980s, Congress may have to start another program to support them. But if the gains made during the last decade persist—most notably, the increase in physician supply and improvement in rural economic conditions—then the small rural hospital has the potential to remain a viable health care provider.
REFERENCES


