Rural Healthcare in Transition

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The American Hospital Association's ("AHA") Section for Small or Rural Hospitals includes membership criteria such as: having 100 or fewer beds, 4,000 or fewer admissions, or being located outside a metropolitan statistical area. In these regions, rural healthcare providers total about 2,000 and serve about 51 million people, as counted by the AHA. Note that there are in total about 5,600 hospitals in the U.S., including rural providers. Under the rural healthcare banner, hospitals are often categorized as (a) critical access hospitals with 25 beds or less and (b) "tweener" hospitals having more than 25 but 100 or less beds.

Critical access hospitals benefit from an exemption to the inpatient and outpatient prospective payments system, and enjoy a cost-plus arrangement under Medicare. The "tweener" category includes hospitals that are often too small to gain enough scale to operate effectively with current government and commercial reimbursement schemes but too big to be exempt from the inpatient and outpatient prospective payments system.

Today, however, the looming mandates of healthcare reform have all of rural healthcare being targeted for cost reductions. No one would likely doubt the need to preserve access to healthcare in less populated areas, some of which support, in a reciprocal fashion, important domestic industries; an example being the American farming industry. Recent reporting by the Kansas-based National Rural Health Association, however, shows that 48 rural hospitals have closed since 2010, and almost 300 are in trouble. The challenges are plenty, including (i) declining federal reimbursements, where it was assumed that States would expand Medicaid and more indigent and uninsured coverage would be expanded, but it is well known that 23 States did not expanded Medicaid, (ii) sequestration caused across-the-board federal cuts resulting in a 2% reduction in Medicare reimbursement since 2013, (iii) disproportionate share or "DHS" payments to rural healthcare providers were cut with the assumption that more people would have coverage under the ACA, but instead high deductibles have emerged as a growing trend and often times require upfront payments of the first $2,500 to $5,000 causing a reduction of volumes, (iv) swing-bed reimbursement is expected to move to the same rate paid to skilled nursing facilities and (v) certain critical access hospitals are losing their status as a result of ongoing CMS review of critical access qualifications.

And the challenges do not stop there. Here comes population health and value-based arrangements. Rural healthcare providers are used to managing on a tight budget, so why not join a value-based care arrangement? The benefit is to share in risk-arrangements that could be profitable, but the challenge often times is that volume, and thus the financial upside, under these arrangements is too low in relation to the cost and maintenance of such programs in the rural setting. As a result, substantial upside may not materialize. Additionally, there will be more and more competition for the premium dollar, which, although expected to grow year-over-year, is expected to grow less quickly.

It is a safe bet that rural healthcare coverage will not go away, but how it is governed, managed and delivered is likely headed for substantial change.

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