No signs of relief: Rural providers on edge over ACA’s uncertain future

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- By Steven Ross Johnson

Roger Knak has made some especially tough decisions in the past few years.

Knak, CEO of Fairview (Okla.) Regional Medical Center in the northwest part of the state, had to lay off one of the center’s three staff physicians. The rest of the employees haven’t gotten a raise in three years.

But the past month has been especially hard. As Senate GOP lawmakers worked toward passing a bill to replace the Affordable Care Act that would have severely cut back Medicaid and tax subsidies to purchase individual health insurance plans, Fairview’s leadership had been preparing for what they feared to be the inevitable—a loss of revenue from cuts to federal healthcare programs.

Consequently, Fairview Regional had started slashing its non-essential services, which could put its Medicare eligibility at risk.

Fairview, a 25-bed critical-access hospital that serves a patient population of roughly 9,000, is just one of the many rural hospitals in Oklahoma and across the country that has been operating on slim margins for some time.

“I don’t know what the next cut would be without taking a drastic action to revisit us as being licensed as a medical-surgical hospital and changing our licensing to some other form,” Knak said.

The latest Republican effort to replace the ACA failed to garner enough vote to pass the Senate, leaving Medicaid programs as they are, for now.

But rural healthcare providers such as Fairview remain concerned that the partisan wrangling over the healthcare law’s future will just perpetuate the inertia over addressing the financial problems most rural hospitals now face.

“It seems to be the same uncertainty without any clear direction,” Knak said.

Republican lawmakers are continuing their effort to get a majority of senators to vote “yes” on the Better Care Reconciliation Act, but remained four votes shy as of deadline. The Senate’s GOP-backed bill would stop Medicaid expansion and cut $700 billion from the program by 2026.
President Donald Trump on July 19 met with GOP senators to try and persuade them to pass the bill, but with seemingly little effect. Sen. Majority Leader Mitch McConnell (R-Ky.) has called for a vote on a repeal-only measure that the Congressional Budget Office estimated would lead to 32 million losing health coverage by 2026.

Medicaid covers nearly one-quarter of non-elderly adults, including 52 million Americans in rural areas.

Thousands of previously uninsured Americans re-

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ceived coverage thanks to the ACA’s Medicaid expansion, which increased eligibility to cover adults earning up to 138% of the federal poverty level in those states that chose to do so. Medicaid expansion was a real boon for rural hospitals in expansion states since rural residents are more likely to be uninsured.

But the ACA’s treatment of Medicaid ended up hurting hospitals in non-expansion states. To help pay for the expansion, policymakers settled on Medicare reimbursement cuts as the primary source, said Andy Fosmire, vice president of rural health for the Oklahoma Hospital Association. Oklahoma never expanded Medicaid after

the Supreme Court in 2012 ruled the ACA couldn’t require states to do so, yet hospitals there are still caring for uninsured patients while facing related hits to Medicare reimbursement.

Bad-debt burden

In addition, since 2013 many hospitals have seen Medicare reduce the share of beneficiaries’ unpaid debt it covers for out-of-pocket costs; the rate dropped from 70% to 65%. But the cut was much deeper for critical-access hospitals, which went from having 100% of that debt covered down to 65% .

“Though we strongly, strongly supported the objectives of the ACA to get people insured, unfortunately where some of the ACA has failed has been in rural areas,” said Maggie Elehwany, vice president of government affairs and policy for the National Rural Health Association.

Ironically, some of the financial problems rural providers have incurred in recent years are a byproduct of having more insured patients since the ACA was passed, with many buying insurance plans through a healthcare marketplace. Many of those patients who visit rural hospitals have low-premium, high-deductible plans. Rural hospitals that receive patients through their emergency department often hold them long enough to stabilize them before transporting them to a larger facility, but are stuck with the cost of the deductible if a patient can’t cover it.
“A patient’s insurance finally kicks in once they are at a larger facility, because they already met their deductible with the rural hospital,” Elehwany said.

Such scenarios have led to a 50% increase in the bad debt rural hospitals have taken on since implementation of the ACA, according to the NRHA.

In Oklahoma, where four rural hospitals have closed since 2010, 53 of the 65 facilities in rural areas operate with a negative margin every month, Fosmire said. Thirty-seven operate with less than 14 days of operating cash on hand.

Nationally, 41% of rural hospitals are operating at a loss, according to a 2016 study by the Chartis Center for Rural Health. Since 2010, more than 80 rural hospitals have closed; the majority were in the 19 states that did not expand Medicaid. Another 670 rural providers are at risk of closing, mostly in non-expansion states that Trump won in last year’s presidential election.

Medicare cuts

Other federal programs were reduced by the ACA as a result of the expected increase in Medicaid coverage, with Medicare disproportionate-share hospital payments being reduced by more than $1.25 billion in 2015 and by another $1.2 billion last year.

“I’ve been laying off employees over the last 12 months,” said David Keith, CEO of McAlester (Okla.) Regional Medical Center, a 171-bed rural hospital. McAlester serves a population of about 200,000 in the southeastern part of the state. For some time now, Keith hasn’t been replacing staffers who quit or were fired. Keith estimated he was on pace to lose 50 of his staffers and see a 30% decline in total revenue if the GOP plan were to pass.

A recent Commonwealth Fund study projected the Better Care Reconciliation Act could lead to 919,000 fewer healthcare jobs by the year 2026. That could hit rural communities with a double whammy: fewer jobs and the loss of essential services.

McAlester is the only local provider with urology and interventional cardiology lines, and it receives referrals from many smaller, critical-access hospitals. Still, Keith is contemplating cutting those lines to make sure it can still provide primary and emergency care.

“If we don’t have those tertiary services, those hospitals are going to have to send their patients 3½ hours away to the big urban centers for their specialty services,” Keith said.

Rural hospitals also may feel the squeeze from proposed changes to the federal 340B drug discount program, which could cut another lifeline for some hospitals (See related story, p. 10).

The ACA allowed more rural and critical-access hospitals to save about $10,000 a month in drug costs as prescription drug spending skyrocketed, according to a 2015 Marshall University study.
But the outlook is not good for the 340B program. Critics say it’s mismanaged and prone to fraud and waste. The CMS this month proposed cutting hospital payments for 340B to 22.5% less than the average sales price for drugs instead of the current rate 6% above the average sales price.

Though HHS Secretary Dr. Tom Price said the move was part of Trump’s promise to address rising drug prices, the change might not influence drug companies to drop their prices. Instead, it would just hit hospital budgets, said Brad Gibbens, deputy director of the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences.

Marginal risk

While only 20% of the population lives in rural areas, rural residents make up more than half of the population of areas that lack basic medical care, according to the U.S. Health Resources and Services Administration. Rural areas make up 58% of all dental-care shortage areas and 53% of all mental health shortage areas across the country.

Gibbens estimated that 54% of North Dakota rural hospitals now have positive financial margins since the state’s Medicaid expansion compared with 46% of providers that still have negative balances. He said providers most at risk of closing were those in counties with populations of just a few thousand residents where the only other healthcare provider is hours away.

For providers such as Fairview and McAlester, continuing the current system is unsustainable.

“We have such short cash reserves on hand that all it’s going to take is one hiccup with reimbursement and we could be (tapping) into an operating line of credit, which is usually the first step toward bankruptcy,” Fairview’s Knak said.

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