Oregon’s Rural Landscape

Oregon’s 32 small and rural hospitals provide essential health care services to more than one million Oregonians. These hospitals are the cornerstones within the communities they serve. For most communities, they are the largest employer, offering family-wage jobs.

What is the Critical Access Hospital Program? (Medicare Reimbursement)

Twenty-five of Oregon’s 32 rural hospitals are Critical Access Hospitals (CAH), which is a federal program designed to improve rural health care access and reduce hospital closures. For its Medicare patients, CAHs receive cost-based reimbursement. As the name implies, cost-based reimbursement pays hospitals to cover the maximum allowable cost assumed by the hospital.

Oregon’s rural hospitals have long depended on cost-based reimbursement from Medicaid and Medicare to remain viable. Prior to the CAH program and cost-based reimbursement, several rural hospitals around the country shut their doors as a result of poor reimbursement levels.

What are A & B Designations? (Medicaid Reimbursement)

Oregon’s rural hospitals also have a state designation based on their size and location. Similar to Medicare for CAHs, the state designation of Type A or B provides Medicaid reimbursement up to 100% of cost.

These rural designations significantly improve the bottom line for many fragile community hospitals. Many rural hospitals lack the operating margins needed to access capital funding to replace or update facilities and purchase necessary health information technology or upgrades. Along with tackling financial challenges, small and rural hospitals must sustain a highly trained work force, including medical providers. Even with strong recruitment efforts, rural hospitals have difficulty attracting and retaining skilled workers. Rural hospitals provide a higher volume of Medicare and Medicaid services, and Oregon physician reimbursement rates rank at the bottom quartile nationally for those beneficiaries.

Oregon’s Small and Rural Hospitals

- Asante Ashland Community Hospital, Ashland (Type B)
- Blue Mountain Hospital, John Day (Type A)*
- Columbia Memorial Hospital (Type B) *
- Coquille Valley Hospital, Coquille (Type B)*
- Curry General Hospital, Gold Beach (Type A)*
- Good Shepherd Medical Center, Hermiston (Type A)*
- Grande Ronde Hospital, La Grande (Type A)*
- Harney District Hospital, Burns (Type A)*
- Lake District Hospital, Lakeview (Type A)*
- Lower Umpqua Hospital, Reedsport (Type B)*
- Mid-Columbia Medical Center, The Dalles (Type B)
- PeaceHealth Cottage Grove Community Health, Cottage Grove (Type B)*
- PeaceHealth Peace Harbor Medical Center, Florence (Type B)*
- Pioneer Memorial Hospital, Heppner (Type A)*
- Pioneer Memorial Hospital, Prineville (Type B)*
- Providence Hood River Memorial Hospital, Hood River (Type B)*
- Providence Newberg Medical Center, Newberg (Type B)
- Providence Seaside Hospital, Seaside, (Type B)*
- Saint Alphonsus Medical Center, Baker City (Type A)*
- Saint Alphonsus Medical Center, Ontario (Type A)
- Samaritan Lebanon Community Hospital, Lebanon (Type B)*
- Samaritan North Lincoln Hospital, Lincoln City (Type B)*
- Samaritan Pacific Communities Hospital, Newport (Type B)*
- Santiam Memorial Hospital, Stayton (Type B)
- Silverton Health, Silverton (Type B)
- Southern Coos Hospital and Health System, Bandon (Type B)*
- St. Anthony Hospital, Pendelton (Type A)*
- St. Charles Madras, Madras (Type B)*
- St. Charles Medical Center, Redmond (Type B)
- Tillamook Regional Medical Center, Tillamook (Type A)*
- Wallowa Memorial Hospital, Enterprise (Type A)*
- West Valley Hospital, Dallas (Type B)*

*Also a Critical Access Hospital
What is the Rural Health Reform Initiative?

The RHRI was formed to help answer the question: How can the state’s small and rural hospitals move from cost-based reimbursement and meet the Triple Aim goals of better care, better health, and lower cost while maintaining the highest levels of quality care?

Oregon’s small and rural hospitals are experiencing unprecedented changes in health care delivery and reimbursement, as the Affordable Care Act and Coordinated Care Organizations overhaul the health care system. With Patient-Centered Medical Homes and a shift to new payment systems, Oregon’s small and rural hospitals have had to rethink their health care delivery and reimbursement structures.

The guiding principles of RHRI are:

- Put patients and communities first.
- Work to achieve Triple Aim goals.
- Develop flexible payment models that keep access to health care local.
- Use the best and most current data available to make informed decisions.

Rural hospitals often have more obstacles to overcome than their urban counterparts. These include fewer patient volumes and a lack of a balanced source of payer types. This generates insufficient revenue to pay for operating expenses and poses a tremendous challenge.

Part of RHRI’s work includes looking at different reimbursement models for Oregon’s rural hospitals. During the last two years, RHRI’s focus has been to provide Oregon’s rural hospitals with the information and tools they will need to meet the challenges of a changing health care system, namely to identify payment models that are viable and share risk (in response to House Bill 3650, Oregon’s Health Transformation Bill).

RHRI is currently working with the state to develop options for alternative payment models for hospitals that must move off of cost-based reimbursement; and develop a framework to determine financial risk for those hospitals that do move off of cost-based reimbursement by July 2014.

The next phase of RHRI will include delivery reform. This work will focus on meeting the goals of the Triple Aim and partnering with communities on making rural Oregon a healthier place to live. Hospitals must change how they deliver services to communities by partnering with physicians and other health-related entities. Moving forward, RHRI will continue to develop resources to help small and rural hospitals meet the diverse and ever-changing needs of their communities.

Learn More

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Rethinking Health Care Delivery in Oregon
As the brilliant health economist Yogi Berra pointed out, “the future ain’t what it used to be.” Clearly, rural hospitals are busy trying to sort out how to best respond to health care reform. “You’ve got to be very careful if you don’t know where you are going,” Yogi admonished, “because you might not get there.”
To understand how delivery systems will be transformed, hospitals should focus their attention on changes in the way health care will be financed: form follows financing. The way we deliver care in the future will be predicated on the way we pay for health care in the future. Yogi further advised, “You can observe a lot just by watching.”

To confirm axiom that form follows financing, look at the financing and structural features of our current health care delivery system. The incentives of fee-for-service medicine push providers to perform higher service volumes and create payment silos that fragment care delivery. Policymakers are working to devise payment systems that will emphasize quality, not quantity, and will reward providers for keeping people well, not just for treating them when they are sick. These alternative payment systems vary—“bundled” payments for hospitals and physicians, flat monthly fees for managing care, pre-set “episode-of-care” payments—but all involve risks for hospitals. Those that manage care efficiently can prosper, but those that don’t will be threatened.

Rural hospitals and other rural providers are already moving in the direction of more coordinated care and more financial risk, and there are a number of steps they can take now to prepare for the future. However, given the vital role that rural hospitals play in their community (in terms of the access and economic support they provide) and given the unique challenges they face now and in the future, it’s important to proceed cautiously. Rural facilities need time to adapt to new payment structures that will ultimately transform the way they deliver health care.

Providing value despite challenges

Despite the myriad payment schemes they face and the transformations taking place around them, rural hospitals are still in the best position to accomplish the goals of the Centers for Medicare & Medicaid Services (CMS) “Triple Aim” of better quality at lower cost and improved health status for communities. As the hub of health care delivery for most rural communities, rural hospitals can bring tremendous value to the health care system, because they can provide the right care at the right time locally.

They serve as an anchor for their region’s health-related services, providing the structural and financial backbone for physician groups, health clinics and long term-care services. In addition, these hospitals also provide essential related social services.

The economic literature also shows that rural hospitals provide a large economic contribution to the local economy, often accounting for the largest portion of an area’s gross product.

Yet in spite of, or perhaps because of, this unique role they play, rural hospitals are still saddled with many challenges:

- Rural residents are older, have lower incomes, are more apt to be uninsured, and are more likely to suffer from chronic diseases.
- The growing shortage of health workers may have a greater impact on rural facilities.
- Access issues, such as longer travel distances and lack of reliable transportation, can delay treatment, aggravating health problems and leading to more expensive care.
- Rural hospitals are smaller but must still maintain a broad range of basic services.
- Costs per case tend to be higher, because fixed expenses are spread over fewer patients. This makes these facilities far more vulnerable to reduced volumes.
- The shift from inpatient to outpatient care is more pronounced in rural hospitals, and rural hospitals are more likely to offer home health, skilled nursing and assisted living services.
- More than sixty percent of gross revenue in rural hospitals comes from Medicare and Medicaid, which generally pay on a cost basis, but at levels insufficient to cover uncompensated care, recruitment costs, or the cost of new technologies—including health information technology—which is vital to manage in the new payment world.

Rethinking payment systems

National health reforms will, of course, bring further challenges but also some opportunities for rural hospitals. On the positive side, the expansion of coverage will improve access and reduce the uncompensated care rural hospitals must absorb. The federal health reform law has also spawned some Medicare payment enhancements and incentives to help curb the shortage of rural health care workers. Yet these positives are tinged with the age-old tendency by policymakers to simply cut payment levels or make abrupt changes to longstanding and stabilizing payment methodologies, like cost-based reimbursement (CBR).

Cost-based payment systems are increasingly out of favor with legislators and policymakers because they believe CBR has contributed to inefficiency and excess payments. However, abrupt elimination of CBR threatens to repeat the errors of the 1980s, when the wholesale replacement continues →
of traditional reimbursement methods by the Medicare Prospective Payment System (PPS) resulted in the closure of more than 10 percent of rural hospitals over a three-year period. The economics of it are pretty simple. These facilities, with their high proportions of fixed costs, simply couldn’t handle the additional risk imposed on them by a prospective system.

Let’s hope this is not “déjà vu all over again,” where access to needed health care services is critically impaired by expedient cuts or abrupt changes in payment policy. Rural hospitals need time to adjust, and policymakers need to take care in how they craft new payment systems.

Yet, we can hope that Congress, state legislators and key policymakers have learned from the past and will avoid “making too many wrong mistakes.” Yogi knew that we all made mistakes, but it is the wrong ones, like abruptly terminating CBR for the smallest and most vulnerable providers in our health system that can have highly negative implications for access.

Value-driven health

If payment reform to change incentives is inevitable, there are both internal steps and organizational steps that should be considered.

First, it is important that rural hospitals take steps to generate and control their own performance data. The return on investment from electronic health records (EHRs) and sophisticated data analytics will come from identifying best practices, driving out unnecessary variation, improving the care experience for patients, and reducing cost.

Second, they should measure and report performance around the metrics of clinical quality, patient experience, and cost internally and to payers. We attend to what we can measure. Attention is the currency of leadership. If leaders want something to get done (like improved clinical care), they attend to it.

Third, they can educate their boards, providers and staff regarding performance. Since we are not all above average, identifying gaps in performance from the norm (or better yet, from the best) can drive improvement.

Fourth, they should consider self-pay and hospital employees (if the organization is self-insured) first for case management activities. The hospital will benefit directly if case management is able to direct patients to low-cost services with equal (or better) quality.

Fifth, they should aggressively apply for value-based demonstrations and grants, which allow rural hospitals...
to test the waters. Discuss opportunities regularly with the hospital association, rural health association, hospital networks, etc.

Sixth, they can negotiate with third-party insurers to pay for quality. Many payers offer financial incentives for quality care. However, payers often direct these incentives to primary care providers with the assumption that better outpatient primary care will decrease hospital utilization.

Seventh, hospital management should seek to transition their organizational structure from hospital-centric to patient/community-centric. Strategic planning questions should ask how to collaboratively deliver continuously improving quality and patient experiences, while reducing costs to the system, rather than ask what is best for the inpatient hospital.

Organizational steps
As new payment methods position hospitals to assume financial risk, hospitals need to develop management structures to manage that risk. Larger rural providers, capable of assuming some additional financial risk, should exploit this capability. Smaller rural hospitals should position themselves by collaborating to share services and organizing themselves into larger, regional risk-bearing entities. However, many factors should be considered before moving in that direction.

Again, there are a number of key steps that should be taken.

First, accelerate collaborations with direct employment of physicians. Physician employment arrangements offer opportunities to restructure physician incentives to be in concert with the new emphasis on improved clinical management. In the new world of payment reform, the traditional division between hospitals and physicians is a false dichotomy.

Second, rural hospitals should manage care beyond the hospital. This is essential for coordinating care and for identifying opportunities to improve quality and reduce cost (such as reduced readmissions). Payments will shift from inpatient hospital care to outpatient primary care. Hospital leadership that limits its scope of influence to inpatient care will not succeed in a value-driven health care system.

Third, having positioned themselves to accept some risk, rural hospitals and other providers must carefully identify the services they wish to go at risk for. At-risk arrangements should include all service categories for which there is a potential to make improvements in efficiency. For example, if a hospital can reduce utilization of emergency services while improving the quality of patient care, then all emergency services should be included within the capitation arrangement so that hospitals can benefit from the cost savings.

Generally, there are four service categories that should be considered for inclusion: inpatient services, outpatient services, primary care services and specialty physician services. There are a number of principles that should be adhered to when determining what services should be included in payment arrangements—such as the interchangeability and substitutability of services and the need for patient follow-up. These principles can help hospitals draw some additional conclusions for what they can and should go at risk for.

Fourth, consideration should be given to the methods used for structuring payment to participating providers. Experience tells us that internal gain-sharing arrangements work best if they are centered on primary care and oriented around the establishment of budgets that cover services to be included in the hospital’s payment arrangement.

Fifth, it is important that a hospital make payment arrangements of this nature apply to as many payers as possible. Multi-payer at-risk arrangements avoid the bifurcation of incentives that rural providers now face given their schizophrenic modes of payment from public and private payers.

Sixth, rural hospitals should develop global budget arrangements where all payers essentially set a figure for all of the expenditures seen as being appropriate in this type of high-performance system.

If current and future health care reforms deliver on broader health care coverage for rural people and if rural hospitals are given enough time and support to adapt to inevitable changes in reimbursement, then rural health care systems would be strengthened. This would improve the economic condition of rural communities and the quality of life for rural residents. However, if we proceed too rapidly, as we did in the 1980s with abrupt changes, disruptions in access and care delivery may result. There are no perfect solutions, but we should learn from past mistakes and assist creative and informed hospital leadership along the way. Besides, “if the world were perfect,” according to Yogi, “it wouldn’t be.”

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The top minds in rural health care gathered in Salem last December to launch Oregon’s newest think tank—the Rural Health Reform Initiative.

The Rural Health Reform Initiative (RHRI), a multi-stakeholder project spearheaded by the Oregon Association of Hospitals and Health Systems, aims to help sustain and support Oregon’s rural hospitals and health systems in a time of reform, both on a federal and state level.

Rural hospitals face special challenges due to their small size, modest assets and financial reserves. Plus, there is a higher percentage of Medicare patients in rural areas, since rural populations are typically older than the average urban population.

The impetus behind the creation of RHRI is to assist rural hospitals in successfully navigating the many changes brought about by state and federal health reform.

“Oregon’s small and rural hospitals recognize the tremendous work ahead to execute proposed changes to the state’s health care delivery system. We must preserve access to vital health care services in rural Oregon,” said Linda Lang, director of strategic initiatives at the Oregon Association of Hospitals and Health Systems, who manages the program.

How We Got Here

“The reason for RHRI is that rural administrators in Oregon are very concerned about the sustainability of rural health care, keeping quality health care available to rural Oregonians, and preparing for the future state of health care” said Ray Gibbons, CEO of Saint Alphonsus Medical Center—Baker City, and chair of the RHRI Committee, a subcommittee of the Association’s Small and Rural Hospital Committee.

To understand the risks that rural hospitals face in making the leap to new payment systems proposed in state and federal reform, Gibbons pointed to the last round of significant changes to Medicare and Medicaid. In 1983, the Centers for Medicare and Medicaid Services, (CMS) enacted a prospective payment system which pays hospitals a pre-determined rate for each Medicare admission. Under this system, hospitals are at risk of incurring financial losses on their Medicare patients if the costs of providing service to them exceeded the predetermined payment rates. During the first six years of this system, rural hospitals had worse financial outcomes for Medicare services than urban hospitals. In the decade following this change, 11 rural hospitals closed in Oregon, and only one of these reopened.

Oregon’s rural hospitals have long depended on cost-based reimbursement from Medicaid...
and Medicare and on other special government programs to remain financially viable.

The Medicare Flex Program was enacted as part of the Balanced Budget Act of 1997 and authorized states to establish State Rural Hospital Flexibility Programs (Flex), allowing certain facilities participating in Medicare to become Critical Access Hospitals (CAH). CAH is a separate provider type that has its own payment method. The CAH Flex Program was created to ensure Medicare beneficiaries living in rural areas had sufficient access to health care services.

“That program has sustained health care in rural communities,” said Gibbons. “But, CAHs are now being threatened.”

To reduce our country’s ballooning federal budget deficit, CMS could well enact changes to the CAH program that would reduce payments to rural hospitals. The spectre of this change has many rural hospital leaders feeling fearful about the future.

State Reform Moves Forward

Oregon health care organizations are abuzz with talk of a new health care delivery model, the Coordinated Care Organization (CCO), which is set to replace traditional Medicaid Managed Care Organizations by 2017.

Coordinated Care Organizations will bring together physical, mental and eventually dental health care providers to managed care for Medicaid enrollees with a fixed sum of money, or “global budget.” CCOs will utilize electronic health records, a new generation of health care paraprofessionals known as community health workers and a robust model of patient care known as primary care homes, among other characteristics.

Although Oregon has mandated that health care providers who care for Medicaid patients move to this structure, it is still unclear to many what it will actually end up looking like, and more daunting, how health care providers must invest to successfully pull it off.

“The concern is: How do we create a rural CCO in low-density population areas where it’s difficult to recruit skilled health care professionals? If we move too fast and don’t have measurable and reasonable trials, we could jeopardize access to care in rural Oregon,” Gibbons said.

Rural hospitals are perfectly willing to embrace the idea of a future state, but they need time to analyze the data that already exists, rural health care leaders say.

To assist rural hospitals in the formation of CCOs, RHRI is dedicating resources to studying health care data about cost, utilization, quality indicators and workforce. RHRI aims to establish collaborative peer groups to analyze these data, and develop education and resources to determine the best strategies and organizational models for rural CCOs, among other goals.

What is a Rural Hospital?

Rural hospitals fall into the following categories:

• **Type A Rural Hospitals**—small and remote, have less than 50 beds, and more than 30 miles from the nearest hospital.

• **Type B Rural Hospitals**—small and rural, have less than 50 beds, and 30 miles or less from the nearest hospital.

• **Type C Rural Hospitals**—considered rural and have 50 or more beds.

• **Critical Access Hospital (CAH)** is a federal designation for rural hospitals. CAHs have 25 or fewer beds, are located in especially remote regions, and are entitled to receive cost-based reimbursement from Medicare (and from Medicaid in some states like Oregon).
“Data will be our common ground,” said Gibbons. “We are creating a collaborative within communities, bringing different groups together, drawing upon skill sets.”

With state and federal health reform deadlines looming, RHRI also hopes to start a dialogue with state leaders about how rural hospitals fit into the bigger picture of reform. In December, CEOs of all 32 rural hospitals in Oregon signed a letter to Dr. Bruce Goldberg, director of the Oregon Health Authority, asking him to join the group in developing ideas and solutions for rural hospitals to traverse health care reform.

“One thing rural hospitals have always done well is that in a time of crisis they come together and find a way to figure it out,” Gibbons said. “What we’re doing with RHRI is beginning the process of speaking with one voice.”

Rural Health Fast Facts

• There are 32 type A and B community hospitals in Oregon, 25 of which are Critical Access Hospitals. More than half of Oregon’s hospitals are in rural communities.

• The Oregon Office of Rural Health defines rural as those geographic areas 10 or more miles from a population center of 40,000 or more.

• Nationally, 20% of the U.S. population lives in rural areas, while 9% of physicians practice there. In Oregon, 38% of the population resides in rural areas, while 19.9% of the state’s physicians have a rural practice.