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NORC | WALSH CENTER FOR RURAL HEALTH ANALYSIS

Financially Distressed Rural Hospitals in Four States

Overview

The Balanced Budget Act of 1997 dramatically changed the payment environment for institutional providers of non-acute health services by mandating a shift in Medicare reimbursement of outpatient, home health, and skilled nursing services from the traditional cost-based approaches to prospective payment. Although they were designed to slow health care spending, these Medicare payment reforms, particularly the outpatient prospective payment system (OPPS) rules, were projected to have a disproportionately negative impact on many rural hospitals. Subsequent revisions to the Balanced Budget Act (BBA) modified the initial legislation to alleviate or postpone the negative financial impact, including a hold harmless provision for small (100-bed or under) rural hospitals. Due to delays in processing hospital cost reports, sufficient data to assess the impact of the new outpatient payment system on small rural hospitals have only recently become available. We simulated the effect of OPPS on the financial performance of rural hospitals in four states - Iowa, Texas, Washington, and West Virginia. Our findings suggest that the profitability and cash position of small, government-owned, and Medicare-dependent hospitals will be adversely impacted by outpatient PPS. The results also suggest that the number of financially distressed rural hospitals will increase significantly. The small rural hospitals currently protected by the hold harmless provision are those that are likely to be hardest hit by OPPS.

Study Methods

Data to assess hospitals' financial positions were gathered from audited financial statements in four selected states where hospital financial records were publicly available: Iowa, Texas, Washington, and West Virginia. Though these states are not nationally representative, they have relatively large rural populations and are diverse in their health care infrastructures. Data for a three-year period, 1996-1998, were used throughout this analysis in order to ensure the stability of estimates. Hospital characteristics were obtained from three files: the 1995 Medicare Cost Report, the 1997 Provider of Service File, and the 1997 PPS Impact File. We excluded 79 hospitals that converted to Critical Access Hospital (CAH) status through July 2003, since they are exempt from outpatient prospective payment.

We use two financial measures of balance sheet and income statement quality: profitability and cash position. Profitability was examined using the hospital's three-year average total margin. Total margin measures the hospital's ability to earn and report a profit for both patient and non-patient activities. Calculating the hospital's "cumulative cash cushion" assesses a hospital's cash position. The cash cushion quantifies the hospital's excess cash after patient operations, minimum debt payments, and routine plant

replacement, and reflects the hospital's long-term ability to invest in strategic activities and weather temporary financial adversity.

Financially distressed hospitals are defined as those with both a negative three-year average total margin and a negative cumulative two-year cash cushion. Although the definition of financial distress used in this study requires both conditions to be met, the impacts of outpatient reform on the total margin and cash cushion were examined separately. Balance sheet data required to calculate the cash cushion of Texas hospitals were not available, so stability among Texas hospitals was examined using only the average total margin measure.

The results of a Centers for Medicare & Medicaid Services' impact analysis conducted to project the effect of the outpatient PPS on hospitals' outpatient revenue are used to simulate the estimated change in Medicare outpatient revenue. The change in Medicare revenue calculated in this study does not consider the transitional rules that allow selected providers relief in the early years of outpatient PPS implementation. For each rural hospital we studied, actual outpatient revenue was adjusted for the estimated change in Medicare outpatient revenue that would result if the OPPS were in place. For post-PPS calculations, each hospital's estimated change in net outpatient revenue was factored into the calculation of net income and operating revenue, impacting the total margin and cash cushion accordingly. Paired t-tests were computed to determine whether differences are statistically significant.

Key Findings

A total of 180 rural hospitals, more than two-thirds of which are located in the state of Texas, were included in this analysis. Of the 180 hospitals studied, 25 percent were classified as financially distressed as of the end of fiscal year 1998 – before the effects of the BBA were simulated. Among this group of hospitals, distressed hospitals tend to be small, have special rural payment status (i.e., Medicare Dependent or Sole Community Hospital), and are primarily government-owned.

We attributed to the outpatient PPS overall a nearly 44 percent decline in the average hospital total margin.

Table 1: **Average Total Margins, 1996 - 1998, by Hospital Characteristics Before and After OPPS Changes – Rural Hospitals in IA, TX, WA, WV**

	N	Before OPPS Changes	After OPPS Changes	Percent Change
All Hospitals	180	2.53	1.43	**-43.5**
Bed Size				
0-49	76	-3.39	-4.82	**-42.2**
50-99	62	6.15	4.80	**-22.0**
100-149	19	7.02	6.64	-5.4
150 +	23	8.49	8.67	2.1
Ownership				
Government	109	4.20	2.99	**-28.8**
Proprietary	19	-10.54	-11.21	-6.4
Voluntary, Non-Profit	52	3.85	2.75	**-28.6**
Disproportionate Share				
High	82	1.09	0.09	**-91.7**
Low	98	3.73	2.55	**-31.6**
Special Payment Status				
Medicare Dependent	26	2.58	0.79	**-69.4**
Rural Referral	22	8.76	8.79	0.3
Sole Community	60	4.70	3.57	**-24.0**
None	72	-1.32	-2.38	**-80.3**
State				
Iowa	19	6.12	4.64	**-24.2**
Texas	121	1.29	-0.09	**-107.0**
Washington	17	5.09	6.07	19.3
West Virginia	23	4.37	3.30	-24.5

Source: NORC Walsh Center for Rural Health Analysis

Note: Hospital groups with significant (< .05) differences in average total margins before and after outpatient PPS, based on paired t-tests are **bolded**.

Table 2: **Characteristics of Hospitals Projected to Become Financially Distressed After Implementation of OPPS**

	N
Total	12
Bed Size	
0-49	6
50-99	5
100-149	1
Ownership	
Government	7
Proprietary	2
Voluntary, Non-Profit	3
State	
Iowa	2
Texas	9
Washington	0
West Virginia	1

	N
Special Payment Category	
None	5
Medicare Dependent	1
Rural Referral Center	1
Sole Community Hospital	5
Teaching Status	
Teaching	0
Non-teaching	12
Disproportionate Share	
High (> 25%)	4
Low (< 25%)	8

Source: NORC Walsh Center for Rural Health Analysis

The largest negative impacts are on the profitability of the smallest rural hospitals and those shown to be in the most distress (*Table 1*). Average total margins among hospitals with fewer than 50 beds are projected to decline by over 40 percent. A more modest decline of approximately 22 percent is projected for hospitals with between 50 and 99 beds. On average, profitability in larger hospitals is expected to remain the same under the outpatient PPS.

The proposed outpatient PPS is not expected to significantly impact proprietary hospitals' total margins. In comparison, government-owned and voluntary hospitals are projected to experience declines in total margins of about 29 percent. Rural hospitals in Iowa and Texas are projected to see significant declines in their average total margins after OPPS, but hospitals in Washington and West Virginia are not expected to see such significant changes.

The outpatient PPS is expected to have a statistically significant negative effect on the average rural hospital's cash position. Across all hospitals, the average cash cushion per bed is projected to decline by approximately 14 percent. Hospitals with fewer than 50 beds are expected to experience one of the largest declines in cash cushion per bed, an estimated 16 percent.

Our simulation of the outpatient PPS classifies twelve hospitals as financially distressed as a result of the outpatient PPS that were not financially distressed before outpatient PPS. Of these twelve hospitals, six have fewer than 50 beds and five have fewer than 100 beds (*Table 2*). Seven of the twelve hospitals expected to become financially distressed have a special payment designation, five as Sole Community Hospitals. Seven hospitals are government-owned.

Discussion

Results suggest that the hold harmless provisions exempt most of the hospitals that are expected to be hardest hit by the OPPS and that, as a group, appear to be in the worst financial position. Once the exemptions expire, the smallest hospitals may be in serious financial trouble. A permanent exemption for small hospitals is one policy alternative that could benefit rural communities at a relatively low cost to the Medicare program. We estimated that a permanent OPPS exemption for rural hospitals with fewer than 50 beds would cost the Medicare program approximately $154.4 million annually and would cost $212.3 million annually if granted to hospitals with fewer than 101 beds. These estimates account for approximately 0.13 and 0.18 percent, respectively, of the 1996 Medicare hospital personal health care expenditures (based on expenditures reported in *Health Care Financing Review, 1998 Statistical Supplement*).

Hospitals with special payment designations are not exempted from the OPPS, but by virtue of their size they are temporarily protected. The substantially large decreases in profitability and cash cushion that were estimated for Medicare Dependent and Sole Community hospitals suggest that policymakers may want to consider extending prospective payment protections to outpatient services as well.

January 2004

This study necessarily assumed that hospital "behavior" remained constant during the period in which these payment reforms occurred. In reality, hospital administrators and staff might engage in various cost-containment or revenue-enhancing strategies in order to strengthen their financial performance, including changing how they code services. In fact, a large proportion of smaller rural hospitals in our study states – about 30 percent – made the strategic choice to convert to CAH status. Additional hospital conversions to CAH after the hold harmless provisions expire or other strategic responses could alter impacts of the new prospective payment system. Moreover, the simultaneous impact of other Medicare reforms must be considered. For instance, hospitals that operate home health agencies or skilled nursing facilities have had to adapt to new prospective payment systems for these services. Recent revenue-enhancing modifications to the inpatient disproportionate share payment formula have had a modest positive impact on rural hospital margins. The combined effect of these reforms on hospital financial performance is unknown and the findings of this study should therefore be interpreted with caution.

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