VIEWPOINT

COVID-19: BEYOND TOMORROW

Sustaining Rural Hospitals After COVID-19
The Case for Global Budgets

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The coronavirus disease 2019 (COVID-19) pandemic is a financial stress test for US hospitals.[1,2] Revenues have declined from the suspension of elective procedures and nonessential services, and many hospitals have experienced a surge of critically ill patients. These circumstances have created an unprecedented challenge for rural hospitals, many of which entered the crisis in poor financial condition due to the loss of patients to regional referral centers and rural depopulation.[3] Of the 4663 acute care hospitals in the US, approximately 47% are located in rural areas across 49 states.[4] The added financial strain of COVID-19 has the potential to accelerate the closure of rural hospitals, draining health care resources and jobs from rural communities that have lost 130 hospitals since 2010.[5,6]

Federal recovery packages, including the Coronavirus Aid, Relief, and Economic Security Act and the Paycheck Protection Program, are providing rural hospitals with short-term aid. Additionally, Medicare and some private payers have offered advance payments to hospitals to temporarily offset lower revenues.[7] However, these short-term measures may not be sufficient to financially sustain rural hospitals if the economic downturn outlasts the public health crisis (as some economists predict) and if hospital volume does not quickly rebound to precrisis levels.[5]

> The COVID-19 pandemic has exposed the fragility of financing these hospitals on a fee-for-service model.

The COVID-19 pandemic will require payers and policy makers to consider more sustainable funding models for rural hospitals. One payment model that could stabilize the finances of rural hospitals and help them adapt to evolving public health needs is an all-payer global budget. Currently, 2 states (Maryland and Pennsylvania) operate these models, but only the model in Pennsylvania focuses on sustaining rural hospitals.[8] This Viewpoint discusses how all-payer global budgets may improve the viability of rural hospitals and describes considerations for expanding this model to additional states.

Global Budgets for Rural Hospitals

Under an all-payer global budget, public and private insurers agree to pay hospitals a fixed amount (ie, a budget) to deliver care to a population over a specified time period. By giving hospitals a predictable stream of income and removing the link between volume and revenue, global budgets can provide rural hospitals with much-needed financial stability and flexibility to respond to changing community health needs.

As a financing mechanism, global budgets help to address economic challenges that have long affected rural hospitals and have been exacerbated by COVID-19. Rural hospitals have high fixed costs and limited cash reserves or access to credit, and rely on outpatient and surgical volume for revenue.[1] The poor financial outlook of rural hospitals prior to COVID-19 has made them less able to weather the rapid decline in revenue from clinic visits and procedures during the crisis.[5] A global budget would insulate rural hospitals from this volatility and could obviate the need for payers to construct piecemeal financial aid packages during crises. It will be important to monitor how globally budgeted hospitals in Maryland and Pennsylvania withstand COVID-19 relative to hospitals with fee-for-service payment models.

The COVID-19 pandemic has illustrated how population health needs can change rapidly. Global budgets may provide hospitals with greater financial flexibility to adapt to these changes, because a hospital on a global budget payment model can redeploy resources while maintaining a fixed level of revenue. Moreover, strategic decisions under a global budget model are governed by the total cost of delivering care, rather than the profitability of specific services. Consequently, a hospital operating on this payment model might be more willing to invest in low-margin services that yield substantial public health benefits (eg, treatment for individuals with substance use disorder, obstetrical care) compared with a hospital operating on a fee-for-service model. A global budget may also relieve pressure on hospitals to make investments in high-margin elective services, such as orthopedic surgery and cancer surgery, that they may consider necessary for short-term survival, but could undermine long-term sustainability as patients increasingly migrate to high-volume referral centers for care. Now, COVID-19 has substantially reduced any near-term prospects of profitability from these services.

Considerations for Policy

Maryland and Pennsylvania have tested hospital global budgets through agreements with the Center for Medicare and Medicaid Innovation (CMMI). The implementation of these models and the mandates under which they operate will require careful consideration and, potentially, reconsideration by other states that may be considering global budgets to sustain rural hospitals.

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First, policy makers will need to balance the goal of preserving rural hospitals with expectations that hospitals will reduce spending under a global budget. In Maryland and Pennsylvania, hospitals are required to reduce Medicare spending under the terms of their states' agreements with CMMI. However, for rural hospitals, many of which operate with zero or negative margins,[1] a requirement to achieve near-term savings may undermine their financial stability and ability to meet community health needs. If the primary goal of a global budget is to sustain rural hospitals, policy makers could refrain from imposing savings mandates or could even increase the budgets of financially distressed hospitals relative to historic spending levels. Accordingly, CMMI could prioritize preservation of access over demonstration of savings in future global budget models for rural hospitals.

Second, implementing all-payer global budgets requires institutional infrastructure to support collaboration among state governments, payers, and rural hospitals. Maryland leveraged its existing all-payer hospital rate-setting system's Health Services Cost Review Commission to develop its global budget model. In Pennsylvania, hospitals, health insurers, and the state government established a jointly governed Rural Health Redesign Center to facilitate the all-payer contracting process, monitor hospital performance, and provide technical assistance.[8] Other states seeking to implement global budget models will need to develop similar structures. The federal government can have an important role in laying the foundation for future state-initiated models. For example, CMMI could develop a new multipayer global budget model open to all states or provide technical assistance to help rural hospitals participate in the Centers for Medicare & Medicaid Services' direct contracting model, which enables provider organizations to be paid a global budget. Alternatively, Congress could allow critical access hospitals (ie, rural hospitals that currently receive cost-based payment from Medicare) to instead receive global budgets under a new global budget assistance program administered by the Federal Office of Rural Health Policy.

Third, in the Pennsylvania program and the first iteration of the Maryland program (implemented from 2014-2018), only hospital facility payments were placed under a budget, while payments to physicians were excluded. The narrow scope of these models may have limited their capacity to catalyze broader changes in care delivery. For example, evidence from Maryland suggests that the state's initial model did not consistently yield improvements in quality or care coordination (eg, reductions in readmissions or increased follow-up care after a hospital stay).[9] Maryland subsequently expanded its program to encompass the total cost of care for Medicare beneficiaries. States that adopt a similarly incremental approach, such as by initially placing only hospitals on a budget, might also see limited short-run gains in quality or care coordination. However, these limitations should not dissuade policy makers from implementing global budgets for rural hospitals if these payment models preserve access to care and position rural health systems to respond to long-term community health needs. Other states designing global budget programs should pay close attention to the evolution of the Maryland and Pennsylvania programs.

Rural hospitals provide a public good. These facilities are often the principal source of acute care for communities that have substantial public health challenges, including an aging population, poverty, and the opioid epidemic, and are often an important component of the economy of rural communities.[6] The COVID-19 pandemic has exposed the fragility of financing these hospitals on a fee-for-service model. The long recovery from the pandemic is likely to prompt reconsideration of how the US finances rural hospital care. With thoughtful planning and implementation, global budgets may have an important role in preserving rural hospitals and positioning them to adapt to changing community needs.

ARTICLE INFORMATION

Published Online: June 10, 2020. doi:10.1001/jama.2020.9744

Conflict of Interest Disclosures: Drs Fried and Liebers reported previously serving as consultants to the Pennsylvania Office of Rural Health. Dr Fried reported receiving personal fees from Pennsylvania Department of Health outside the submitted work. Dr Liebers reported receiving personal fees from the Pennsylvania Office of Rural Health outside the submitted work. Dr Roberts was supported by a grant from the Agency for Healthcare Research and Quality (K01HS026727).

Disclaimer: This content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality, the Pennsylvania Office of Rural Health, or the Pennsylvania Department of Health.

Additional Contributions: We thank Julie Donohue, PhD (Department of Health Policy and Management, University of Pittsburgh Graduate School of Public Health), and Derek Angus, MD, MPH (Department of Critical Care Medicine, University of Pittsburgh School of Medicine), for helpful comments on an earlier draft of this article. The authors also gratefully acknowledge the contribution of Mark Herzog, MD, MPP (1992-2020), in inspiring our writing.

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