

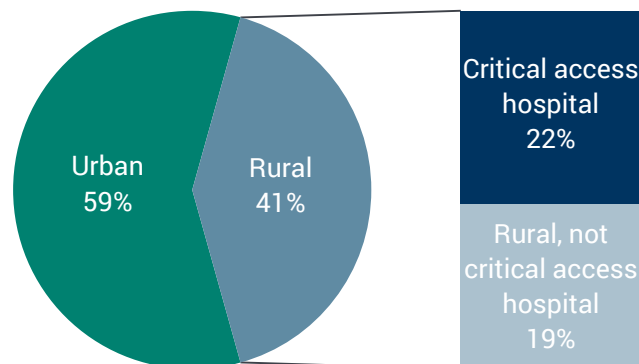
Rural Hospitals and Medicaid Payment Policy

State Medicaid programs have broad flexibility to determine payments for hospital services, and many states have established special payment policies for rural hospitals. Compared to urban hospitals, rural hospitals report lower operating margins and thus are at greater risk of hospital closure. This fact sheet describes the role of rural hospitals in serving Medicaid beneficiaries and how Medicaid programs pay rural hospitals.¹

Characteristics of Rural Hospitals

In 2015, 41 percent of U.S. hospitals were located in rural areas and about half of rural hospitals were designated as critical access hospitals (Figure 1). The Health Resource Services Administration (HRSA) Federal Office of Rural Health Policy defines a rural hospital as one located in a non-metropolitan county or as a hospital within a metropolitan county that is far away from the urban center, as defined by a rural-urban community area code of four or above (HRSA 2017). Critical access hospitals receive a special payment designation from Medicare because they are small (fewer than 25 beds) and are often the only hospital provider in the community (MedPAC 2017a).²

FIGURE 1. Urban and Rural Hospitals as a Share of All Hospitals, 2015



Notes: Analysis includes 5,983 hospitals that submitted 2015 Medicare cost reports. Rural status is defined by the Health Resource Services Administration (HRSA) Federal Office of Rural Health Policy. Critical access hospital status is defined by Medicare.

Source: MACPAC, 2018, analysis of Medicare cost reports.

Rural hospitals are generally smaller than urban hospitals and serve fewer patients. According to Medicare cost reports, rural hospitals provided 7.3 percent of all Medicaid inpatient hospital days in 2015, which was lower than the share provided by urban hospitals (92.7 percent).³



Although the share of rural residents with Medicaid coverage is higher than the share of residents in urban areas, Medicaid patients account for a lower share of patient days at rural hospitals compared to urban hospitals. In 2015, 24 percent of nonelderly residents in rural areas were enrolled in Medicaid, which was higher than the Medicaid coverage rate in urban areas (22 percent) (Foutz et al. 2017). However, according to 2015 Medicare cost reports, Medicaid patients accounted for 19 percent of total patient days at rural hospitals, which was lower than the Medicaid utilization rate reported for urban hospitals (24 percent).

Rural hospitals have lower operating margins than urban hospitals, and rural hospital closures have increased in recent years. In 2015, the aggregate operating margin for rural hospitals was -0.2 percent compared to 1.2 percent for urban hospitals. Between 2010 and 2015, there were 53 rural hospital closures and 74 urban hospital closures (MedPAC 2017b). However, since 2015, the number of rural hospital closures has increased: between January 2016 and April 2018, an additional 30 rural hospitals have closed (Sheps Center 2018).

Rural hospital closures affect access to care for all residents in the community, including Medicaid enrollees. For example, Medicaid is the primary payer for most births in rural areas, and between 2004 and 2014, 9 percent of rural counties experienced a loss of all hospital obstetric services (Hung et al. 2017). When a rural hospital closes or reduces its services, low-income and elderly patients are more likely than others to report delaying or forgoing needed care because of transportation challenges (Wishner et al. 2016).

Payment Methods for Rural Hospitals

States have broad flexibility to design Medicaid payment methods for hospitals and can apply different payment methods for different types of hospitals, such as rural hospitals. While states can develop their own criteria for identifying rural hospitals, most use Medicare's designation of critical access hospitals for identifying small, rural hospitals that receive special consideration. Below we describe how states set two types of payments to rural hospitals: (1) base payments for services and (2) supplemental payments, which are typically made in a lump sum and are not tied to particular services.⁴

Base payments

In fee-for-service (FFS) delivery systems, states often establish special payment policies for rural hospitals. They may use a different payment method for rural hospitals than they do for other hospitals (e.g., basing rural hospital payments on costs rather than on a fixed rate per patient) or make adjustments to payment rates (e.g., paying a higher rate to rural hospitals than they do for other hospitals for the same service). In managed care delivery systems, health plans typically have flexibility to determine the rates that they pay providers.

Several states use cost-based payment methods for inpatient and outpatient services provided at critical access hospitals (Table 1). Medicare also pays critical access hospitals and some other types of rural hospitals on a cost basis (MedPAC 2017).⁵ For small hospitals that serve a low number of patients whose costs are difficult to predict, cost-based payment can help ensure that the facility receives enough funding



to maintain its operations. Such methods, however, do not provide an incentive for hospitals to constrain their costs.

TABLE 1. Number of States Using Specific Medicaid Payment Methods, by Hospital Type

Hospital type	Primary payment method for FFS inpatient hospital services (2018)				Primary payment method for FFS outpatient hospital services (2015)			
	Diagnosis-related groups	Per diem	Cost-based	Other	Bundled payment	Fee schedule	Cost-based	Other
Urban hospitals	37	10	1	2	19	13	16	1
Rural, not critical access hospitals	34	11	2	3	15	16	16	2
Critical access hospitals	16	10	17	7	6	11	25	7

Notes: FFS is fee for service. Information on FFS inpatient payment policies is based on MACPAC’s review of Medicaid state plans as of March 2018 and information on FFS outpatient payment policies is based on MACPAC’s review of Medicaid state plans as of November 2015. Analysis excludes the District of Columbia, which does not have rural hospitals. FFS outpatient hospital payment policies are not available for Tennessee because the state pays for these services exclusively through managed care. For more information about different types of payment methods for hospital services, see MACPAC’s issue briefs on [inpatient hospital payment policy](#) and [outpatient hospital payment policy](#).

Sources: MACPAC 2015 and MACPAC 2018.

States also frequently make adjustments to payment rates by varying how rates are calculated and by applying special rules for certain hospital types. As of March 2018, 19 states reported payment policy adjustments for inpatient hospital services provided by rural hospitals; in late 2015, six states reported adjustments for outpatient hospital services provided by rural hospitals (MACPAC 2016; MACPAC 2018a). Examples of these adjustments include:

- **Different base rates.** Michigan uses different diagnosis-related group (DRG) payment rates for critical access hospitals. The DRG rates for these hospitals are calculated based on critical access hospital costs alone and do not factor in the costs of providing similar services at other types of hospitals.
- **Wage index adjustments.** Virginia adjusts diagnosis-related group (DRG) payment rates based on the wages in the hospital’s wage index area. For rural hospitals, the state uses a wage index from the nearest metropolitan area, which is typically higher than the average wages in the rural area.
- **Service-specific adjustments.** New Hampshire pays a higher DRG rate for maternity care provided by critical access hospitals in the state’s least populated rural county.



Supplemental payments

Several states target Medicaid supplemental payments to rural and critical access hospitals. The two largest types of Medicaid supplemental payments to hospitals are disproportionate share hospital (DSH) payments, which support hospital uncompensated care for both Medicaid-enrolled and uninsured patients, and upper payment limit (UPL) supplemental payments, which are intended to fill the gap between FFS Medicaid base payments and the amount that Medicare would have paid.

In state plan rate year (SPRY) 2013, about half of rural hospitals received Medicaid DSH payments totaling \$1.8 billion, and hospitals that received DSH payments also reported receiving \$1.1 billion in non-DSH supplemental payments, such as UPL payments.⁶ Urban hospitals received more DSH payments in SPRY 2013 (\$15.6 billion), but as a share of total hospital revenue, DSH payments for urban and rural hospitals were about the same (3 percent of net patient revenue).

DSH payments. Fifteen states explicitly target DSH payments to rural or critical access hospitals (MACPAC 2017). These include states that distribute DSH payments to all rural hospitals and states that target DSH payments to hospitals in particular rural regions of the state, such as a particular county. Rural hospitals that receive DSH payments in other states qualify based on other state-defined criteria, such as serving a high share of Medicaid and low-income patients.

UPL payments. Nine states explicitly target inpatient hospital UPL payments to rural or critical access hospitals; three states target outpatient hospital UPL payments to these hospitals (MACPAC 2016, MACPAC 2018a). As with DSH payments, rural hospitals can receive UPL payments even if the payments are not explicitly targeted to rural hospitals as long as they meet other state-defined criteria.

Learn more:

- [Medicaid base and supplemental payments to hospitals](#) (June 2018 issue brief)

Base payments

- [State Medicaid payment policies for inpatient hospital services](#) (July 2018 state policy compendium)
- [Medicaid inpatient hospital services payment policy](#) (March 2016 issue brief)
- [State Medicaid payment policies for outpatient hospital services](#) (July 2016 state policy compendium)
- [Medicaid outpatient payment policy](#) (July 2016 issue brief)

Supplemental payments

- [Annual analysis of disproportionate share hospital allotments to states](#) (Chapter 3 in MACPAC's March 2018 *Report to Congress on Medicaid and CHIP*)
- [Improving the targeting of disproportionate share hospital payments to providers](#) (Chapter 3 in MACPAC's March 2017 *Report to Congress on Medicaid and CHIP*)
- [Examining the policy implications of Medicaid non-disproportionate share hospital supplemental payments](#) (Chapter 6 in MACPAC's March 2014 *Report to the Congress on Medicaid and CHIP*)



Endnotes

¹ Detailed information about state payment policies is available in MACPAC's compendia of state fee-for-service (FFS) payment policies for [inpatient](#) and [outpatient](#) hospital services (MACPAC 2016; MACPAC 2018a).

² A small number of critical access hospitals are located in urban areas because they were designated by their state as a necessary provider (MedPAC 2017).

³ Medicaid patient days reported on Medicare cost reports do not include days for patients who are dually eligible for Medicare and Medicaid.

⁴ More information about each of these types of payments is available in MACPAC's issue brief on [Medicaid base and supplemental payments to hospitals](#) (MACPAC 2018b).

⁵ Specifically, critical access hospitals receive Medicare payments that cover 101 percent of their costs. Medicare also makes cost-based payments for inpatient services provided by rural hospitals that are designated as sole community hospitals and Medicare-dependent hospitals (MedPAC 2017).

⁶ Provider-specific data on non-DSH supplemental payments for all hospitals are not available. Non-DSH supplemental payments include UPL payments, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations.

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