HealthCare for All Maine
Lunch & Learn with Maine Legislators
2/16/23
Dr. Ted Sussman
Handout

Information and Data Sources:

Page 2-3:
Maine: A Health-Focused Landscape Analysis

A report by the Northern Border Regional Commission and Maine Rural Health Research Center

https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1029&context=population_health

Citation: Ahrens, K., Burgess, A., Milkowski, C., Munk, L., Jonk, Y., & Ziller, E. (2022). Maine: A Health-Focused Landscape Analysis. [Chartbook]. University of Southern Maine, Maine Rural Health Research Center.

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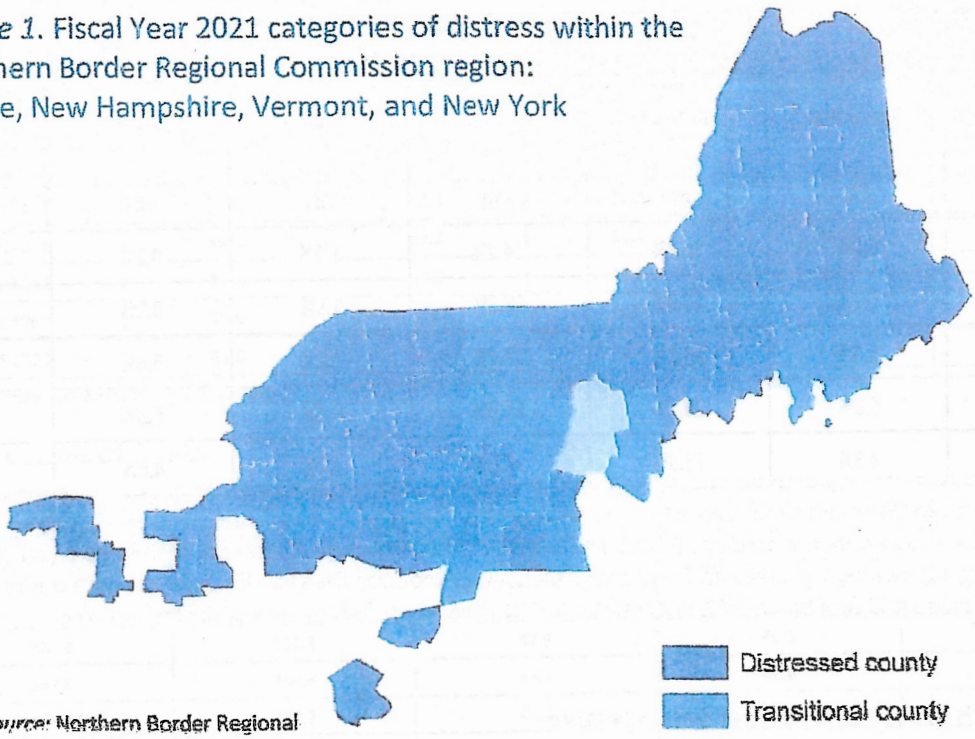
Page 4:
Rural Hospitals at Risk of Closing
A report by Saving Rural Hospitals,
Center for Healthcare Quality and Payment Reform
https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

https://ruralhospitals.chqpr.org

Figure 1. Fiscal Year 2021 categories of distress within the Northern Border Regional Commission region: Maine, New Hampshire, Vermont, and New York



Data source: Northern Border Regional Commission. *NBRC Annual Economic & Demographic Research for Fiscal Year 2021: To Determine Categories of Distress within the Northern Boarder Regional Commission Service Area.* March 2021.

SECTION I. Demographic Characteristics

Geography	Population	Rurality	Age		Sex	Race/ethnicity[1]						Language
		Living in a rural area	Below 18 years of age	Age 65 and older	Female	Non-Hispanic white	Non-Hispanic Black	Hispanic	American Indian & Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Not proficient in English
	(N)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
United States	328,239,523	19.3%	22.3%	16.5%	50.8%	60.1%	12.5%	18.5%	1.3%	5.9%	0.2%	4.3%
Maine	1,344,212	61.3%	18.5%	21.2%	51.0%	93.0%	1.6%	1.8%	0.7%	1.3%	<0.1%	0.5%
New Hampshire	1,359,711	39.7%	18.8%	18.7%	50.4%	89.8%	1.5%	4.0%	0.3%	3.0%	<0.1%	1.0%
New York	19,453,561	12.1%	20.7%	16.9%	51.4%	55.3%	14.5%	19.3%	1.0%	9.0%	0.1%	6.9%
Vermont	623,989	61.1%	18.3%	20.0%	50.6%	92.6%	1.3%	2.0%	0.4%	1.9%	<0.1%	0.6%

Data sources: Census Population Estimates, 2010 and 2019; American Community Survey, 2015-2019 5-year estimates.
[1] Race/ethnicity data may not sum to 100% due to missing data.

SECTION II. Socioeconomic Characteristics

Geography	Employment			Income				Social support	Education	
	Employed full time, ages 16 to 64	Unemployed, ages 16 and older seeking work	Employed in healthcare and social assistance	Median household income	Population in poverty	Children in poverty	Children eligible for free or reduced-price lunch	Children in single-parent households	High school graduation rate	Adults with some college completion
	(%)	(%)	(%)	($)	(%)	(%)	(%)	(%)	(%)	(%)
United States	66.4%	3.7%	15.8%	65,712	12.3%	16.8%	52.2%	25.5%	85.0%	66.1%
Maine	63.1%	3.0%	21.7%	58,824	10.9%	13.8%	44.1%	20.6%	85.9%	68.3%
New Hampshire	65.4%	2.5%	15.4%	78,571	7.5%	8.1%	27.0%	19.1%	88.9%	70.8%
New York	66.4%	4.0%	19.9%	72,038	13.1%	18.2%	53.9%	27.0%	82.4%	68.7%
Vermont	62.2%	2.4%	19.0%	63,293	10.1%	10.8%	36.4%	21.2%	85.5%	68.7%

Data sources: American Community Survey, 2015-2019 5-year estimates; Bureau of Labor Statistics, 2019; Small Area Income and Poverty Estimates, 2019; National Center for Education Statistics, 2018-2019; EDFacts, 2017-2018.

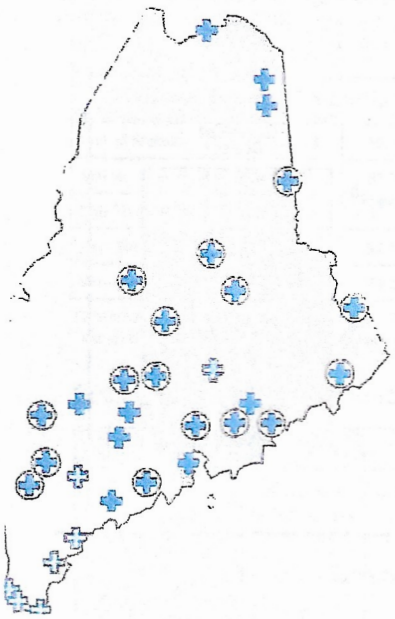
TION VII. Death Rates per 100,000 Population, Cause Specific

Geography	Length of life	Injury-related deaths	Injury-related death subcategories			
	Premature death (years of potential life lost before age 75, # per 100,000)	All injury deaths (# per 100,000)	Suicide deaths (# per 100,000)	Firearm deaths (# per 100,000)	Drug overdose deaths (# per 100,000)	Motor vehicle crash deaths (# per 100,000)
United States	6,906.6	72.3	13.8	11.9	21.2	11.4
Maine	7,020.8	93.0	17.7	11.4	28.4	11.5
New Hampshire	6,373.8	88.5	17.9	10.6	32.7	8.6
New York	5,406.3	50.5	8.1	4.2	19.1	5.7
Vermont	6,277.2	85.6	17.0	11.7	22.4	9.6

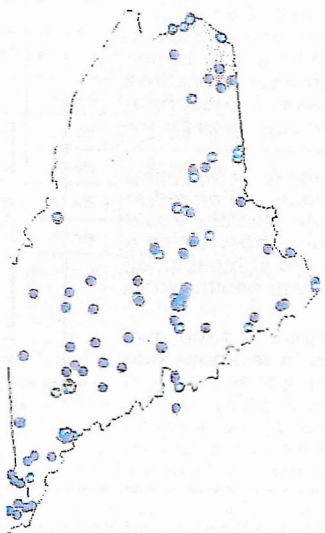
Data source: National Center for Health Statistics – Mortality Files, 2013-2019.

SECTION VIII. Top Five Causes of Death

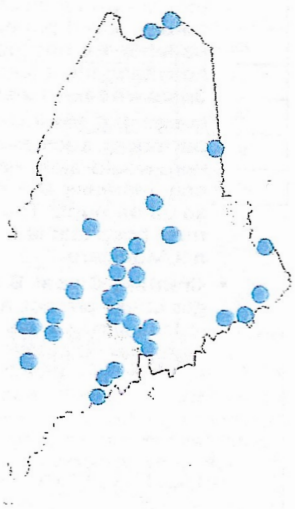
Geography	Top five causes of death (Age-adjusted rate of death per 100,000 population)				
	Heart disease	Cancer	Accidents (unintentional injuries)	Chronic lower respiratory diseases	Stroke (cerebrovascular diseases)
United States	164.8	152.3	47.5	40.2	37.3
Maine	147.8	168.6	63.3	48.6	33.9
New Hampshire	148.7	153.7	62.6	40.8	27.9
New York	173.7	141.5	33.7	28.6	24.9
Vermont	153.1	158.7	55.9	40.6	30.7



Hospitals



FQHCs



RHCs

The Causes of Rural Hospital Closures

Rural hospitals are being forced to close because they are not paid enough to cover the cost of delivering services in rural areas. Most of the hospitals that have closed had losses on patients with private health insurance as well as on Medicare, Medicaid, and uninsured charity care patients, and they did not have other sources of income sufficient to offset these losses.

It costs more to deliver essential services in rural communities because of the smaller number of patients served, not because rural hospitals are inefficient. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher. A payment that is sufficient to cover the cost of ED visits at a large hospital may fall far short of the cost of visits at a small rural hospital.

A common myth about rural hospitals is that most of their patients are on Medicare and Medicaid. In fact, more than half of the services at the average rural hospital are delivered to patients with private insurance (including both employer-sponsored insurance and Medicare Advantage plans). Low margins or losses on patients with private insurance, combined with losses on Medicaid and uninsured patients, can force small rural hospitals to close.

Commonly Proposed "Solutions" Won't Prevent Most Closures

Several policies that have been developed or proposed to help rural hospitals would not solve their financial problems, and some would make them worse:

- **Creating "Rural Emergency Hospitals."** Requiring rural hospitals to eliminate inpatient services would increase their financial losses while reducing access to inpatient care for local residents. Residents of rural communities would have had even more difficulty finding a hospital bed during the pandemic if their hospital had been converted to a Rural Emergency Hospital.
- **Expanding Medicaid Eligibility.** Making more patients eligible for Medicaid would help low-income patients afford better care and it would reduce a portion of hospitals' losses on uninsured patients and bad debt. However, uninsured patients are not the primary cause of losses at most rural hospitals; most losses are caused by low payments for patients who have insurance.
- **Increasing Medicare payments.** An increase in Medicare payments, such as eliminating the 2% sequestration reduction, would be beneficial for rural hospitals, but this would only increase the margin at a typical rural hospital by a small amount. The biggest cause of losses at most small rural hospitals is low payments from private health plans, not Medicare.
- **Creating Global Budgets.** Giving a hospital a fixed budget could protect a hospital from losses in revenues due to lower service volume, but it does nothing to address the increases in costs that most hospitals are currently facing, and it would prevent hospitals from delivering new services their communities need.

How to Prevent Rural Hospital Closures

The only way to prevent rural hospital closures is for health insurance plans to pay rural hospitals adequately to cover the cost of delivering essential services in their communities. Although most payers are underpaying small rural hospitals, the biggest cause of negative margins in most small rural hospitals in most states is low payments from private insurance plans and Medicare Advantage plans.

It would only cost about $3 billion per year to prevent closures of the at-risk hospitals and preserve access to rural healthcare services. This would represent an increase of only 1/10 of 1% in total national healthcare spending. Most of the increase in spending would support primary care and emergency care, not inpatient services, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Spending would likely increase as much or more than this if hospitals close because reduced access to preventive care and failure to receive prompt treatment will cause residents of the rural communities to be sicker and need more services in the future.

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are not paid at all for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and other staff to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive ***Standby Capacity Payments*** from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and Service-Based Fees would cover the variable costs of those services. More details on this approach are available at RuralHospitals.org.