Reimagining the Role of Maine's Rural Hospitals:
Preparing for the Future

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ABSTRACT

Maine's rural hospitals struggle with workforce shortages, high operating costs, inadequate reimbursement, and patients bypassing their local hospitals to access services outside of the community. Since 2013, four Maine acute care hospitals have terminated inpatient operations. Evolving challenges include a declining need for inpatient beds, growth in Medicare Advantage and value-based payment plans, escalating healthcare costs, and the Reconciliation Act (HR 1), which contains provisions expected to harm rural hospitals, providers, and residents. To partially offset the anticipated negative impact of the bill, HR 1 also provides $50 billion in funding for a five-year Rural Health Transformation Program (RHTP). This paper reimagines the role of rural hospitals to focus on the delivery of comprehensive primary care and essential services, proposes regionalizing services to maintain access to care, discusses the role of the state in supporting rural hospitals and applying for RHTP funds, and offers a Rural Community Health Transformation Collaborative model to engage communities in planning for and supporting their local and regional hospitals and delivery systems.

INTRODUCTION

Rural hospitals in Maine and across the United States have long struggled with the risk of closure (Shiftmed Team 2025; Gale et al. 2024). Between January 2005 and July 2025, 195 US rural hospitals closed (110) or converted to another model of care (85).[1] Among these are three Maine hospitals that ceased inpatient operations but remained open as urgent or emergency care facilities (Goodall Hospital, Parkview Adventist Medical Center, and Saint Andrews Hospital) and one that completely closed in May 2025 (Northern Light Inland Hospital).

Longstanding issues faced by rural hospitals include chronic workforce shortages, high operating and staffing costs, inadequate reimbursement, a high number of patients who bypass their local hospital to access care outside the community, and the challenging demographics of rural communities (Gale et al. 2024). Evolving issues further destabilizing rural hospitals in Maine and across the United States include a declining need for inpatient beds, growth in Medicare Advantage and value-based payment plans, escalating healthcare costs, the acquisition of rural hospitals by larger health systems, and the anticipated negative impact of HR 1— An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (Dayan 2025).

HR 1, signed into law on July 4, 2025, contains extensive changes to Medicaid, the Affordable Care Act (ACA) Marketplace, and Medicare reimbursement. These changes are expected to disproportionately harm Maine's rural hospitals (Myall 2025). To help offset its impact on rural providers and citizens, HR 1 established the Rural Health Transformation Program (RHTP) to assist states in stabilizing their rural hospitals and rural healthcare infrastructure (Levinson et al. 2025). Despite a commitment of $50 billion over five years, there is widespread concern that the proposed level of funding is insufficient to offset the anticipated damage to rural providers and residents. Nationally, the $50 billion in RHTP funding represents only 37 percent of the estimated loss of federal Medicaid funding in rural areas (Levinson and Neuman 2025). Maine's share will be a fraction of the estimated $5 billion in losses that Maine will experience under the law (Office of Governor 2025a).

To inform the discussion of the future of Maine's rural hospitals, this paper explores opportunities to reimagine the role of these hospitals. It reviews past efforts to support rural hospitals, describes the challenges facing rural hospitals, discusses the role of the state in supporting rural hospitals and in applying for and implementing its share of the RHTP funds, identifies core values to guide reform efforts, and advocates for the development of a vision for the future of rural hospitals and healthcare in Maine. Finally, it discusses options for hospital payment reform and

offers an innovative model to support improved regional collaboration between Maine's rural hospitals and other health-producing organizations, as well as better engagement with community members to transform local and regional delivery systems.

While this paper also reviews the potential harms that may result from HR 1 and the funding opportunity through the Rural Hospital Transformation Program, the reality is that the application process and the decision on Maine's funding request will be complete by the time this paper is published; only the hard work of implementation will remain. The RHTP funds are an opportunity for the state, but they are just one option for the state to support rural hospitals and transform rural health. The suggestions presented in this paper, including the need for a rural health vision and plan, can help guide the implementation of initiatives funded by the RHTP, encourage alignment with other resources, and contribute to Maine's efforts to build a better future for rural hospitals and health.

HISTORY OF FEDERAL RESPONSES TO RURAL HOSPITAL CLOSURES

Concerns over potential rural hospital closures emerged in 1973, when small rural hospitals struggled to meet Medicare's requirements for registered nursing supervision (Gale et al. 2024). To minimize the risk of closure and related loss of access, an Arthur D. Little study proposed a limited-service rural hospital model targeting rural hospitals with 50 or fewer beds located more than 30 minutes from another hospital. The model offered relief from staffing requirements in exchange for limitations on the services provided. The study recommended that states be empowered to implement their own limited-service rural hospital models with support from the federal government. Despite limited initial interest, the model became the foundation for ongoing efforts to support small rural hospitals.

The implementation of the Medicare fixed-rate prospective payment system in 1983 renewed interest in the limited-service rural hospital model, with eight states implementing their own versions. Montana's Medical Access Facility was the most successful of these models, focusing on rightsizing rural hospitals by limiting services that were difficult to sustain with quality in low-volume facilities in exchange for enhanced volume-appropriate reimbursement and regulatory relief.

By the late 1980s, another wave of closures created a demand for a national solution. Influenced by Montana's Medical Access Facility demonstration, the 1991 Essential Access Community Hospital/Rural Primary Care Hospital demonstration evaluated the limited-service rural hospital model across seven geographically diverse states. Faced with an additional wave of closures in the mid-1990s, Congress, informed by these two demonstrations, created the Critical Access Hospital provider type in 1997. As of April 2025, 1,377 critical access hospitals were operating in 45 states, with 18 located in Maine (CGSCHSR 2024). These 18 critical access hospitals represent 75 percent of Maine's 23 rural hospitals.

Over time, additional Medicare provider types were developed to support struggling non-critical access rural hospitals with enhanced reimbursement. Maine hospitals with these designations include Northern Light Maine Coast Hospital and Penobscot Bay Medical Center (sole community hospitals), MaineGeneral Medical Center (a rural referral center), Northern Light A.R. Gould Hospital and Cary Medical Center (Medicare dependent hospitals) and Northern Light Maine Coast Hospital and Northern Light A.R. Gould Hospital (participants in the Rural Community Hospital demonstration) (CGSCHSR 2024; CMS 2025). Although no Maine hospitals are currently designated as Rural Emergency Hospitals (the newest Medicare provider type without inpatient beds), it may be an option for hospitals that can no longer sustain inpatient services due to the impact of HR 1 and changing market conditions.

MAINE'S RESPONSES TO RURAL HOSPITAL CLOSURES AND PAYMENT REFORM

In response to concerns about the instability of Maine's rural hospitals in 2019, Governor Janet Mills established the Maine Department of Health and Human Services' (DHHS) Rural Health Transformation Team. This decision acknowledged that "Maine's rural communities faced a growing crisis in meeting the healthcare needs of their residents."[2] The Transformation Team was tasked with engaging communities and key stakeholders in discussions about transformation; enhancing Maine's healthcare infrastructure; exploring regional models for high-need services; and developing innovative pilot projects. The onset of COVID-19 diverted the attention and resources of DHHS and the Maine Centers for Disease Control (CDC) from the work of the Transformation Team, which concluded in April 2020.

Other DHHS efforts to support providers, including rural hospitals, involved value-based purchasing strategies designed to reduce costs and improve quality and outcomes for MaineCare members. Recent initiatives include the Accountable Communities and MaineCare PC Plus programs. Accountable communities are similar to Medicare's Accountable Care Organizations, in that the program contracts with groups of providers to participate in a shared risk savings model. PCPlus is MaineCare's value-based approach designed to transition providers away from a volume-based (fee-for-service) payment system to one that provides population-based payments tied to cost- and quality-related outcomes. These programs provide a framework that can be used to support the payment reform described later in this paper.[3]

THE STATUS OF RURAL HOSPITALS IN MAINE

Maine's remaining rural hospitals continue to struggle in the current healthcare environment. In addition to the closed hospitals described earlier, two critical access hospitals (Calais Regional and Penobscot Valley) filed for bankruptcy in 2019 (Flaherty 2020).[4] Fortunately, both hospitals were able to restructure their finances and remain viable.

Although a 2024 Maine Hospital Association report suggests that Maine's critical access hospitals are in better shape than critical access hospitals in New Hampshire and Vermont due to enhanced MaineCare reimbursement, rural hospital experts continue to raise concerns about their long-term viability (Ashley 2024). The Center for Healthcare Quality and Payment Reform estimates that nearly 33 percent of rural hospitals nationwide are at risk of closure, with more than 300 in "immediate danger" due to prolonged financial instability or dangerously low reserves. The center has further estimated that four of Maine's remaining rural hospitals are now at immediate risk of closure, following the passage of HR 1 (Steinmetz 2025).

Maine's rural hospitals are also struggling to maintain obstetrical care and other essential services. Over the past decade, 11 hospitals have closed their obstetrical units, with four closures occurring within the last year (Lundy 2025). These closures disproportionately affect rural communities. Maine has the longest drive times for obstetrical care in New England, with an average time of 45 minutes one-way for those whose nearest hospital does not have a birthing unit. Rural residents with high-risk pregnancies frequently travel to Bangor or Portland for specialty obstetrical care.

THE POTENTIAL IMPACT OF HR 1 ON MAINE'S RURAL HOSPITALS AND RESIDENTS

Maine's rural hospitals are expected to experience significantly greater financial instability, with fewer people able to afford care after the loss of MaineCare and ACA Marketplace coverage. Estimates of the number of Maine residents expected to lose MaineCare coverage range from 31,000 to 40,000 individuals (US Congress JEC 2025). Close to 23,000 Maine residents are projected to face significantly higher premium prices through the Marketplace due to the loss of tax credits. Estimates of those who will become uninsured due to the inability to afford the premium increases range from 9,500 to 10,000 (Office of Governor 2025b).

Maine's rural hospitals are expected to incur higher rates of uncompensated care as the individuals who lose coverage turn to emergency departments and hospital-owned clinics for care (Nelb 2025). The Congressional Budget Office estimates that hospital uncompensated care costs will grow by an additional $42.4 billion by 2034, and the Center for American Progress estimates that uncompensated care in Maine could increase by up to $86 million by 2034 due to HR 1 (Arguello and Ducas 2025). HR 1 will also affect Maine's rural hospitals through its planned expansion of the current 2 percent sequestration cut on Medicare provider payments to 4 percent in 2026 (Pitts et al. 2025).

As the financial stress on rural hospitals increases, many will be forced to examine the continuation of essential services. The trends in the closure of labor and delivery care are likely to continue, as Medicaid pays for more than 40 percent of US births nationally, extends postpartum coverage to 12 months for children whose births were paid for by Medicaid in 49 states (including Maine), and covers more than 40 percent of the nation's young children under age six. Mental health services are also likely to be at risk as Medicaid covers treatment to nearly 25 percent of adults experiencing mental illness nationally (Wright Burak and Johnson 2025).

The MaineCare program will absorb a greater portion of costs due to cuts to allowable provider taxes mandated by HR 1 (Henderson et al. 2025). Prior to HR 1, all states were permitted to tax healthcare providers up to 6 percent to help fund their share of Medicaid program costs. HR 1 will reduce the amount that Medicaid

expansion states, such as Maine, are allowed to tax healthcare providers to 3.5 percent by 2031. MaineCare will also incur increased administrative costs to comply with work and enrollment requirements (Maine DHHS 2025).

These changes will increase the risk of closure for the most vulnerable rural hospitals in Maine and nationwide. Remaining rural hospitals may be compelled to reassess their service mix, staffing patterns, and charity-care policies to stay viable, thereby reducing access to care and raising the cost of care for those not covered by Medicaid or ACA Marketplace plans (Galewitz et al. 2025).

It should be noted that many of HR 1's changes will be phased in over time. For example, the changes to the eligibility checks for Medicaid recipients are scheduled to begin in 2027. The work requirements will begin in 2028. The phased implementation of the provisions of HR 1 may provide a very brief window for the state and its rural hospitals to begin to adapt to the changes. It will be essential to monitor efforts to modify HR 1 as our legislative leaders begin to understand the bill's impact on rural hospitals, providers, and residents.

RURAL HOSPITAL TRANSFORMATION PROGRAM FUNDING

To partially offset the losses resulting from changes to Medicaid and the ACA marketplace, HR 1 included $50 billion ($10 billion per year for five years) for a Rural Health Transformation Program (RHTP), administered by the Centers for Medicare & Medicaid Services (CMS) (Kammerer 2025). The notice of funding opportunity, released on September 15, 2025, required states to submit a rural health transformation plan and budget to CMS by November 5, 2025, with decisions on funding to be made by December 31, 2025.[5] This is an exceedingly short window for preparing and submitting a substantial five-year funding proposal.

States must use the funds to *make rural America healthy again* by supporting rural health innovations and new access points; support *sustainable access* by helping rural providers to become long-term access points for care; attract and retain a high-skilled *healthcare workforce;* spark the growth of *innovative care models* to improve health outcomes, coordinate care, and promote flexible care arrangements, and foster use of *innovative technologies* that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients.[6]

Fifty percent of the funds in each year will be distributed equally to all 50 states ($100 million per year per state), the remaining 50 percent will be distributed to a subset of states based on factors specified by CMS. States must undertake a minimum of three specified activities that focus on evidence-based interventions to improve access to acute, chronic, and preventive care; improve workforce recruitment and retention; support care delivery in rural hospitals; assist communities in rightsizing their healthcare delivery systems; enhance access to treatment for substance use disorders and mental health issues; and develop innovative models of care supported by value-based care arrangements and alternative payment models.[7]

A VISION FOR THE FUTURE OF MAINE'S RURAL HOSPITALS

Given the rapidly evolving policy context in Washington, the ongoing threats to Maine's rural hospitals, and the unlikely prospects for significant federal reform of the American healthcare system and related payment policies, it is clear that the status quo for Maine's rural hospitals can no longer be sustained and that change is needed to stabilize our rural health hospitals and health systems. The burden of responsibility for this change, at least for the near future, will fall to the state of Maine to explore opportunities to transform its rural hospitals and delivery systems. In a worst case scenario, Maine must also be prepared to consider the options if one or more of its hospitals are no longer viable.

A clear statement of vision for the future is essential to efforts to use RHTP funds to support Maine's rural hospitals. This vision statement should describe the current state of Maine's rural hospitals, define a new future with clear expectations for change, identify the necessary resources and policies to create incentives for the desired improvements in performance, integrate the initiatives funded by the RHTP across the five-year funding cycle and with other non-RHTP initiatives, and specify a glide path to accomplish the desired change. This vision statement would provide a roadmap to guide Maine's rural hospitals from their current state to a better, more sustainable future. The absence of a vision for the future makes it difficult to develop consensus around needed changes, engage stakeholders in the process, reconcile competing interests for scarce resources, and realign incentives. The following principles are offered to guide Maine's development of this vision:[8]

- Maine should focus on building a sustainable rural system of care and services that is person- and family-centered, improves access, and meets the needs of rural residents, rather than focusing primarily on *saving* rural hospitals and other provider types.
- Maine's rural residents should have timely access to a set of essential services, including primary care, mental health, substance use, wellness, oral health, chronic disease management, select specialty services (i.e., obstetrical and oncology care), urgent or after-hours care, and emergency medical services.
- Rural patients and providers must adapt to different delivery modalities, such as artificial intelligence (AI), telehealth, and team-based care, to accomplish this goal.
- Efficient rural hospitals and healthcare delivery systems should be collaborative and organized at both local and regional levels to improve efficiency and access, while minimizing duplication, waste, and unnecessary competition.
- Rural health systems should include a robust collaborative public health infrastructure.
- Community engagement is crucial for encouraging support, ownership, and use of local services by establishing formal processes to solicit community input in the development and operation of these services.
- A sustainable rural hospital system should provide high-quality and efficient care, demonstrating its value through public reporting of quality and operational measures.
- Financing and reimbursement policies should compensate rural hospitals and providers fairly for the provision of services, reflect the higher fixed costs and lower volumes of rural hospitals, and realign incentives to achieve the desired improvements in service delivery and system performance.

Admittedly, this is a comprehensive list of values, and it would be challenging to address all these principles simultaneously, particularly the needed revisions to financing and reimbursement policies. Maine could, however, begin to work through these values to build a foundation to support rural hospitals and health systems by focusing on opportunities to rationalize rural health delivery systems through the regionalization of essential services, development of incentives to encourage collaborative partnerships to minimize unnecessary competition through hub-and-spoke models,[9] exploration of regulatory and planning strategies to manage and support rural delivery systems, and engagement of communities as partners in supporting and sustaining their hospitals and health systems.

REIMAGINING MAINE'S RURAL HOSPITALS

As noted earlier, traditional rural hospital support programs and models have helped mitigate, but not prevent, the closures of rural hospitals. Given the history of states as laboratories for hospital reform, Maine should explore innovative options to support its rural hospitals and ease the negative impact on Maine's rural residents and hospitals.

One option would be to encourage Maine's rural hospitals to realign their service mix to deliver a comprehensive array of primary care and other essential services through financing reform and a focus on value-based care. This recommendation is consistent with the American Hospital Association's Task Force on Ensuring Access in Vulnerable Communities and the Maine Rural Health Action Network's Building Blocks for Healthy Rural Communities (AHA 2016; MRAHN 2020). Supporting the proposed focus on providing comprehensive primary care is the growing recognition of primary care as a public good (Etz and Stange 2024). The National Academies of Sciences, Engineering, and Medicine's (NASEM's) 2021 report, *Implementing High-Quality Primary Care,* affirmed the vital, but under-resourced, importance of primary care and recommended policies to rebuild the nation's primary care infrastructure (NASEM 2021).

A high-functioning primary–care-focused rural health system holds the potential to improve the health of Maine's rural residents and moderate the escalating cost of care in Maine (Basu et al. 2019; NASHP 2025). Access to high-quality primary care is associated with greater life expectancy, reduced burden of chronic disease, better patient satisfaction, fewer hospitalizations and emergency department visits, and reduced healthcare costs over time. In the absence of a regulatory approach to cost containment, reimagining rural delivery systems to expand access to high-quality, comprehensive primary care provides one of the few options to fundamentally shift, over time, the healthcare cost equation in Maine.

The discussions on reimagining Maine's rural hospitals should also include the need for post-acute and long-term services and supports, given the aging of rural

Maine. The Federal Reserve Bank of Boston noted that nursing home closures in New England have exceeded those in the rest of the country since fiscal year 2010 and that Maine has had the highest rate of closures (Cover 2024). The shortage of nursing home beds significantly affects Maine's hospitals. In March 2024, an estimated 200 people requiring nursing home care were unable to be transferred from Maine hospitals due to a lack of nursing home beds (MHA 2025).

STATE'S ROLE IN SUPPORTING RURAL HOSPITALS AND DELIVERY SYSTEMS

In light of the ongoing struggles of Maine's rural hospitals and the expected harm resulting from HR 1, it may be time to reinstate the Transformation Team with broad representation from hospitals, health systems, Federally Qualified Health Centers, rural health clinics, nursing homes, behavioral health providers, emergency medical services, public health, the business community, local government, community representatives, and other relevant stakeholders.

As discussed earlier, the funding available under HR 1's RHTP will be insufficient to offset the impact of HR 1's changes to Medicaid, the ACA Marketplace, and Medicare on rural hospitals and providers. Given the magnitude of the potential effects of HR 1, there will be difficult discussions on the use and distribution of these funds. A reinvigorated Transformation Team could help create the vision needed to transform rural health in Maine and a related transformation strategy to effectively leverage RHTP funding. It could also help balance the expected conflicting demands for the funding, coordinate RHTP-funded initiatives across the five-year funding cycle, provide transparency into how the funds are used, and monitor the impact of these initiatives and how they fit into Maine's long-term vision for rural hospitals and rural systems of care.

LESSONS LEARNED FROM PAST EFFORTS TO SUPPORT RURAL HOSPITALS

Several lessons from efforts to support rural hospitals offer insight into strategies for transforming rural delivery systems in Maine. These include the need to engage communities in key decisions about their hospitals and local delivery systems, the importance of regionalizing and coordinating services to create rational delivery systems, and opportunities to mitigate workforce shortages by improving use of existing scarce resources.

Improving Community Engagement and Ownership of Rural Hospitals and Delivery Systems

Past efforts to support rural systems of care highlight the importance of community engagement (Gale et al. 2020, 2024). Engaging community stakeholders in making decisions about their hospitals and local delivery systems can instill a sense of community ownership and control, improve use of local services, engage stakeholders in population health improvement, and encourage development of partnerships local healthcare and social service providers, public health, local government, schools, and the local business community.

Regionalizing and Coordinating Services by Creating Rational Delivery Systems

Rural communities are losing essential specialty services , such as obstetrical and oncology care. The challenge of recruiting providers and the cost of providing these services may be beyond the reach of many rural hospitals. One option would be to encourage rural hospitals to work with consortia of other hospitals and providers to develop "centers of excellence" and create incentives for providers to work together to ensure access to high-quality care for rural residents (Gale et al. 2020, 2024). For example, hospital collaboratives could create "obstetrical centers of excellence" with one facility (the hub) providing delivery services and critical access hospitals and other community providers (the spokes) providing prenatal, postnatal, diagnostic, transportation, and other necessary services, with consultative obstetrical support provided through telehealth and other technologies. This would allow consolidation of delivery services in the hub, thereby providing sufficient volume to invest in the recruitment of obstetricians, general surgeons, and anesthesiologists to support high-risk deliveries and ensure the quality of care provided.

Efforts to create rational and efficient rural delivery systems would be best managed at the state or regional levels. An original condition of funding for the Medicare Rural Hospital Flexibility (Flex) Program required development of a state rural health plan that encouraged regionalization of services and networking relationships between critical access hospitals and larger hospitals (Gale et al. 2024). Although state rural health planning is no longer a focus of the Flex Program, the initial

rationale behind the requirement for a regional health plan remains valid.

Examples of efforts to develop coordinated systems of care using the hub-and-spoke model include Vermont's hub-and-spoke opioid treatment program (Silva and Whitter 2022), Munson Healthcare's regional oncology service in northern Michigan (Munhoz et al. 2024), the Texas Rural Maternity and Obstetrics Management Strategies network (Hostetter and Klein 2021), and MaineHealth's public health-focused Center for Health Improvement (Mills 2025). Although the implementation of hub-and-spoke models can be challenging, they provide a potential pathway to improve access to care and the efficiency of rural delivery systems.

One last benefit of improved regional collaboration between rural hospitals, Federally Qualified Health Centers, rural health clinics, and other safety net providers would include the opportunity to coordinate efforts to share the burden of caring for Maine residents who have lost their coverage due to the provisions of HR 1.

Mitigating Workforce Shortages

While discussions of workforce shortages typically focus on supply-side solutions (e.g., rural training track and pipeline programs), efforts to better use existing scarce human resources may offer more immediate relief to struggling rural hospitals by expanding the use of team-based care along with the use of telehealth, AI, and evidence-based clinical guidelines to expand access to care, transform clinical practices, and improve productivity. Examples of team-based care options include the implementation of a successful team nursing model using nurse interns, nursing technicians, licensed practical nurses, and certified nursing assistants to mitigate nursing shortages by Aspirus Keweenaw Hospital in Michigan and the use of new staffing types such as community health workers and community paramedics (Donnelly and Sopata 2022; Gale 2023). Examples of the effective use of telehealth technology include expanding access to after-hours care, chronic care management, mental health, and substance use services. Practical examples of AI applications include speech recognition technology to reduce the burden of documentation on providers; billing and scheduling tools to improve operational efficiency; diagnostic support tools to assist providers in reaching accurate and timely diagnoses; algorithms to analyze x-rays, MRIs, and CT scans; remote patient monitoring tools; and applications to streamline patient communication and follow-up (Ellis 2024; LAPU 2023).

This is not to say that that the use of AI is an immediate solution to the challenges facing Maine' rural hospitals. Volande, Davis, and Goldstein (2025), three physicians from Dartmouth Health, observed that "AI can bolster—but also fracture—the informal support network that is rural medicine's lifeline. Whether it helps depends on design choices that respect limited bandwidth, honor local culture, and maintain fragile community trust." Broadband access remains an issue in many rural communities. Physicians and other clinicians must learn to incorporate technology in their daily practices. AI systems should offer actional recommendations in plain language, adapt to local caregiving norms and infrastructure limitations, and accommodate the limitations of users most likely to benefit from AI, especially older adults managing chronic conditions. Ideally, AI should not be treated as a standalone substitute for care. Rather, it should combine digital communication with human follow-up, caregiver networks, and emergency response capacity (Volandes et al. 2025). Rural hospitals and providers in Maine would benefit from information and technical assistance on successful efforts to improve the use of existing resources.

ENCOURAGING CHANGE THROUGH PAYMENT REFORM

The changes discussed in this paper are not possible without some element of payment reform or incentives to change providers' behavior. The payment policies developed for rural emergency hospitals hold a clue to potential payment reform options for critical access hospitals and other rural hospitals under MaineCare. Rural emergency hospitals receive an additional monthly facility payment to support access and stand-by response capacity for emergency and urgent care services, as well as to cover the fixed costs of providing care in rural areas. Unlike critical access hospitals, this enhanced volume-appropriate reimbursement is not added to a rural emergency hospital's fee-for-service payment rate (Gale et al. 2024). Medicare also reimburses rural emergency hospitals at 105 percent of the Medicare fee schedule (and limits patient copays to 20 percent of the fee schedule rate). This payment methodology acknowledges CMS's long-standing policy of providing enhanced payments to low-volume rural providers, such as critical access hospitals, while mitigating the negative impact on their ability to compete for business from Medicare Advantage, managed care

plans, or commercial payers. Given that MaineCare already pays an enhanced rate to critical access hospitals, this change could potentially be implemented in a way that would encourage movement towards delivery of essential services as described earlier in this paper.

In addition to exploring applying the rural emergency hospitals payment method to critical access hospitals and other rural providers, MaineCare may also consider the following options to guide conversations on rural hospital and payment reform:

- Limit enhanced reimbursement to a set of comprehensive primary care and essential services, including obstetrical and oncology care, consistent with the needs of rural communities and the focus of the RHTP notice of funding opportunity on rightsizing rural providers. Critical access hospitals, for example, could continue to offer other specialty services but would be reimbursed under the normal MaineCare fee schedule.
- Implement a team-based care payment methodology that reimburses the team for the delivery of services, rather than individual providers. This would conserve scarce clinical resources by encouraging clinicians to practice at the top of their licenses, aligning work flows to team skill sets, and delegating tasks that can be safely completed by other members of the team such as community health workers and community paramedics. Clinical team leaders would be responsible for overseeing the delivery of care and enforcing appropriate quality standards.
- Create incentives for the use of telehealth and technology to improve access to services including urgent and after-hours care, remote patient monitoring, and chronic care management.
- Create incentives for collaboration between regional providers and the development of hub-and-spoke models and regional centers of excellence.

AN INNOVATIVE MODEL TO SUPPORT RURAL HOSPITALS, PROVIDERS, AND COMMUNITIES

One option to support rural hospitals and delivery systems would be the development of a Rural Community Health Transformation Collaborative (RCHTC) model, which could facilitate and fund regional planning and collaboration, community engagement, and population health improvement. This conceptual framework of this model is informed by elements of national and state transformation models and programs. These elements include the Flex Program's state rural health plans that focused on rural health networks, regionalization of health services, and access to hospitals and health services; the rural hospital transformation plans that were a component of the Pennsylvania Rural Health Model; the Community-Oriented Primary Care model, which was described by NASEM as the best model to improve population health outcomes and health equity goals; the Accountable Health Communities model, which tested whether identifying and addressing health-related social needs through screening, referral, and community navigation services would reduce healthcare costs and unnecessary use; and regional hub-and-spoke models used to organize services for opioid treatment, oncology services, maternity care, and population or public health.

Key elements of the proposed RCHTC model include oversight by a lead organization that convenes partnerships of relevant health-producing organizations, empowered local decision making, a regional or community-based health improvement and planning budget funded by MaineCare and private-sector sources, a focus on building a community-oriented system that improves coordination between primary care, public health, rural hospitals, and community services, linkages to better-resourced hospitals to increase the flow of resources and improve care coordination and continuity for rural residents, development of a mandatory regional health transformation plan to improve access to primary care, chronic care management, mental health, substance use, and other services that address health-related social needs and priority gaps in services; funding for primary care, public health, population health, and health-related social needs initiatives, and accountability for achieving short and intermediate-term measures established in the rural health transformation plans.

The RCHTC model would address the recommendations identified in this paper by refocusing critical access hospitals, rural hospitals, and rural community health systems on improving health by concentrating on primary care, other essential services, public and population health, and health-related social needs. It would also provide a funding source to directly engage collaborative partnerships of key stakeholders in developing regional delivery systems that meet their needs and restores an element of community control.

CONCLUSIONS

Maine's rural hospitals will face increasing financial challenges as the provisions of HR 1 are implemented. These changes are expected to negatively affect the financial performance of rural hospitals by reducing MaineCare enrollment and coverage through the ACA Marketplace, reducing the ability of MaineCare to levy provider taxes to fund its share of program costs, and increasing the reductions in Medicare payment rates under sequestration. These changes will increase the risk of rural hospital closures and service reductions as these hospitals struggle to remain viable. In the absence of significant federal reform related to rural hospitals, the burden of supporting rural hospitals and their delivery systems, as well as mitigating the harm to rural residents, will fall to the state of Maine.

This paper recommends a framework to support rural hospital and delivery system reform based on lessons learned from past state and federal efforts. It also suggests an opportunity to engage providers and rural stakeholders in creating a rural health vision to guide the implementation of projects funded under Maine's share of the RHTP funding, defining a better future with clear expectations for longer-term changes in rural hospital and delivery system performance, and implementing regulations and incentives to move rural hospitals and delivery systems to that better future. It concludes by describing a proposed transformation model that incorporates key elements outlined in this paper: payment reform; collaborative partnerships between hospitals, clinics, public health, and other health-producing organizations to create regional systems of care; community engagement; rightsizing facilities and delivery systems; and an emphasis on supporting primary care, chronic care management, and population health services.

NOTES

1 "Rural Hospital Closures: 195 Rural Hospital Closures and Conversions since January 2005," Cecil G. Sheps Center for Health Services Research, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

2 "Transforming Rural Health," Maine DHHS, https://www.maine.gov/dhhs/initiatives/transforming-rural-health.

3 "Accountable Communities," Maine DHHS, https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities; "Primary Care – Primary Care Plus (PCPlus)," Maine DHHS, https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/primary-care

4 "About Calais Community Hospital," Calais Community Hospital, https://www.calaishospital.org/about-us/

5 "Rural Health Transformation (RHT) Program," Centers for Medicare and Medicaid Services, https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

6 https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

7 https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

8 These principles were informed by the work of the Kansas Hospital Association's Rural Health Visioning Task Force to identify a set of principles for a sustainable rural health delivery system (KHA 2016). They also align with Maine Rural Health Action Network's Building Blocks for Healthy Rural Communities (MRHAN 2020).

9 Hub-and-spoke models organize services around a central facility (the hub) that provides specialized care and consultative support, supported by secondary local facilities (the spokes) that provide less intensive care and services. The intent is to improve local access to care, while centralizing high-cost specialty care.

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