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RURAL HOSPITAL SUSTAINABILITY:

New Data Show Worsening Situation for Rural Hospitals, Residents

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BACKGROUND

Rural hospitals are essential to the health of the 60 million Americans who live in rural communities.[1] Beyond providing care, they're also economic engines, often the largest employers and drivers of additional businesses and jobs to communities.

But for close to three decades, rural population growth has been significantly lower than urban areas,[2] a factor contributing to the closing of 95 rural hospitals across 26 states since 2010.[3] And the economic effects are immediate — a study found[4] that when a community loses its hospital, per capita income falls 4% and the unemployment rate rises 1.6%.

ANALYSIS OF RURAL HOSPITAL FINANCIAL VIABILITY, COMMUNITY ESSENTIALITY

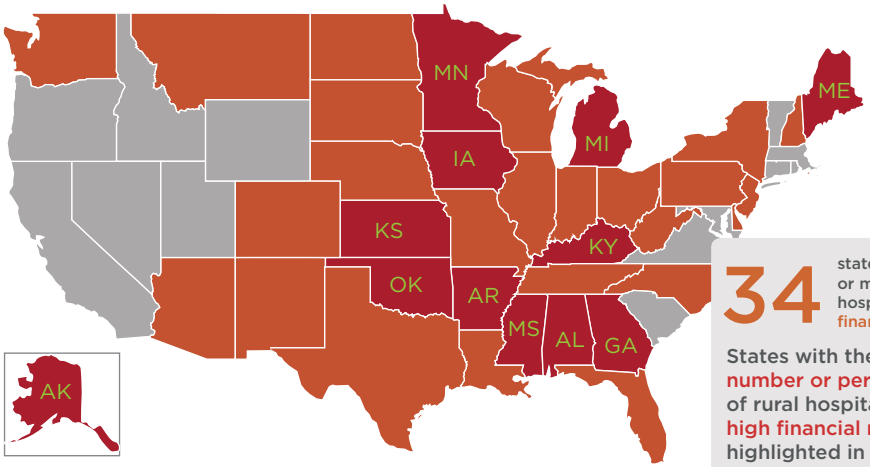
Rural Hospital Financial Risk

A Navigant analysis* of the financial viability (total operating margin, days cash on hand, and debt-to-capitalization ratio) of rural hospitals nationwide shows 21% or 430 hospitals across 43 states are at high risk of closing unless their financial situations improve. These hospitals represent 21,547 staffed beds, 707,000 annual discharges, 150,000 employees, and $21.2 billion total patient revenue. State-by-state data can be found in Figure 1 and Exhibit A.

Figure 1: Rural Hospital Financial Risk

THE NUMBER AND PERCENTAGE OF RURAL HOSPITALS AT HIGH RISK OF CLOSING*

21% OF U.S. RURAL HOSPITALS are at a HIGH RISK OF CLOSING unless their financial situations improve



34 states have 5 or more rural hospitals at high financial risk

States with the highest number or percentage of rural hospitals at high financial risk are highlighted in red

*(DE, NJ, and RI have no qualifying rural hospitals)

STATE	HOSPITALS AT HIGH FINANCIAL RISK	PERCENT AT HIGH FINANCIAL RISK
AL	21	50.0%
MS	31	48.4%
GA	26	41.3%
ME	8	40.0%
AK	6	40.0%
AR	18	36.7%
OK	17	29.3%
KS	29	28.7%
MI	18	25.4%
KY	16	24.6%
MN	19	21.3%
IA	17	17.9%

1. "One in Five Americans Live in Rural Areas," United States Census Bureau, August 9, 2017, https://www.census.gov/library/stories/2017/08/rural-america.html.
2. Brian D. Feinstein, JD, PhD, "RURAL AMERICA IS LOSING YOUNG PEOPLE," Penn Wharton Public Policy Initiative, March 23, 2018, https://publicpolicy.wharton.upenn.edu/live/news/2393-rural-america-is-losing-young-people-.
3. University of North Carolina Cecil G. Sheps Center for Health Services Research, "95 Rural Hospital Closures: January 2010 – Present," https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
4. George M. Holmes et al., "The Effect of Rural Hospital Closures on Community Economic Health," Health Services Research, April 2006, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/.

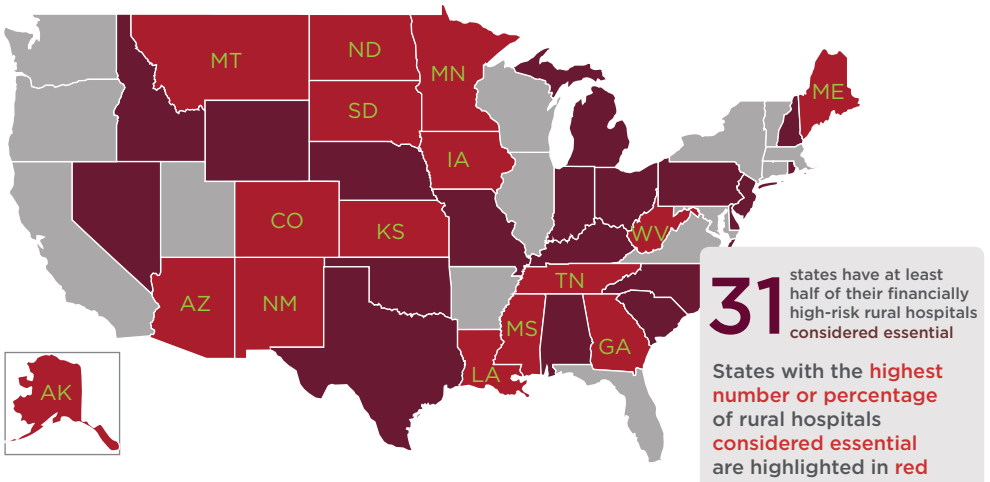
Rural Hospital Community Essentiality

Further analysis of the community essentiality (trauma status, service to vulnerable populations, geographic isolation, economic impact) of rural hospitals at high financial risk shows 64% or 277 of these hospitals are considered essential to their communities. See Figure 2 and Exhibit B for individual state results.

Figure 2: Rural Hospital Community Essentiality

THE NUMBER AND PERCENTAGE OF HIGH FINANCIAL-RISK RURAL HOSPITALS CONSIDERED ESSENTIAL TO THEIR COMMUNITIES*

Of high financial-risk rural hospitals, 64% ARE CONSIDERED ESSENTIAL to their communities



31 states have at least half of their financially high-risk rural hospitals considered essential

States with the highest number or percentage of rural hospitals considered essential are highlighted in red

*(based on an analysis of trauma status, service to vulnerable populations, geographic isolation, economic impact)

STATE	ESSENTIAL AT-RISK RURAL HOSPITALS	PERCENT ESSENTIAL AT-RISK RURAL HOSPITALS
MT	12	100%
AK	6	100%
CO	5	100%
ND	5	100%
AZ	8	89%
IA	15	88%
ME	7	88%
KS	25	86%
TN	6	86%
NM	6	86%
WV	8	80%
LA	8	80%
SD	4	80%
GA	20	77%
MN	12	63%
MS	19	61%

FACTORS DRIVING RURAL HOSPITAL CRISIS

The factors that have led to this rural hospital crisis are as complex as the ones that helped hollow out the communities they're meant to serve. In some ways, they're interconnected.

Payer mix degradation. A loss of agricultural and manufacturing jobs has led to a corresponding degradation of the payer mix. Residents who remain in rural communities tend to be either very old or very young, and these communities often have higher rates of uninsured, Medicaid, and Medicare patients, leading to more uncompensated and under-compensated care. Medicare payment reductions are also a major factor, with the average rural hospital counting on Medicare for 46% of gross patient revenue.[5]

Declining inpatient care driving excess capacity. Many rural hospitals were originally built in the post-World War II era to provide a level and volume of care that is no longer needed. This factor, combined with the ascendance of managed care and an increased focus on outpatient services, has left many rural hospitals overstaffed and underused. According to research,[6] the average rural hospital has 50 beds and 321 employees, but a daily census of just seven patients.

Inability to leverage innovation. Many already budget-strapped rural hospitals have been unable to keep up with technological trends as they lack the capital to invest in updated, innovative technology, such as electronic health records (EHRs) and advanced imaging platforms.

5. United States Government Accountability Office, "Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors," August 2018, https://www.gao.gov/assets/700/694125.pdf.
6. Jane Wishner et al., "A Look at Rural Hospital Closures and Implications for Access to Care," Kaiser Family Foundation, July 7, 2016, https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/.

LEGISLATIVE ACTION, HEALTH SYSTEM PARTNERSHIPS NEEDED

While rural hospital struggles have been documented for years, our analysis shines a new light on a crisis that must be addressed. The fact that all of this is happening during the longest uninterrupted period of economic growth in American history[7] should be added cause for concern. Local, state, and federal politicians, as well as health system administrators, need to act.

Advance legislation — In 2017, Senators Chuck Grassley, R-Iowa, Amy Klobuchar, D-Minn., and Cory Gardner, R-Colo., reintroduced the Rural Emergency Acute Care Hospital Act, or REACH Act.[8] The bipartisan legislation was meant to help rural hospitals by allowing them to sidestep a regulatory hurdle that had become an added burden.

Many rural hospitals are designated as Critical Access Hospitals, meaning they are required to provide a certain number of inpatient beds along with an emergency room. Those requirements often force hospitals that could still be turned around to close instead.

The REACH Act offers them another option: to resize and stabilize. Under a new classification known as the Rural Emergency Hospital, these hospitals would be able to rid themselves of the excess inpatient beds. Instead, they would have to maintain enough operational flexibility to move patients to larger hospitals — academic health systems in particular — while focusing on outpatient services.

While the REACH Act has been read in, it has not been voted upon by the appropriate committee.

Tertiary and academic health system collaboration — Partnerships between rural hospitals and regional tertiary and academic health systems need to be advanced in such areas as telehealth, back office functionality (revenue cycle, human capital, finance, EHR use), physician training, and clinical/service line optimization. Through these partnerships, rural hospitals can leverage the resources and capabilities of their better-funded, savvier peers.

For example, EHR provisioning allows hospitals with EHR technical and operational acumen to extend their capabilities to community/rural facilities hard-pressed to afford and operate a top-shelf EHR. In addition, extension of tertiary/academic specialty clinical programs can help develop a hub-and-spoke network of clinical care that augments rural hospital services. This leverages regional/academic specialty expertise while allowing care to remain local at rural partner facilities.

CONCLUSION

While the potential for a rural hospital crisis has been known for years, this predictive data sheds light on just how dire the situation could become. Now, by being able to accurately assess the economic health of all rural hospitals in America, there is no choice but to pay attention. Local, state, and federal political leaders, as well as hospital administrators, must act to protect the well-being of rural hospitals nationwide and the communities they serve.

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7. Heather Long, "The U.S. is on track for the longest expansion ever, but it's coming at a cost," The Washington Post, April 18, 2018, https://www.washingtonpost.com/news/wonk/wp/2018/04/18/the-u-s-is-on-track-for-the-longest-expansion-ever-but-its-coming-at-a-cost/?noredirect=on&utm_term=.7866192988e8.
8. Sen. Chuck Grassley, "Grassley, Klobuchar, Gardner Introduce Legislation to Help Rural Hospitals Stay Open, Focus on Emergency Room Care, Outpatient Services," May 16, 2017, https://www.grassley.senate.gov/news/news-releases/grassley-klobuchar-gardner-introduce-legislation-help-rural-hospitals-stay-open.

Exhibit A: Rural Hospitals at High Financial Risk

The number and percent of rural hospitals that are at high risk of closing unless their financial situations improve.

STATE	TOTAL RURAL HOSPITALS	HOSPITALS AT HIGH FINANCIAL RISK	PERCENT AT HIGH FINANCIAL RISK
CT	5	3	60.0%
AL	42	21	50.0%
MS	64	31	48.4%
GA	63	26	41.3%
AK	15	6	40.0%
ME	20	8	40.0%
WV	27	10	37.0%
AR	49	18	36.7%
FL	23	8	34.8%
NH	17	5	29.4%
OK	58	17	29.3%
KS	101	29	28.7%
SC	15	4	26.7%
NM	27	7	25.9%
MI	71	18	25.4%
AZ	36	9	25.0%
KY	65	16	24.6%
IN	39	9	23.1%
MO	61	14	23.0%
PA	41	9	22.0%
MN	89	19	21.3%
MT	57	12	21.1%
LA	50	10	20.0%
TN	37	7	18.9%
NY	48	9	18.8%
IA	95	17	17.9%
IL	75	13	17.3%
WA	40	6	15.0%
ND	34	5	14.7%
NC	47	6	12.8%
ID	25	3	12.0%
WI	75	9	12.0%
CO	43	5	11.6%
NE	70	8	11.4%
SD	44	5	11.4%
OH	65	7	10.8%
HI	10	1	10.0%
TX	127	12	9.4%
CA	50	4	8.0%
NV	13	1	7.7%
WY	21	1	4.8%
VA	22	1	4.5%
OR	28	1	3.6%
MA	6	0	0.0%
MD	5	0	0.0%
UT	17	0	0.0%
VT	13	0	0.0%
TOTAL	2045	430	21.0%

(DE, NJ, and RI have no qualifying rural hospitals)

Exhibit B: Essentiality of High Financial-Risk Rural Hospitals

The number and percent of high financial-risk rural hospitals considered essential to their communities.

STATE	TOTAL AT-RISK RURAL HOSPITALS	ESSENTIAL AT-RISK RURAL HOSPITALS	PERCENT ESSENTIAL AT-RISK RURAL HOSPITALS
KS	29	25	86%
GA	26	20	77%
MS	31	19	61%
IA	17	15	88%
MT	12	12	100%
MN	19	12	63%
OK	17	11	65%
KY	16	10	63%
MI	18	10	56%
AL	21	10	48%
AZ	9	8	89%
WV	10	8	80%
LA	10	8	80%
TX	12	8	67%
AR	18	8	44%
ME	8	7	88%
MO	14	7	50%
AK	6	6	100%
NM	7	6	86%
TN	7	6	86%
ND	5	5	100%
CO	5	5	100%
NE	8	5	63%
IN	9	5	56%
PA	9	5	56%
SD	5	4	80%
OH	7	4	57%
IL	13	4	31%
SC	4	3	75%
NH	5	3	60%
NC	6	3	50%
FL	8	3	38%
NY	9	3	33%
ID	3	2	67%
WA	6	2	33%
WI	9	2	22%
NV	1	1	100%
WY	1	1	100%
CA	4	1	25%
CT	3	0	0%
HI	1	0	0%
VA	1	0	0%
OR	1	0	0%
MA	0		
MD	0		
UT	0		
VT	0		
TOTAL	430	277	

(based on an analysis of trauma status, service to vulnerable populations, geographic isolation, economic impact)

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***Rural Hospital Sustainability Index Data**

All analyses based on most recently available data submitted by hospitals to the Centers for Medicare & Medicaid Services.

Financial risk — Derived from a weighted analysis of the following hospital metrics tied to Moody's bond ratings ratios.

- Total operating margin performance trended over three years: Less than 1.4% (Moody's Baa median/lowest investment grade) each of past three years
- Days cash on hand: Less than 78.5 days (half of Moody's Baa median)
- Debt-to-capitalization ratio: More than 49.8% (Moody's noninvestment grade grouping median)

Hospitals were assigned a score of 1-3 on each metric. Total scores of 3 or 4 are considered high financial risk.

Community essentiality — Hospitals meeting all the following metrics are considered essential.

- Trauma status: Hospitals designated a Level I or II trauma center are automatically designated essential, regardless of scoring on other indicators.
- Service to vulnerable populations: Either Medicaid days as a proportion of or uncompensated care as a percentage of net revenue are above national averages.
- Geographic isolation: Hospital represents at least 25% of beds in 25-mile radius.
- Economic impact on community: Hospital employee-to-county population ratio in the 3rd quartile or above, or at least 4.8 employees per 1,000 residents.

Hospitals were assigned a score of 1-3 on each metric. Total scores of 3 to 6 or hospitals designated Level I or II trauma centers are considered essential to communities.