Data Shows Rural Hospitals At Risk Without Special Attention from Lawmakers

As Affordable Care Act Faces Uncertainty in America’s Healthcare Future, Rural Hospitals Barely Hang On Compared to Urban Hospital Counterparts

A newly released data-driven study shows that rural hospitals are performing considerably worse than their urban counterparts – and many rural hospitals stand on shaky financial ground. The findings underscore the need for special attention on rural hospitals as Congress is determining America’s healthcare future.

Nashville-based Healthcare Management Partners, LLC used its proprietary platform HMP Metrics™, to study the performance of approximately 1,300 rural hospitals and 1,200 urban hospitals across the country over the past seven years. Teaching hospitals were excluded from the study.

Top line findings:

- Rural hospitals, in contrast to their urban counterparts, are financially precarious due to a combination of demographic, technological and economic factors;
- Nearly two-thirds (63%) of inpatient care in rural hospitals, compared to less than half (49%) of inpatient days in urban hospitals, are reimbursed by Medicare or Medicaid, and they receive additional federal patient revenues under the Affordable Care Act.
- The Affordable Care Act has materially reduced rural hospital losses from uncompensated care by improving the percentage of rural residents with health coverage.
- Rural hospitals in states that have expanded Medicaid under the ACA have generally performed better than their counterparts in non-expansion states.
- The combination of financial fragility and heavy reliance on federal insurance programs makes rural hospitals acutely financially vulnerable to reductions in the number of patients or scope of services covered by those programs.
- Rural hospitals have average margins of less than one half percent. Even relatively small reductions in federal payments will force the closure of large numbers of rural hospitals.
- Reflecting the general urban-rural partisan divide, over 95% of rural hospitals are located in Republican congressional districts.

If federal policymakers fail to take into account the vulnerability of rural hospitals as they reform federal health programs, it is likely that numerous rural hospitals will fail within the next few years. Medicaid changes now under consideration would, if enacted, rapidly accelerate the rate of closings. Large areas of rural America will be affected. Rural hospital closures can be expected to result in economic and social dislocations that reach far beyond their impact on health care delivery.

Rural hospitals have a vital role to play not only in the physical health but the economic health of their communities. They are often the single largest employer, and have an indirect employment impact through commerce with local businesses. Across the country, rural hospitals directly and indirectly employ around 750,000 people and generate revenues of almost $70 billion per year. In Tennessee alone, the rural hospitals included in the study serve almost 1 million people and have combined annual
net patient revenues over $1 billion. They directly employ over 10,400 full-time staff, and on average support another 6,000 non-healthcare jobs. That’s on average 6.5% of total employment in the rural counties where they are located.

Rural hospitals face different challenges than urban hospitals. Declining population in rural areas means the market is reducing each year, not only on the patient side but also the availability of skilled labor. Conversely, urban populations are increasing. Many rural facilities are aged, oversized and in need of capital. Yet funding sources are scarce, particularly for those that are already financially supported by local counties and resident tax dollars. Rural hospitals rely heavily on government payers due to a higher proportion of Medicare patients. They are critically important in serving the frail and elderly population that may not have the financial or physical wherewithal to travel long distances for medical care. The economics surrounding an urban hospital are much more favorable, and as the study proves, the profitability of urban hospitals is far ahead of rural hospitals.

Nonetheless, the study shows that there is a significant excess supply of hospital beds in both urban and rural areas. The proposed solution is not to preserve all rural hospitals and maintain the status quo, but recognize that preserving access to high quality healthcare in rural communities is imperative to protecting America’s rural economy. Having access to high quality healthcare services may mean that some hospitals need to be reconfigured to efficiently deliver services that meet the needs of the communities they serve. In the case of any Affordable Care Act (ACA) repeal and replacement, the legislature should help facilitate this needed change by providing incentives and legal or licensing structures that promote the efficient delivery of high quality care in rural communities.

Healthcare policy change impacts rural hospitals and the communities they serve in a unique way, and their challenges should be heard as Congressreshapes the future of American health care. Rural hospitals must continue to evolve. But they will not be able to do so, and they will not survive, if there is any reduction in the federal funds on which rural hospitals must depend.

**On average, rural hospitals perform far worse financially than urban hospitals**

In understanding the nature of rural hospitals, it is important to first establish how much worse, on average, rural hospitals fare financially than urban hospitals.

**Occupancy:** The rate of inpatient occupancy is a key metric in understanding the relative utilization of a hospital building and its resources. On average, the occupancy rate of urban hospitals has declined slightly over the past 7 years, from a high of 60% in 2009 to a low of 57% in 2014. In 2015, the average occupancy rate increased to 58% which reflected a decrease in supply of hospital beds rather than an increase in demand, since the number of inpatient discharges declined by 6% from 2014 to 2015. Conversely, rural hospitals have experienced sharper declines in occupancy rates, from 49% in 2009 to 42% in 2015. With average occupancy rates near 40%, rural hospitals carry the financial pressure of high fixed costs relative to the size of their patient activity levels.
The optimal average occupancy rate for a general acute care hospital is approximately 75%, so it is evident there is excess capacity in hospitals in both rural and urban areas. Industry trends indicate that the decline in demand for inpatient beds is expected to continue, and be countered by an increase in demand for outpatient services. Accordingly, hospitals need capital to reconfigure their business model to invest in the equipment and infrastructure needed to keep pace with the change in healthcare services and new technologies. Particularly in rural areas, there is a need to restructure hospitals in a planned, coordinated manner that will eliminate the excess supply of beds and position hospitals for the provision of high quality outpatient services.

**Profitability:** The operating profit margin measures profit relative to revenue from the hospital’s core activities (i.e. providing patient services). It excludes non-operating revenue sources such as donations, governmental appropriations, or earnings from investments.

Hospitals normally need a profit margin of 3% to 4% to fund the capital expenditure required to run a financially sustainable operation. Urban hospitals generally performed within that range of profitability from 2009 to 2015, with operating profit margins of 2.8% in 2009 and 4.4% in 2015. For rural hospitals, it is a completely different story. Rural hospitals on average incurred operating losses from 2011 to 2014. In 2014 there was a 5.6% gap in operating profit margin between rural hospitals and urban hospitals. (Rural hospitals in Medicaid expansion states fared better, with average margins of .4%.) While it is difficult to isolate the reasons for the increase in operating profit margin from 2014 to 2015, it did coincide with a slight uptick in inpatient occupancy as well as the full year effect of the decrease in the uninsured population from the ACA.

When it comes to operating losses, it begs the questions of who funds the losses, and who funds the capital expenditure required when operating cash flows are insufficient? There are 3 primary sources of funding: cash reserves, debt, or other sources of revenue. In hospitals that are government owned, and often supported by tax-backed debt, it is ultimately the local tax budget that bears the brunt of its local
hospital’s losses. In many rural communities where the hospital is county-owned, it’s the local taxpayers that ultimately feel the pinch.

**Rural hospitals rely on government payers more than urban hospitals**

The reliance on government payers is much higher for rural hospitals, which leaves them more exposed than urban hospitals to changes in government policy. In 2015, more than 63% of rural hospital inpatient days were paid by Medicare or Medicaid. For urban hospitals, government funded patients accounted for just 49% of inpatient days. On average in 2015, 55% of inpatient days at rural hospitals were funded by Medicare compared to just 41% for urban hospitals. Medicaid accounts for 8% of inpatient days in both rural and urban settings. Medicaid enrollment is generally higher in rural areas.
With the higher proportion of Medicare patients, it is clear that rural hospitals serve the elderly and frail population in their communities. In considering policy change and the fact that rural hospitals will be disproportionately impacted compared to urban hospitals, protecting the availability of high quality healthcare services for this vulnerable demographic should be prioritized.

Medicare coverage serves as the predominant payer and is not directly affected by the American Health Care Act. However, as evidenced by rural hospitals’ already inadequate operating profit margins, Medicare revenues cannot sustain rural hospitals in the event of significant reductions in patient revenues from Medicaid and subsidized commercial coverage under the Affordable Care Act.

**There has been an increase in the insured population post-ACA**

For rural hospitals, the level of uncompensated care can be onerous particularly considering the relatively high percentage of government-funded patients and lower levels of commercially insured patients. Normally, commercial insurance payment rates are more favorable than government payment rates, which tends to help fund the cost of uncompensated care. With lower levels of commercially insured patients, rural hospitals are at a disadvantage to urban hospitals.

At a macro level, it is difficult to pinpoint the financial impact of the ACA in supporting rural hospitals, however it is clear that the ACA significantly decreased the rate of uninsured patients in the USA. In most cases, having a higher rate of insured patients would result in lower levels of uncompensated care, thereby providing revenue to hospitals for the provision of services instead of them bearing the full cost burden.

This effect is seen in a comparison of rural hospitals in Medicaid expansion vs. non-expansion states. In FFY 2015, the first full year of expanded Medicaid coverage, rural hospitals’ bad debt decreased by 24%, to an average of 5% of revenue. Rural hospitals’ bad debt in non-expansion states remained essentially unchanged at 13% of revenue.
In Tennessee, the rate of uninsured patients in the rural counties included in the study dropped by 33% from 2013 to 2016. Put another way, the number of uninsured people in those counties dropped from 169,000 to 113,000 in just three years.

The Congressional Budget Office estimates under the American Health Care Act 14 million fewer Americans will have health insurance by 2018 and 23 million fewer by 2026. The CBO also projects that the AHCA will reduce federal Medicaid payments by $834 billion over the next decade.

With most rural hospitals barely breaking even and many suffering severe losses, any legislative change that results in a decrease in compensated care could have devastating consequences for rural hospitals.

**It must be noted that the forces causing change in healthcare are bigger than reimbursement policy**

While the structure of the healthcare system dictated by policy is an important factor, the financial challenges faced by rural hospitals aren’t exclusively related to reimbursement and legislative change. Other factors include:

- **Population shrinking in rural areas, resulting in:**
  - A decline in rural hospitals’ service population, and therefore a reduction in market size;
  - A decline in rural economies and fewer available trained healthcare staff;
  - Patient “outmigration”, where those patients with transport drive to the larger metropolitan hospital for higher acuity care and avoid using the local rural hospital; and
  - Fewer tax payers in rural areas to support county budgets (and hospitals)

- **Technological advances in healthcare, resulting in:**
  - A decline in demand for inpatient beds due to the shift from inpatient care to outpatient care, and lower average lengths of stay in a hospital;
  - Changes in the supply and demand of physicians by specialty;
  - Capital demands to purchase new equipment to deliver modern medicine; and
  - Growing need for Information Technology (“IT”) infrastructure and expertise to manage and utilize data effectively.
• The increasing complexity of clinical knowledge and hospital management, resulting in difficulties recruiting:
  o Clinical expertise (doctors, nurses, licensed professionals) to deliver specialist services and provide coverage 24 hours a day;
  o Administrative expertise, including management (CEO, CFO, CNO) and back office operations (IT support, billing specialists, compliance and legal experts).

Because of this reality, many rural hospitals are consolidating into multi-hospital systems, outsourcing corporate services, or exploring clinical partnerships with larger urban hospitals in an effort to combat the enormous challenges they face.

Healthcare is changing rapidly and the industry must adapt. This study reinforces that whatever is done, lawmakers must pay special attention to rural hospitals in whatever comes next for American healthcare. It is worth repeating: rural hospitals have a critical role to play not only in the physical health but the economic survival of their communities.

The rural-urban disparities in hospital financial vulnerability mirror the nation’s political divide: Over 95% of rural hospitals are in Republican congressional districts.
Description of Methodology & Data Sources

Hospital Data: The study included a quantitative and qualitative assessment of all short-term general acute and critical access hospitals across the United States. It excluded hospitals designated as Teaching Hospitals as well as Federal or Specialty hospitals. The quantitative analysis was prepared using the Centers for Medicare and Medicaid Services ("CMS") Healthcare Provider Cost Reporting Information System (HCRIS) data, reported and certified in over 35,000 Cost Reports filed by more than 5,000 hospitals for fiscal years 2009 to 2015. The metrics were calculated using Healthcare Management Partners’ proprietary analytic software called HMP Metrics™. Using HMP Metrics™, the raw data is “scrubbed” to exclude partial period or statistically aberrant data elements, thereby creating more robust statistics.

The designation as a “rural” or “urban” hospital is determined by CMS and is identified in the Cost Report.

Industry Trends: The quantitative analysis was complemented with qualitative analysis describing healthcare market factors and trends based upon both independent research and the authors’ extensive experience in managing and advising hospitals and local governments over the last 30 years. A summary of the authors’ background and experience is included at the end of this report.

Insurance Rates & Demographic Information: United States Census Bureau information was utilized to source demographic information. Data from Enroll America (https://www.enrollamerica.org/) was used to source statistics around the insured population.

About Healthcare Management Partners, LLC (“HMP”)

Healthcare Management Partners provides turnaround management and advisory services for healthcare services organizations of all types. As many rural hospitals look to navigate their way through an exceedingly difficult healthcare landscape, HMP has become one of the national leaders in executing rural hospital turnarounds. HMP’s leadership is comprised of hospital executives with an average of 25 years of management experience in healthcare organizations.

In addition to executive turnaround management, HMP’s core services include financial advisory, and litigation support (expert testimony). It also provides data analysis and benchmarking tools utilizing it’s proprietary product, HMP Metrics™.

Further information on HMP, as well as case studies, can be found at hcmpllc.com.
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Scott has more than 30 years of healthcare industry management and consulting experience. Prior to founding Healthcare Management Partners in 1997, he served as the president and chief executive officer of an academic medical center and as the chief financial officer of a faith-based multihospital system operating 12 hospitals across seven states. Scott has significant management and consulting experience with government, tax exempt and investor-owned healthcare service providers.

Scott is a bona-fide technical expert but also brings a uniquely creative approach to problem solving and strategic planning. He has a palpable passion for healthcare delivery and in 2016 he led the analytics behind a series of White Papers that researched rural healthcare in the USA. As a result, HMP worked closely with state leaders and hospital associations in determining the best way forward to ensure the continued delivery of high quality healthcare in rural parts of the USA.

Scott graduated from the University of Florida with a Bachelor of Science in Accounting. He is a Certified Public Accountant (inactive status) and member of numerous professional organizations.

Clare Moylan is the Managing Partner of HMP and a healthcare professional with a broad base of experience, including operations management, restructuring and crisis management, strategic planning, business analysis, consulting, and litigation support. Her experience covers the public, private, and not-for-profit sectors across the healthcare continuum: primary care, acute care hospitals, nursing homes, hospice, and home health care.

Clare has a deep experience in data analytics, benchmarking and performance improvement, and leads the HMP Metrics™ data analytic team.

Clare is a CFA Charterholder (Chartered Financial Analyst). She has a Bachelor of Business Administration/Bachelor of Laws (First Class Honors)
Infographics available (if useful)

Population Moving Towards Cities and Metro Areas

What does this mean for healthcare?

- Decline in rural hospitals’ service population
- Fewer tax payers in rural areas
- Decline in rural economy & fewer available trained healthcare staff
- City-based hospital “hubs” for higher acuity
- Patient outmigration to cities for healthcare

Technological Advances in Healthcare Delivery

What does this mean for healthcare?

- Declining demand for inpatient hospital services and declining ALOS
- Increasing demand for outpatient services
- Changes in the supply and demand of physicians by specialty
- Demands for new equipment to deliver modern medicine
- Growing need for IT infrastructure and knowledge

The Changing Role of Hospital Leadership

It’s increasingly difficult to recruit & retain expertise needed

- Clinical expertise
- IT infrastructure & equipment
- Strategic leadership
- Billing and corporate services
- Compliance & Legal