Rural Focus

June 2020

Trends in Rural Hospital Financial Viability, Community Essentiality, and Patient Outmigration

By David Mosley, Partner, Daniel DeBehnke, M.D., Partner, Sarah Gaskell, Associate Director, and Alven Weil, Associate Director, Guidehouse

U.S. rural hospitals are not only essential to the health and wellness of nearby residents, they're often a rural county's largest employer and a crucial economic link for other local businesses and job creators.

But rural hospitals nationwide continue to close at an alarming rate, including a one-year high of 19 hospitals in 2019 and eight in 2020 to date.[1] Research has found that populations served by rural hospitals experienced mortality rate increases of 5.9 percent after closures, due in part to increased travel times for patients and healthcare providers leaving these communities.[2] In addition, when a community loses its hospital, per capita income generally falls around 4 percent and the unemployment rate rises about 1.6 percent.[3] The situation will only worsen as hospitals nationwide are negatively impacted by the COVID-19 pandemic.

Key Board Takeaways

Opportunities exist for all hospital and health system leadership and boards to help mitigate the rural healthcare crisis:

- Work with state legislators to develop state-based Medicare demonstration waivers to change local and regional rules regarding inpatient beds and emergency designation.
- Advance partnerships that allow rural and critical access hospitals to leverage the scale of larger hospitals and health systems, telehealth providers, payers, and other entities. Such collaboration can lead to opportunities to improve the financial position of all organizations involved.
- Ensure active engagement among hospital leadership, board members, community leaders, and employers to identify opportunities to promote and sustain their local hospital and retain outmigrating patients.

Following a 2019 Navigant (now Guidehouse) study, we once again used publicly available data to analyze the correlation of financial viability and essentiality of rural hospitals prior to the COVID-19 pandemic.[4] What we found was alarming:

- A quarter of rural hospitals are at a high risk of closing unless their financial situations improve. The 354 at-risk rural hospitals span 40 states and represent more than 222,350 annual discharges, 51,800 employees, and $8.3 billion in total patient revenue (see **Exhibit 1** on the following page).
- Of these hospitals, 81 percent, or 287 hospitals, are considered highly essential to the health and economic well-being of their communities (see **Exhibit 2** on the following page).

We then analyzed the migration patterns of residents who live in rural counties in six states and found that 76 percent of patients with a local hospital outmigrated for care (e.g., bypassed their local area and hospital to receive care elsewhere),

1 The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, "171 Rural Hospital Closures: January 2005–Present (130 since 2010)."

2 Kritee Gujral and Anirban Basu, "Impact of Rural and Urban Hospital Closures on Inpatient Mortality," National Bureau of Economic Research, August 2019.

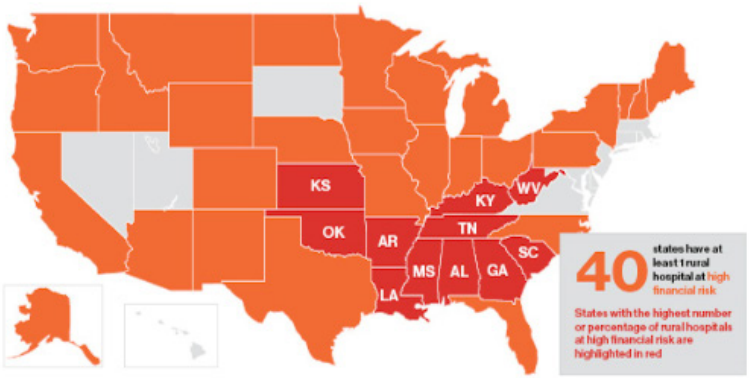
3 George M. Holmes et al., "The Effect of Rural Hospital Closures on Community Economic Health," Health Services Research, April 2006.

4 David Mosley and Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents*, Navigant, February 2019.

Exhibit 1: Rural Hospital Financial Risk

The Number And Percentage Of Rural Hospitals At High Risk Of Closing*

25% of U.S. rural hospitals are at a high risk of closing unless their financial situations improve



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

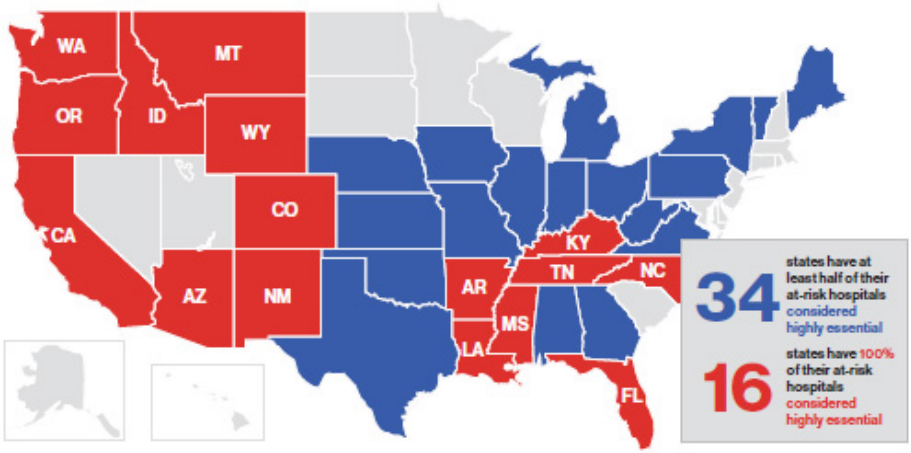
State	Rural Hospitals At High Risk	% of Rural Hospitals At High Risk
TN	19	68%
AL	18	60%
OK	28	60%
AR	18	53%
MS	25	50%
WV	9	50%
SC	4	44%
GA	14	41%
KY	18	40%
LA	11	37%
KS	26	31%

guidehouse.com

Exhibit 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, **81% are considered highly essential to their communities**



State	Highly Essential At-Risk Rural Hospitals	% of Highly Essential At-Risk Rural Hospitals
MS	25	100%
TN	19	100%
AR	18	100%
KY	18	100%
LA	11	100%
MT	7	100%
CA	6	100%
NC	6	100%
WA	5	100%
CO	4	100%
ID	4	100%
OR	4	100%
NM	3	100%
WY	3	100%
FL	2	100%
AZ	1	100%

compared to 35 percent and 23 percent of suburban and urban patients, respectively (see **Exhibit 3** on the following page).

As more complex care often can't be provided at community hospitals, we also divided rural outmigration data into three levels based on patient acuity (see **Exhibit 4** on the following page). While rural hospitals should be able to keep most lower-acuity cases for which the hospital provides associated services, 68 percent of patients still outmigrated for this level of care. Every patient that outmigrates for care that's also offered in their community represents a revenue loss for the local hospital, as well as revenue leaving the local economy.

Another factor contributing to the rural hospital crisis is the loss of agricultural and manufacturing jobs and 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 percent of gross patient revenue.[5] The exception to this is critical access hospitals (CAHs), which are paid cost-plus for Medicare fee-for-service patients. In some states, CAHs are paid cost-plus by managed Medicaid plans as well.

Additional reasons for the rural hospital crisis include an inability to leverage technology due to a lack of capital, clinician shortages, and suboptimal revenue cycle management.

> While there is no one-size-fits-all solution for the rural hospital crisis, opportunities do exist to transform rural healthcare.

Legislative Action, Collaboration, and Transformation Needed

The fact that these rural hospital struggles occurred during the longest period of uninterrupted economic growth in American history was already troubling.[6] A major crisis like the COVID-19 pandemic or any significant economic downturn makes the situation even more dire. While there is no one-size-fits-all solution for the rural hospital crisis, opportunities do exist to transform rural healthcare.

Advance Legislation

The coronavirus has shown the power of state-level responses to healthcare issues, and there are steps that governors can take now to overcome the lack of federal action.

Reintroduced in 2017 by senators Chuck Grassley (R-Iowa), Amy Klobuchar (D-Minn.), and Cory Gardner (R-Colo.), the Rural Emergency Acute Care Hospital (REACH) Act was meant to help CAHs by allowing them to transform their delivery model in alignment with the needs of their community, without the financial disincentive of losing cost-plus reimbursement.[7] The bipartisan legislation would create a new Medicare classification under which CAHs would be able to rid themselves of excess inpatient beds and focus on outpatient services instead. The REACH Act has been read in, but it has not been voted upon by the appropriate committee.

While waiting for federal legislation, providers can collaborate with their state legislators to develop state-based Medicare demonstration waivers to change local and regional rules regarding inpatient beds and emergency designation. This could promote regional stabilization and an opportunity to pilot novel approaches to rural healthcare.

Strategic and Operational Collaboration and Transformation

Independent and health system-owned rural and CAHs have opportunities to transform their business models to drive financial viability. The challenges vary by hospital, but independent rural and CAHs may benefit from accessing scale through partnerships with regional tertiary and academic health systems, other rural facilities, physician groups, payers, accountable care organizations, and other entities. Areas of collaboration can include:

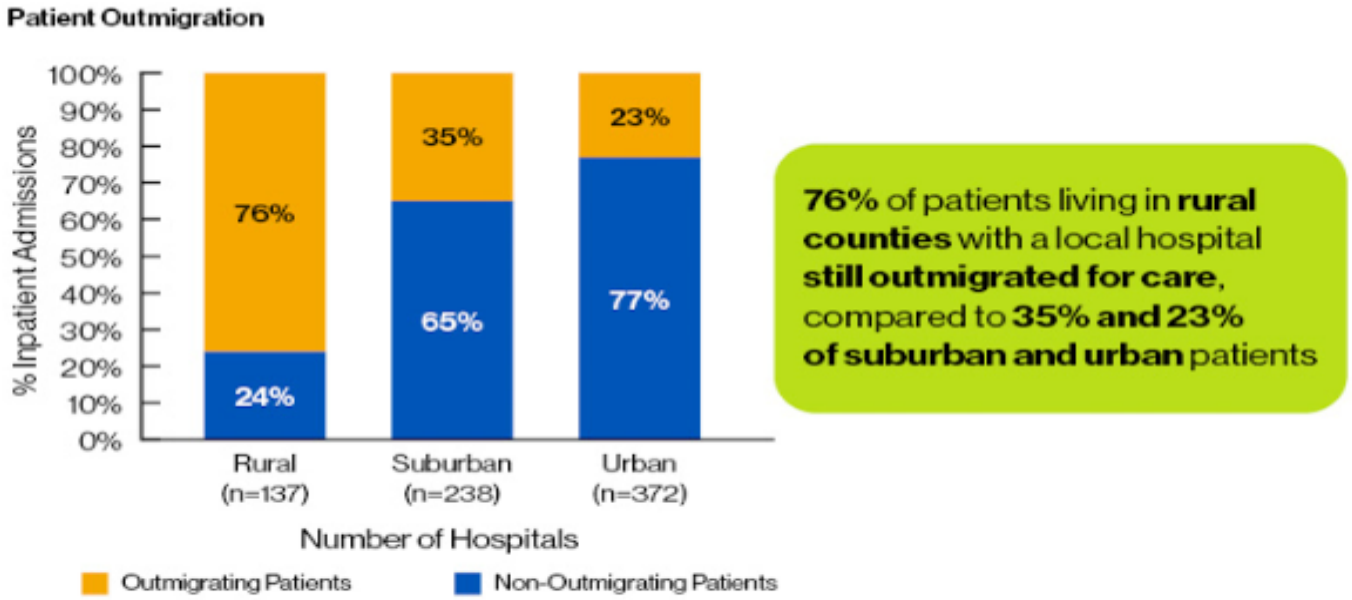
- Telehealth

5 United States Government Accountability Office, Report to Congressional Requesters, *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, August 2018.

6 Matt Egan, "The Longest Bull Market...and Longest Expansion in History Are in Danger," CNN Business, March 11, 2020.

7 "Grassley, Klobuchar, Gardner Introduce Legislation to Help Rural Hospitals Stay Open, Focus on Emergency Room Care, Outpatient Services," May 16, 2017.

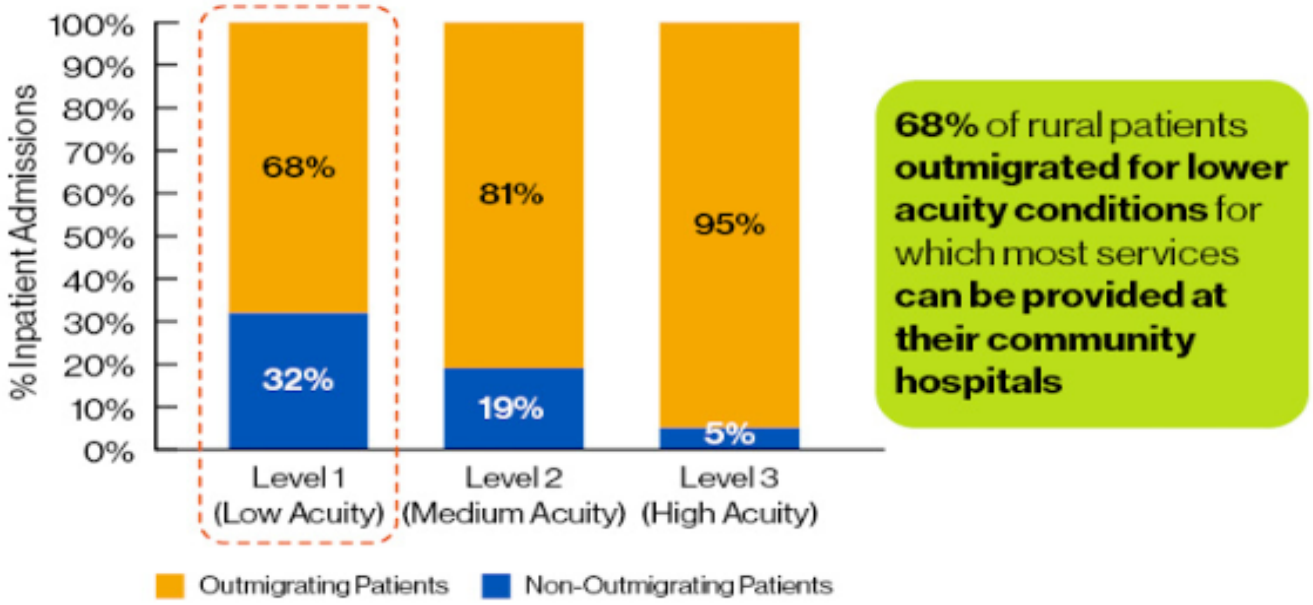
Exhibit 3: Patient Outmigration Trends



Analysis of Colorado, Florida, North Carolina, Oregon, Pennsylvania, and Washington.

guidehouse.com

Exhibit 4: Rural Patient Outmigration by Acuity Level



Analysis of Colorado, Florida, North Carolina, Oregon, Pennsylvania, and Washington.

guidehouse.com

- Back-office functionality (revenue cycle, human capital, finance, EHR use)
- Physician training
- Clinical/service line optimization

Through these partnerships, rural hospitals can leverage the resources and capabilities of their larger peers.

A review of opportunities specific to system-owned rural hospitals and CAHs may yield opportunities to improve the financial position of both the rural hospital/CAH and the system. Strategic opportunities extend across all types of facilities and include partnering with larger facilities or telehealth providers to extend access to care, grow service lines, and engage in value-based care.

For example, many rural providers are using second-tier EHR solutions or are considering replacement of their current EHR due to support sunset or a lack of contemporary functionality. This is a capital-intensive endeavor and one where partnership with a larger health system can "extend" their instance of the EHR to the rural facility with decreased total cost of ownership as a viable solution. This provides a "sticky" relationship with the larger health system, streamlined communication, and referral support, and could serve as the foundation for extension of clinical services (specialty expertise) to the rural facility to allow care to remain local.

Community Engagement

Hospital leadership should engage their board members and local community leaders to identify opportunities to promote and sustain their local hospital and retain outmigrating patients. Local economic leaders and employers must assist in this process since every rural patient that outmigrates for a service offered in their community hospital represents medical spend leaving the community. This level of active engagement may provide specific information to guide the transformation of the hospitals and their services toward models that are economically sustainable due to alignment with community needs, expectations, and support.

Rural hospitals and their communities are facing a crisis that can't be ignored, one that could significantly worsen with a pandemic like COVID-19 or a downturn in the economy. Political leaders and hospital administrators must act to protect the well-being of rural hospitals and communities. Through legislative action, affiliation, and engagement, local hospitals can once again become and remain facilities that their communities can embrace, utilize, and sustain.

The Governance Institute thanks David Mosley, Partner, Daniel DeBehnke, M.D., Partner, Sarah Gaskell, Associate Director, and Alven Weil, Associate Director, Guidehouse, for contributing this article. *They can be reached at david.mosley@guidehouse.com, dan.debehnke@guidehouse.com, sarah.gaskell@guidehouse.com, and alven.weil@guidehouse.com.*