CHARTIS

Rural Health Safety Net Under Renewed Pressures as Pandemic Fades

NRHA POLICY INSTITUTE CONFERENCE

February 2023

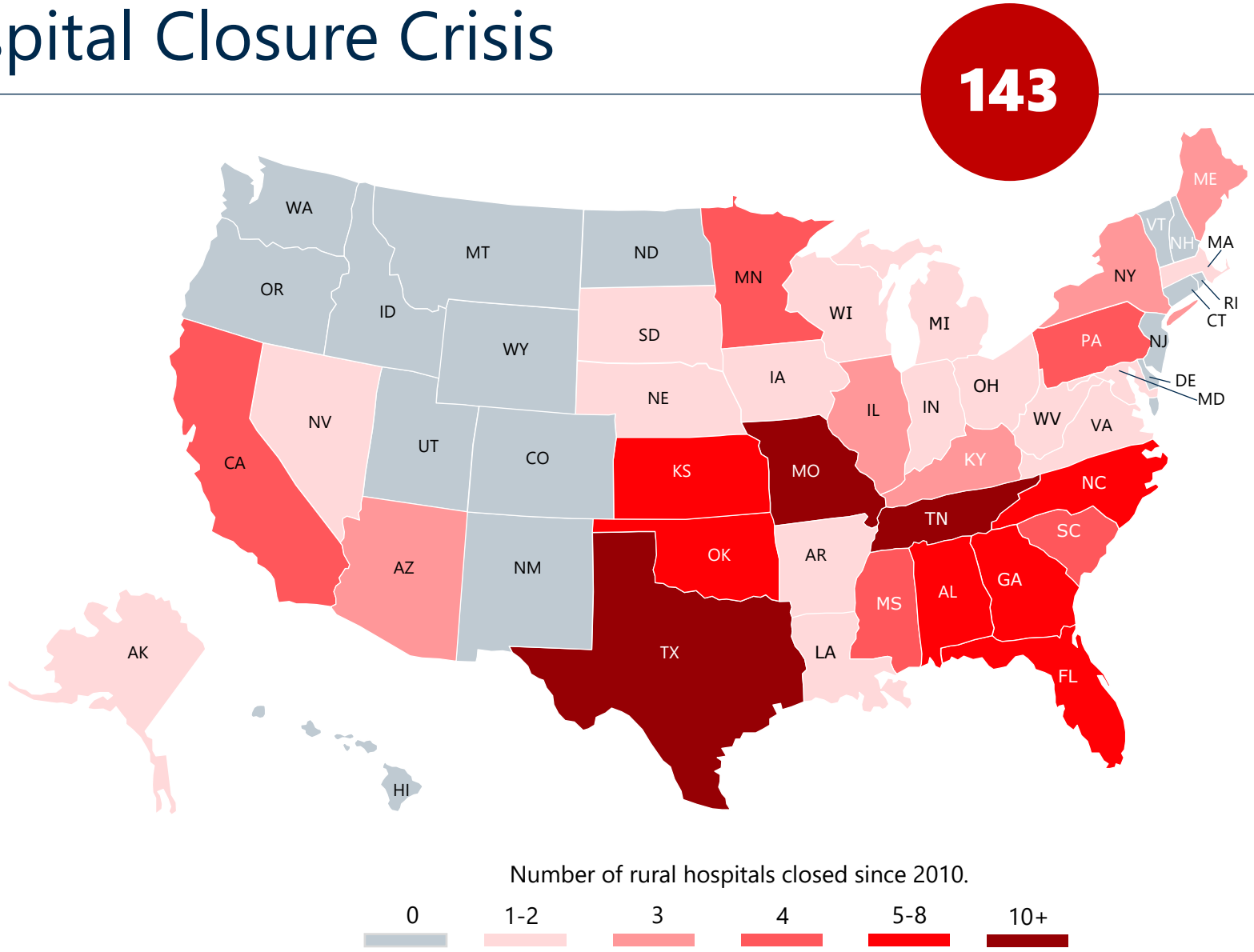
Persistent Pressure Points on Rural Hospitals

America’s Rural Hospital Closure Crisis

Since 2010, **143 rural hospitals have closed** their doors.

Highest number of closures tend to be in **states resisting** (or slow to adopt) **Medicaid Expansion**.

Pandemic relief **eased closure rate** but didn’t address key factors impacting rural hospitals.



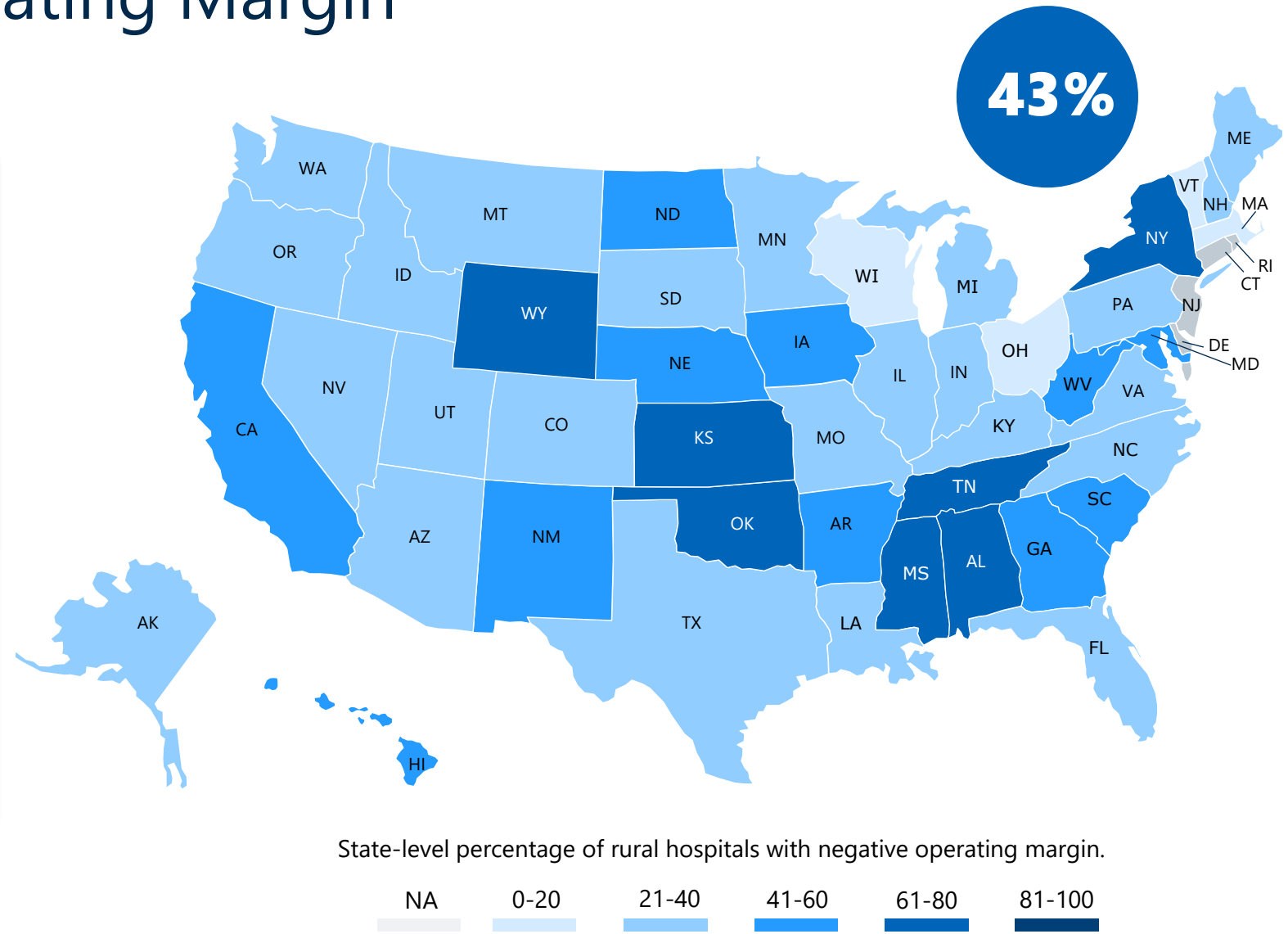
Closure Source: Cecil B. Sheps Center for Health Services Research, 01/17/23.

Rural Hospital Operating Margin

Overall, **43% of America's rural** hospitals are operating in the red.**

Higher utilization and **suspension of sequester** helped **boost** hospital operating margins.

In the **12 non-expansion states**, **51%** of rural hospitals are operating **in the red**.*



Source: The Chartis Center for Rural Health,

*South Dakota counted as a non-expansion state as it has not implemented as of 1/24/23.

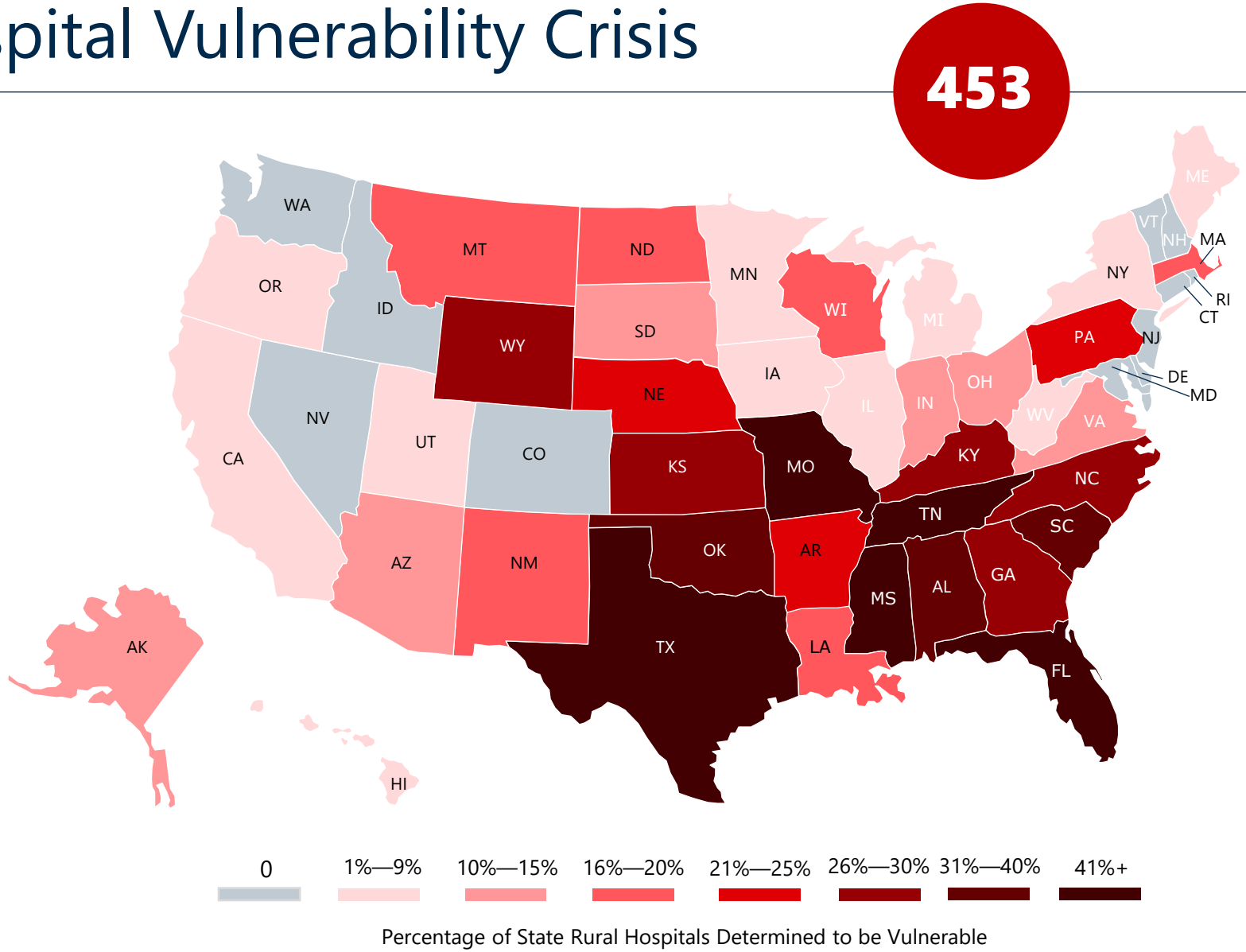
**CMS Healthcare Cost Report Information System (HCRIS) Q4 2022. Operating margin is computed in accordance with Flex Monitoring Team guidance. Outliers are excluded. Hospitals for which data are unavailable are excluded. Reported Covid-19 PHE Funds (Worksheet G-3 line 24,50) excluded from operating margin. Adjustments made to operating margin to reflect full 2% sequester.

America’s Rural Hospital Vulnerability Crisis

453 rural hospitals across America are **vulnerable to closure**.

Highest concentration of vulnerable hospitals in **states resisting Medicaid expansion** (e.g., TX, TN, MS, FL).

States with **most vulnerable** have also experienced **high number of closures** since 2010 (e.g., TX, TN).

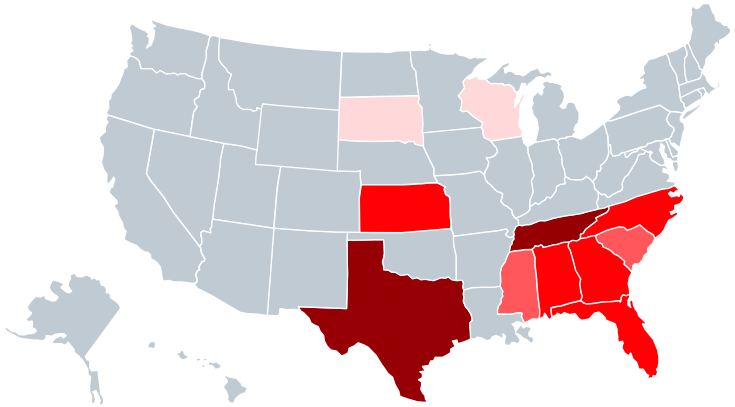


Source: The Chartis Center for Rural Health,

The Safety Net at Its Weakest

States yet to adopt or implement Medicaid Expansion

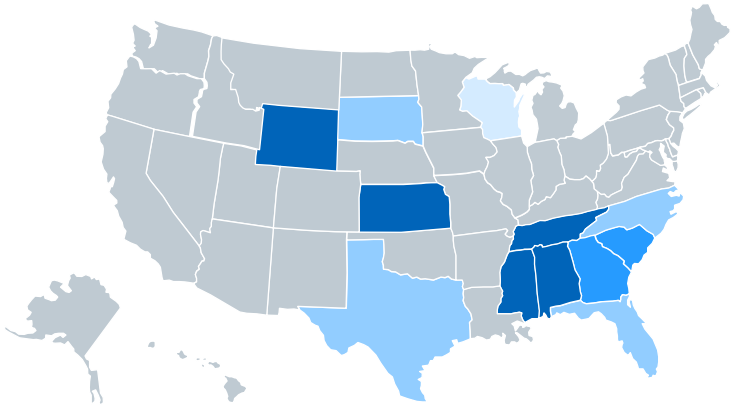
Hospital Closures



81 closures since 2010

Texas – 21
Tennessee – 17

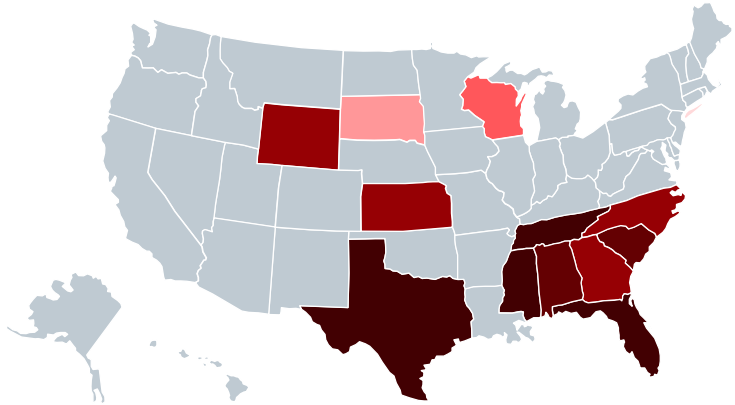
Operating Margin



51% of rural hospitals in the red

Kansas – 79%
Wyoming – 78%

Vulnerability



254 hospitals vulnerable to closure

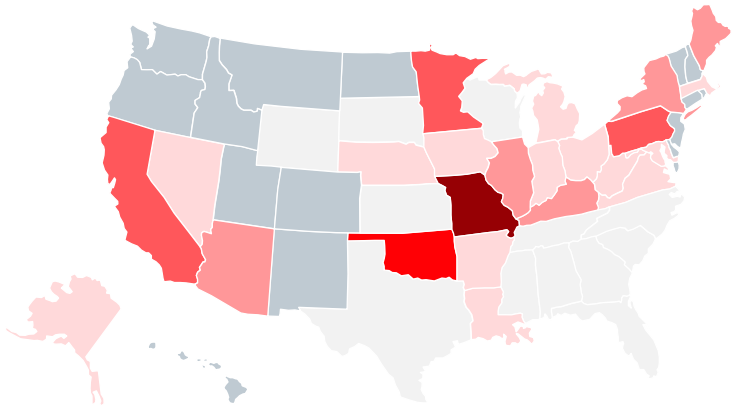
Tennessee – 53%
Florida, Texas – 50%

Source: The Chartis Center for Rural Health, See slides 3, 4, and 5 for map legend pertaining to hospital closures, operating margin and vulnerability.

Where the Safety Net is Stronger

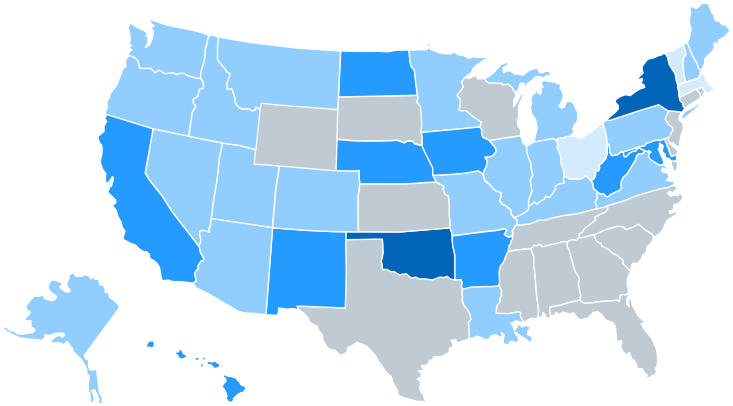
Medicaid Expansion States

Hospital Closures



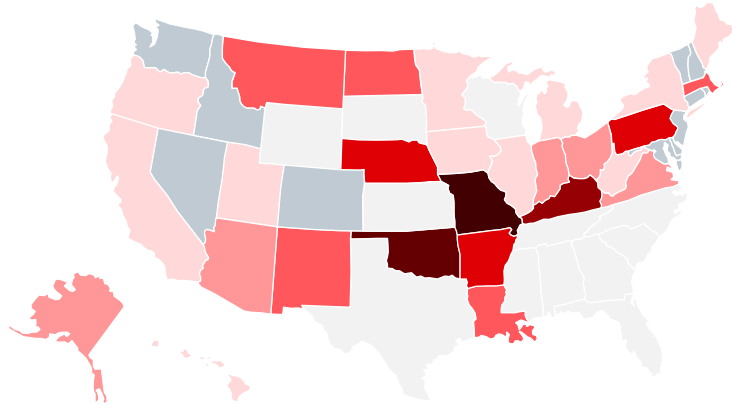
60 closures since 2010

Operating Margin



39% of rural hospitals in the red

Vulnerability



199 hospitals vulnerable to closure

In Medicaid Expansion states, the median operating margin is **2.6%** compared to just **-0.5%** in states that have not yet adopted or implemented expansion.

Source: The Chartis Center for Rural Health, See slides 3, 4, and 5 for map legend pertaining to hospital closures, operating margin and vulnerability.

RURAL HEALTH SAFETY NET UNDER RENEWED PRESSURE AS PANDEMIC FADES

Access and Staffing Crises

Diminishing Access to Care in Rural America

"A Very Dangerous Place to Be Pregnant is Getting Even Scarier."

Businessweek
August 4, 2022

Obstetrics

217

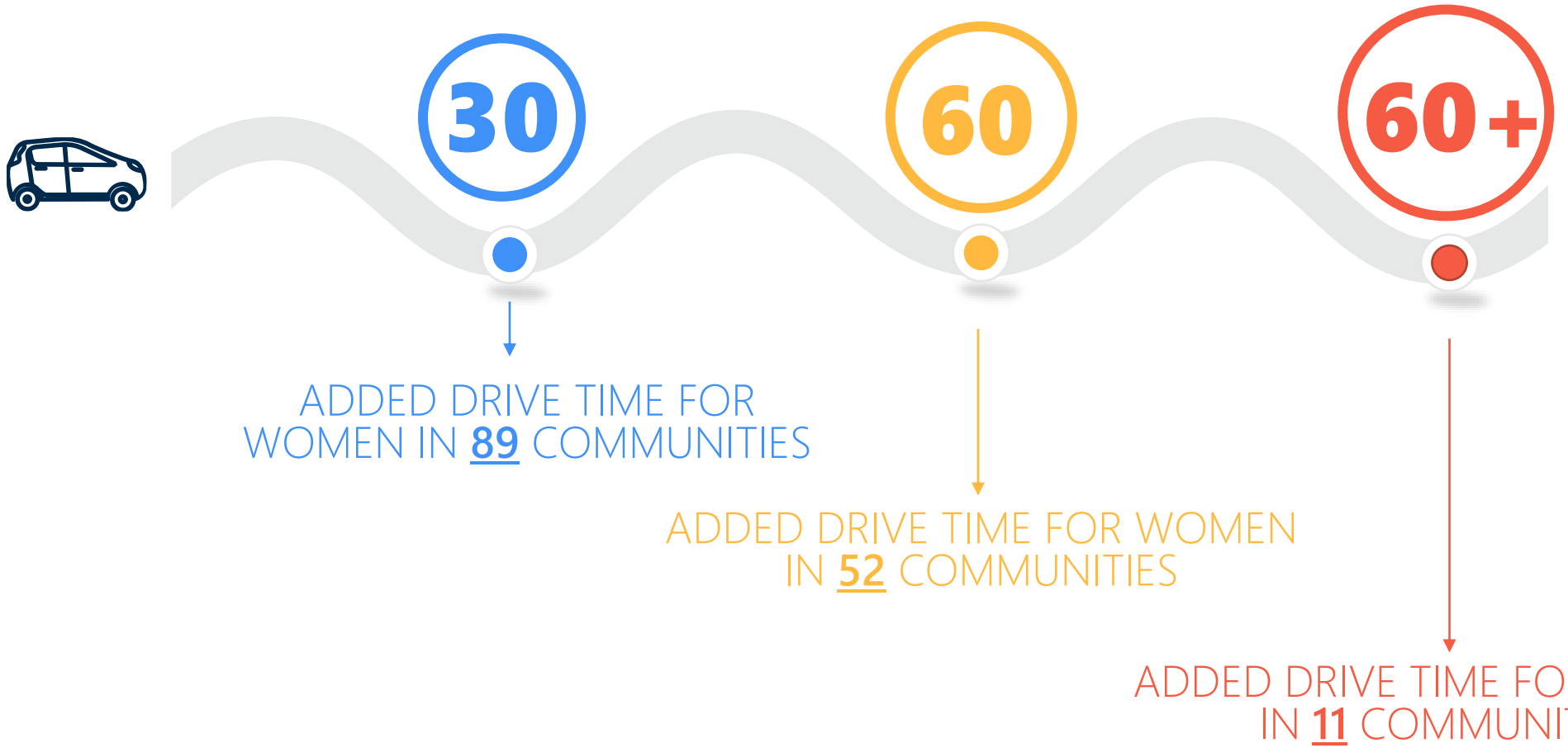
RURAL HOSPITALS STOPPED PROVIDING OB. (2011-2020)

Chemotherapy

353

RURAL HOSPITALS STOPPED PROVIDING CHEMO. (2014-2021)

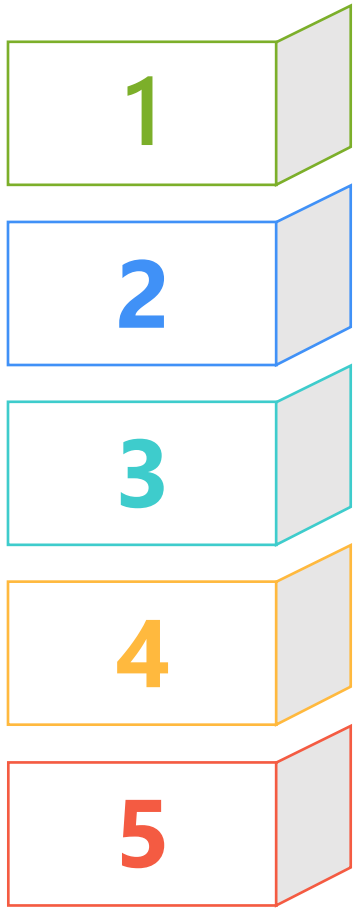
More Time in the Car to Receive Care



Source: The Chartis Center for Rural Health, 2019

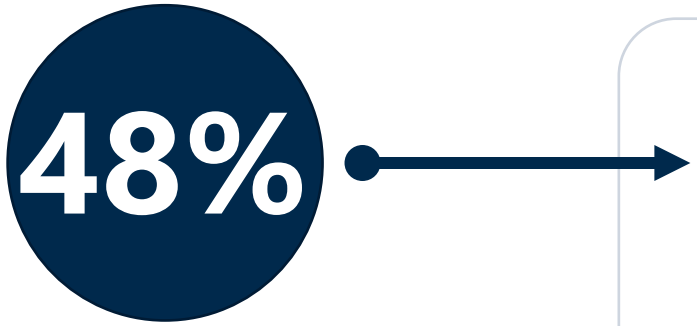
Peeling Back the Layers of the Staffing Crisis

Key Take-Aways from 3 Surveys to Rural Hospital Leaders between Spring 2021 and Spring 2022.



- While some rural hospital staff remain unvaccinated, vaccination exemptions likely helped ease mandate-related staff departures
- Rural hospitals are racing to fill multiple nursing positions as nurses depart in droves.
- Staffing shortages continue to chip away at access to care in already vulnerable rural communities.
- Nursing departure decisions are driven less by pandemic-related issues and more by attractive financial opportunities with staffing agencies.
- Sign-on bonuses and other recruiting incentives—while widely used by rural hospitals—have had little impact on easing the staffing crisis.

What's the #1 Reason Behind Nursing Departures?



1. More financially lucrative opportunities at **staffing agency**
2. More financially lucrative opportunities at another hospital
3. Pandemic Burn Out
4. Retirement
5. Unwillingness to comply with vaccine mandate
6. Other

*Survey conducted March 2, 2022 – April 15, 2022.

Lack of Nurse Staffing Chips Away at Access to Care

1

Number of Open Bedside Nurse Positions

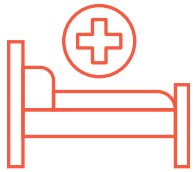
56% have 1 to 5 open positions
16% have 6 to 10

V-26

2

Patient Admissions

36% said staffing issues prevented patients from being admitted in last 60 days



3

Suspension of Services

17% said staffing issues resulted in suspension of services

RURAL HEALTH SAFETY NET UNDER RENEWED PRESSURE AS PANDEMIC FADES

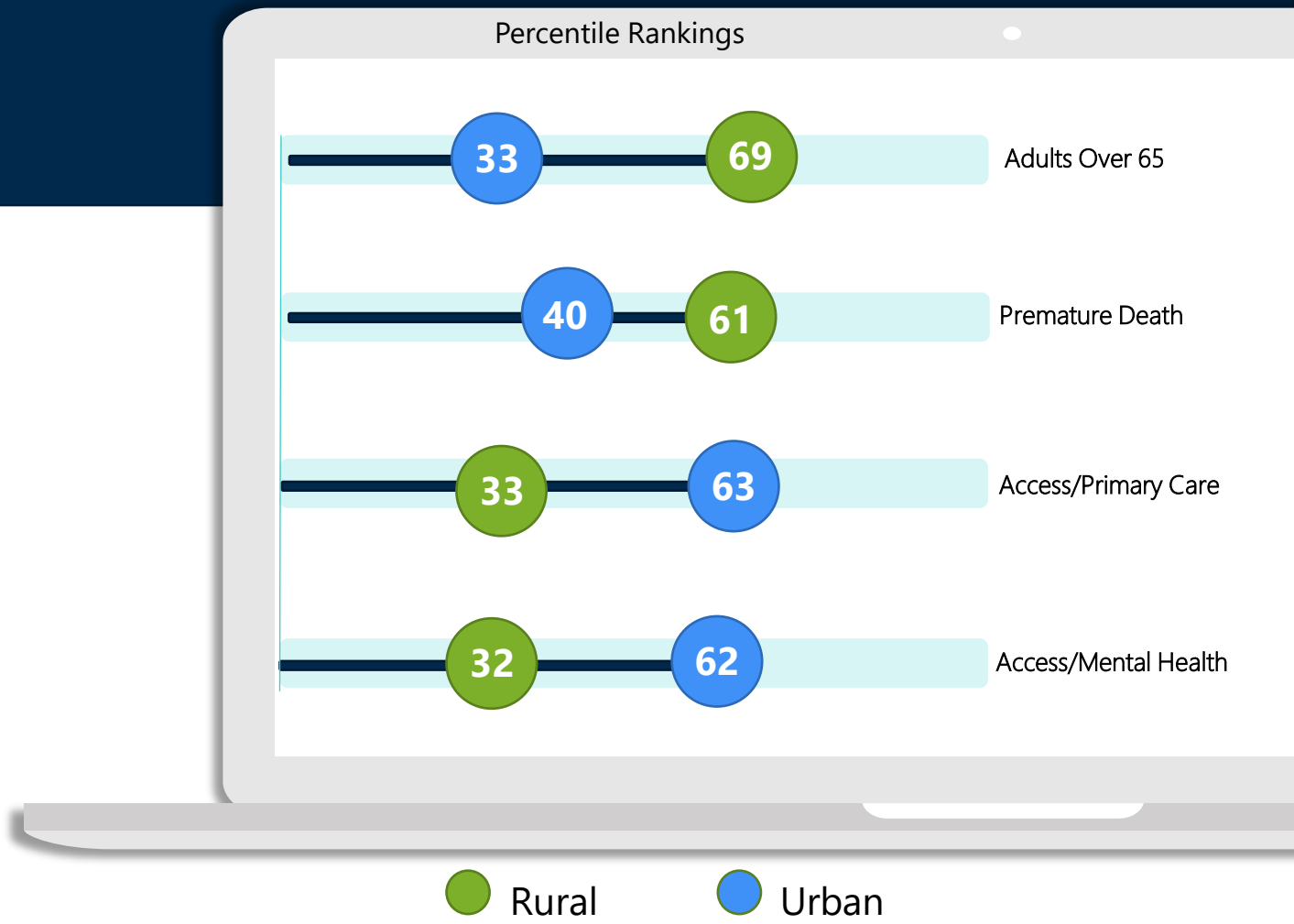
Population Health Disparities

The Rural / Urban Divide

Health Disparities **widen** during Pandemic

Rural populations are older, poorer, sicker, have less access to care and suffer worse outcomes than their more urban peers.

Increasingly…



Surge in rural "Deaths of Despair" during Pandemic

"Rates for the top 10 causes of death in 2019 (including heart disease, cancer and accidents) were [all higher in rural areas](#)."

"Geographical setting a key driver of Death of Despair trends, with rural areas exhibiting the worst despair-related mortality outcomes."

1 **Opioid Overdose**

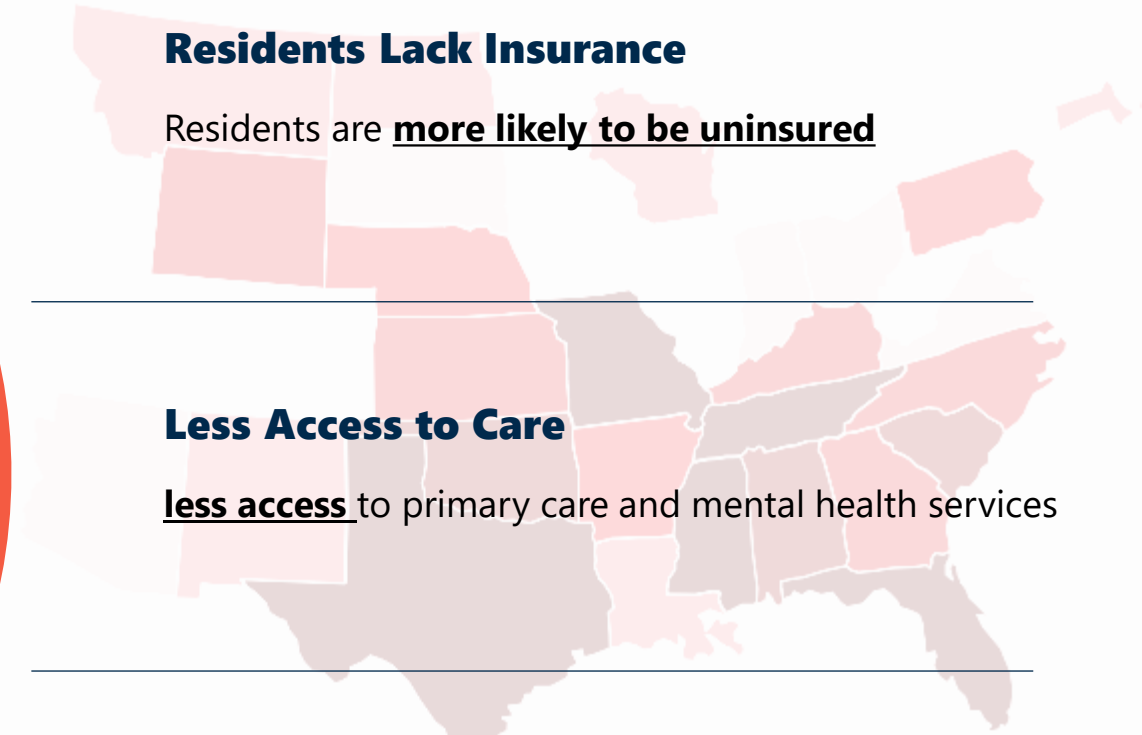
2 **Alcohol Deaths**

3 **Veterans Suicide**

4 **Suicide**

“Vulnerable to Closure” Rural Communities vs. *Rural* Baseline

Where the safety net is weakest, residents are more disadvantaged.



Residents Lack Insurance

Residents are **more likely to be uninsured**

Less Access to Care

less access to primary care and mental health services

Greater Likelihood of Premature Death

Residents are **more likely to die** prematurely

453

Communities with the greatest health disparities & greatest need are most at risk of losing their hospital

RURAL HEALTH SAFETY NET UNDER RENEWED PRESSURE AS PANDEMIC FADES

Relief: The Rural Emergency Hospital (REH) Designation

Rural Emergency Hospital Designation (REH)

What this designation is:

- An opportunity for hospitals that struggle with low patient volume to strengthen their financial footing, avert closure and continue to provide some services to their community as a **"Rural Emergency Hospital."**

What this designation is NOT:

- A large-scale legislative solution addressing the widespread instability that has spread across the rural health safety net in the last 12 years.

Early REH Reaction: Driven by Circumstance

Sturgis Hospital works toward transition to rural emergency facility

Dan Cherry Special to the Journal
Published 6:04 a.m. ET Sept. 7, 2022

Modern Healthcare

August 25, 2022 06:00 AM

New rural hospital model draws interest - and questions

ALEX KACIK MAYA GOLDMAN

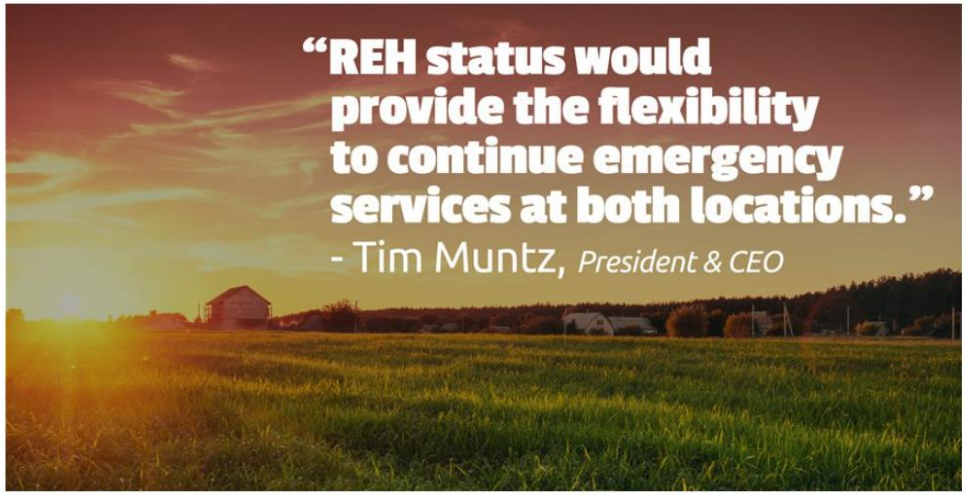
POLITICO

Rural hospitals plan to reject Congress' program

By **DANIEL PAYNE** and **KRISTA MAHR** | 10/27/2022 10:00 AM EDT

St. Margaret's Health
SMP Health

A Message to the Community



REH Fundamentals: Service Requirements

Mandatory Services

- Emergency, Observation

Optional Services

- Outpatient, Distinct Part Skilled Nursing Unit, Rural Clinic, Ambulance Service

Excluded

- Acute inpatient (no swing beds), Participation in 340B

REH Conversion Requirements

- Maintain Emergency Department, Observation and other services
- Meet CAH equivalent CoPs for Emergency Care
- Patient LOS 24 hours or less
- Level 1/Level 2 Trauma Center Transfer Agreement
- Meet Licensing Requirements and Report Quality Data
- **No inpatient care, No Swings Beds, No 340B**

REH Fundamentals: Payment Structure

Fixed monthly payment ($3.2M for 2023)

OPPS rates +5% for outpatient services

Applicable payment rate for services not paid under OPPS

Evaluating REH conversions

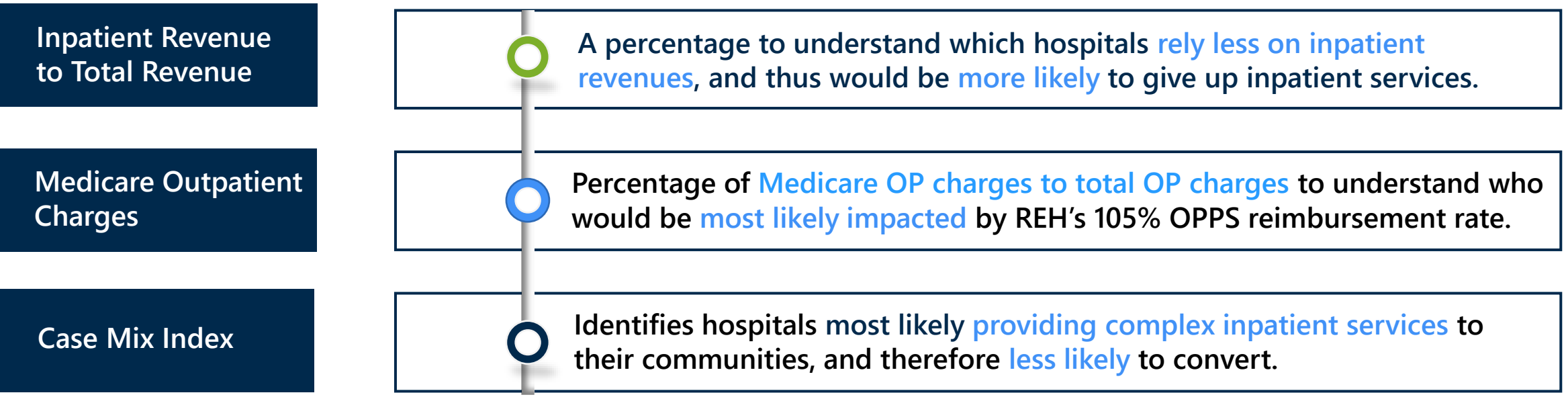
Which hospitals would likely consider converting to REH?

*Out of **1,557 eligible hospitals** stratify on a scale of 1 to 100.*

REH Model Indicators

Years Negative Operating Margin	A 3-year look back to determine which facilities have shown sustained unprofitability, and therefore likely to benefit most from REH payments.
Net Patient Revenue	Measuring incoming revenue to determine facilities with lower NPR would be more likely to convert for the financial benefits.
Average Daily Census (Acute)	Since REH requires hospitals to drop acute, inpatient care facilities with higher utilization would be less likely to convert.
Average Daily Census (Swing/SNF)	CAHs with high swing/SNF utilization would not be likely to convert as this would be a necessary service to provide to the community.

REH Model Indicators



Our REH Index percentile ranks a hospital's performance for each indicator. We then percentile rank the sum of all 7 measures to arrive at an overall facility score. All measures are equally weighted.

Evaluating REH Conversion: 1,557 Eligible Rural Hospitals

Which rural hospitals would likely consider converting to REH?

- 390 hospitals (271 CAH/119 RPPS)
- 389 hospitals (337 CAH/52 RPPS)
- 389 hospitals (356 CAH/33 RPPS)
- **389 hospitals (374 CAH/15 RPPS)**

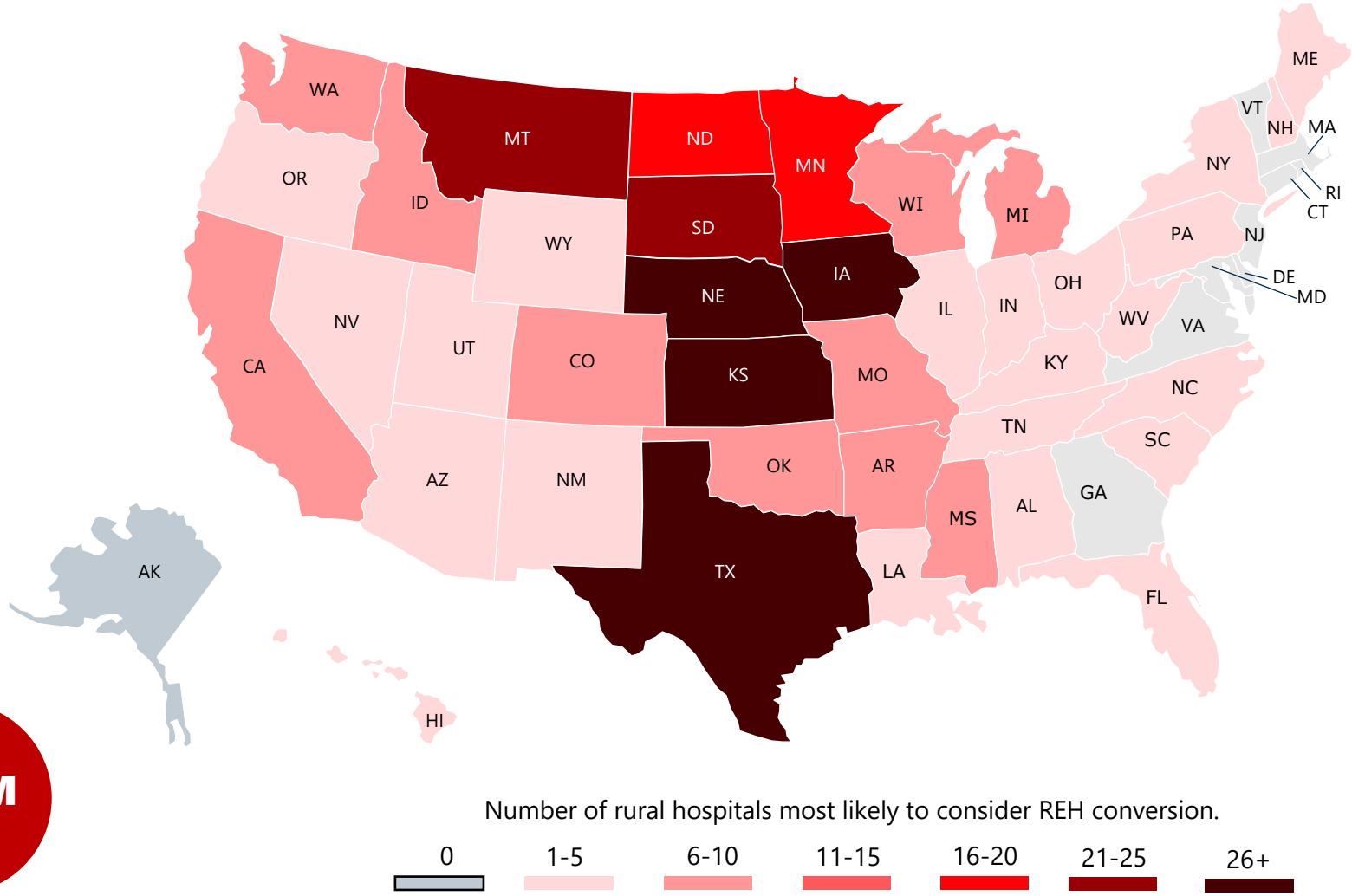
Quartile 1: Most Likely to consider REH Conversion

Model identified **389 rural hospitals most likely to consider conversion**. Nearly every state is represented.

Highest concentration of most likely candidates for conversion runs from Texas up to the Dakotas.

Median years in the red is 2 and median NPR is $11.6M.

~$26M



Beyond the data:

Key Considerations for REH Conversion

340B participation: Given the benefits associated with the 340B program, converting to REH **may not offset the loss of savings/reimbursement**

System Affiliation: For CAHs affiliated with health systems conversion means the loss of corporate allocations and **cost-based reimbursement from Medicare.**

Government Control Status: Facility ownership by a government entity (e.g., county) **may create an added layer of tax/financial and political complexity.**

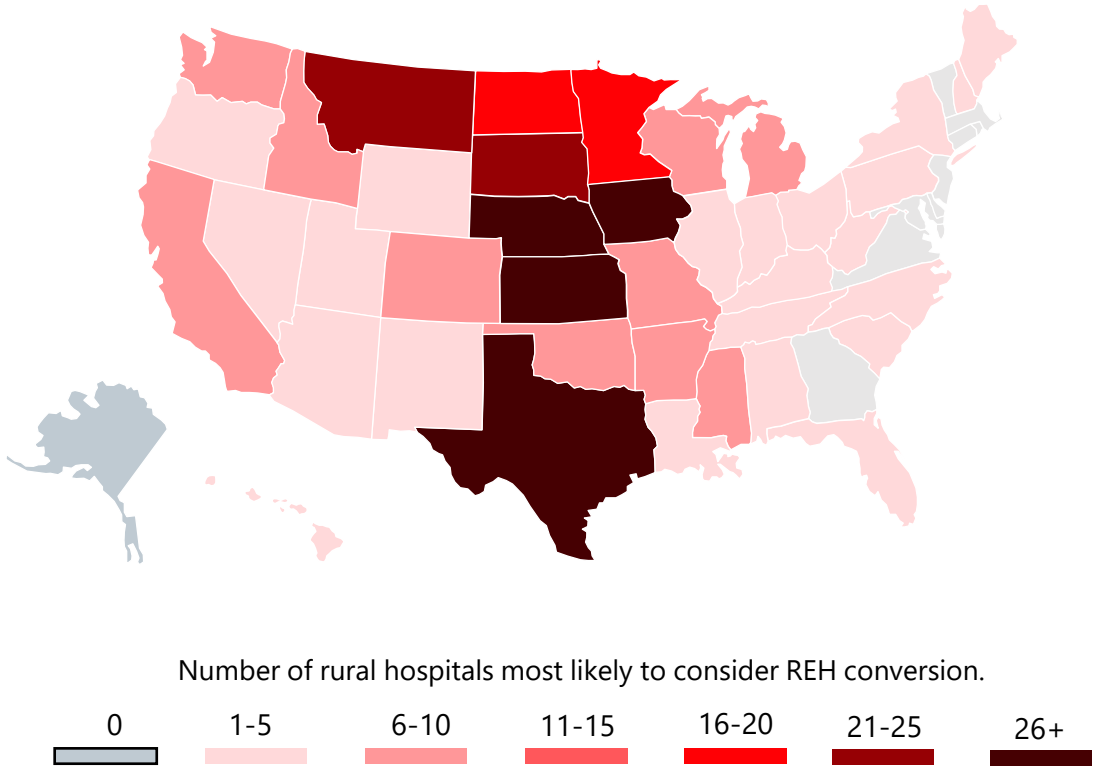
Beyond the data:

Key Considerations for REH Conversion

- **Hospital Staff Perspective:** Medical staff and other key stakeholders will have to "buy in" to new status and **loss of inpatient services and supporting ancillaries**.
- **Community Relations:** Even if government control status isn't applicable, communities **may react negatively** – and vocally – to the idea of losing their hospital, access to inpatient services and the loss of jobs.
- **Safety and Quality Standards:** Conversion and the expected adjustments in staff and processes may impact safety and quality programs **with new requirements**.
- **Staff Retention and Recruitment:** Although conversion may keep the hospital open, the loss of inpatient services means the **potential loss of nurses**.

Quartile 1: Median Characteristics

Metric	Quartile 1	REH Eligible
Total Number	389	1,557
Number Critical Access	374	1,338
Years Negative Operating Margin	2	0
Net Patient Revenue	$11.6M	$24.3M
Average Daily Census (Acute)	1	3
Average Daily Census (Swing/SNF)	1	2
Inpatient Revenue to Total Revenue	17%	19%
Percentage of Medicare OP Charges	40%	30%
Case Mix Index	1.07	1.20
System Affiliated	178	881
Corporate Allocation	$1.1M	$2.9M
340B Program Participation	321	1,257



Looking Across the Model's Four Quartiles

1,557 eligible rural hospitals

	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
Years Neg. Operating Margin (median)	2	1	0	0
Net Patient Revenue (median)	$11.6M	$20.9M	$31.3M	$57.3M
Average Daily Census-Acute (median)	1	2	4	9
Average Daily Census-Swing (median)	1	2	2	2
System Affiliated	46%	54%	57%	68%
Corporate Allocation (median)	$1.1M	$2.5M	$3.1M	$6.7M
340B Participant	83%	82%	82%	78%

Does One Size Fit All with Conversion?

First Quartile
Most likely to consider conversion

	Hospital A	Hospital B
Years Negative Operating Margin	3	3
Net Patient Revenue	$5.7 M	$35 M
Average Daily Census-Acute	0	3
Average Daily Census-Swing	1	1
System Affiliated	N	Y
Corporate Allocation	NA	$9.1M
340B Participant	N	Y

How Many Ideal Candidates for REH?

77

Within 1st quartile, those at the bottom (0-4th %ile) are ***ideal candidates*** for REH conversion

Ideal Candidate Characteristics

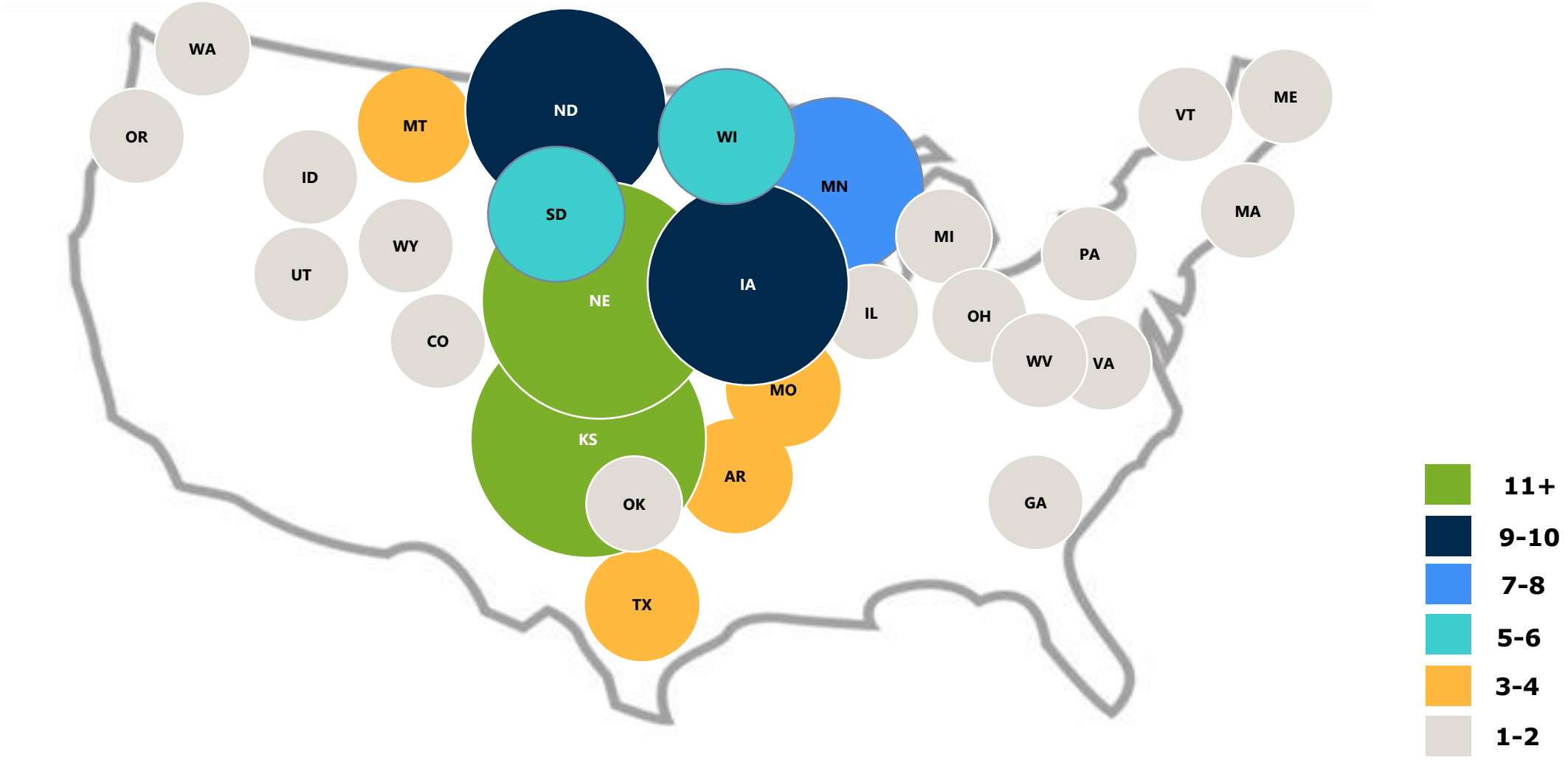
Metric	0-4th %ile
Total Number	77
Number Critical Access	77
Years Negative Operating Margin	3
Net Patient Revenue	$7.9M
Average Daily Census (Acute)	1
Average Daily Census (Swing/SNF)	1
Inpatient Revenue to Total Revenue	14%
Percentage of Medicare OP Charges	44%
Case Mix Index	1
System Affiliated	32
Corporate Allocation	$697K
340B Program Participation	59

The smallest facilities with low patient volumes and mired in unprofitability.

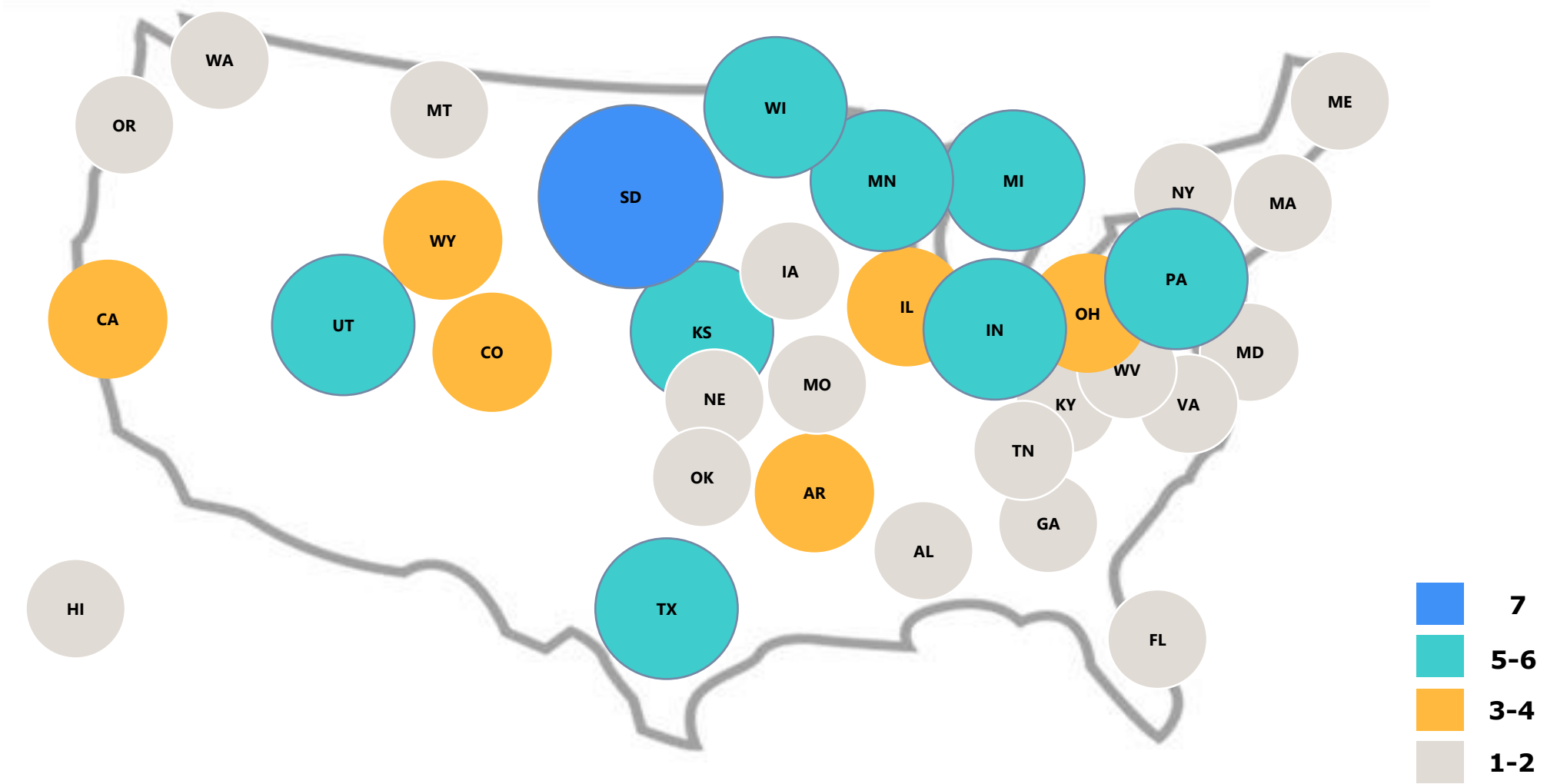
RURAL HEALTH SAFETY NET UNDER RENEWED PRESSURE AS PANDEMIC FADES

2023 Top 100 Rural Providers

2023 Top 100 Critical Access Hospitals

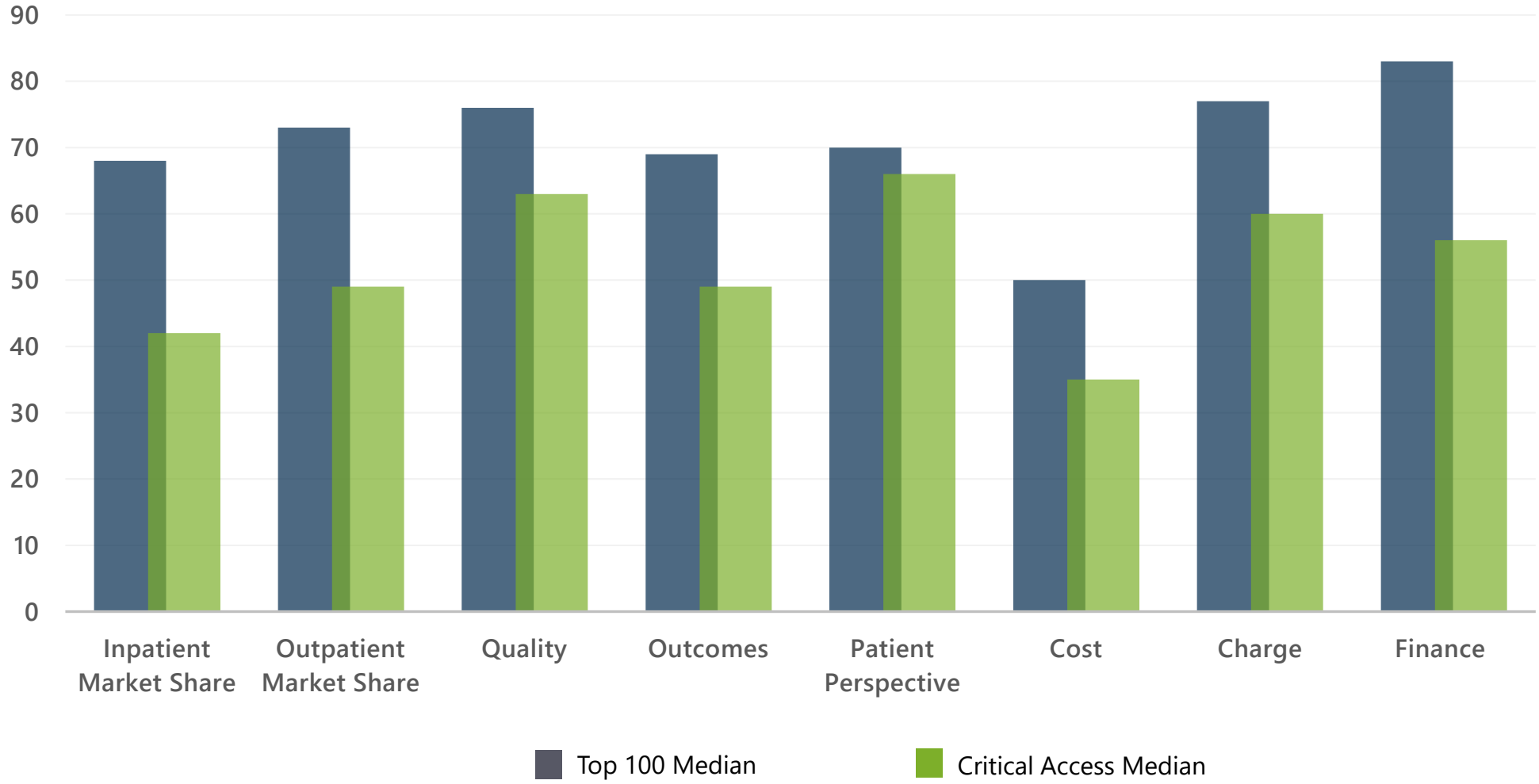


2023 Top 100 Rural & community Hospitals



Characteristics of Top 100 Performance

2023 Top 100 Critical Access Hospitals



Top 100 Performance – All Time – by the Numbers

421

Total number of CAHs recognized since 2011.

12

HOSPITALS HONORED 10 OR MORE TIMES.

States with the most Top 100 Critical Access Hospitals

IA 45

KS 38

States with the most Top 100 Rural & Community Hospitals

MI 17

WI 14

246

Total number of RPPS recognized since 2016.

29

HOSPITALS HONORED 7 OR MORE TIMES.

From one year to the next, roughly *20% of the Top 100 are first time award winners*

POLICY INSTITUTE CONFERENCE

Attendee Advocacy Materials

Policy Institute Advocacy: State Data Impact Tables

CHARTIS

Impact of Policies on Rural Communities

Arizona

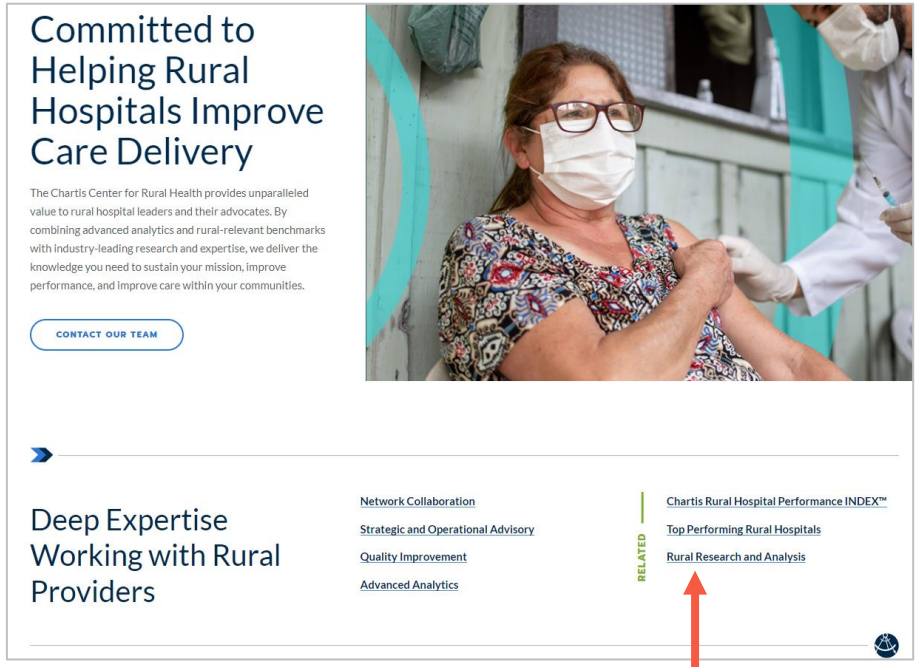
Provider Name/Number	Provider Type	Operating Margin [1]	Sequestration [2] 2% Inpatient and Outpatient Medicare Revenue Cut: Annual Revenue Lost [3]	Sequestration: Potential Job Loss [4]	Sequestration: Potential GDP Loss [5]	Bad Debt Reimbursement Cut [1] 35% Medicare Bad Debt Reimbursement Cut: Annual Revenue Lost [3]	Bad Debt Reimbursement Cut: Potential Job Loss [4]	Bad Debt Reimbursement Cut: Potential GDP Loss [5]
Banner Payson Medical Center (031318)	CAH	8.8%	$208,882	3	$451,076	$83,273	1	$179,826
Benson Hospital (031301)	CAH	25.0%	$120,865	3	$358,575	$70,586	2	$209,410
Chinle Comprehensive Health Care Facility (030084)	RPPS	82158.4%	$254,160	5	$672,154	$0	0	$0
Cobre Valley Regional Medical Center (031314)	CAH	12.2%	$183,398	3	$458,234	$5,769	0	$14,415
Copper Queen Community Hospital (031312)	CAH	19.6%	$61,979	1	$171,765	$62,510	1	$173,237
Holy Cross Hospital (031313)	CAH	27.3%	($38,598)	-1	($78,104)	$128,164	2	$259,346
Hopi Health Care Center (031305)	CAH	38292.4%	$164,237	4	$478,817	$0	0	$0
Hu Hu Kam Memorial Hospital (031308)	CAH	59218.3%	$415,255	12	$1,662,204	$0	0	$0
La Paz Regional Hospital (031317)	CAH	0.3%	$130,566	3	$438,516	$65,755	2	$220,842
Little Colorado Medical Center (031311)	CAH	7.4%	$85,211	2	$218,673	$24,399	0	$62,614
Mt. Graham Regional Medical Center (030068)	RPPS	-5.9%	$256,626	4	$580,737	$28,652	0	$64,839

Operating margin and policy impact data for every rural hospital on a state-by-state basis.

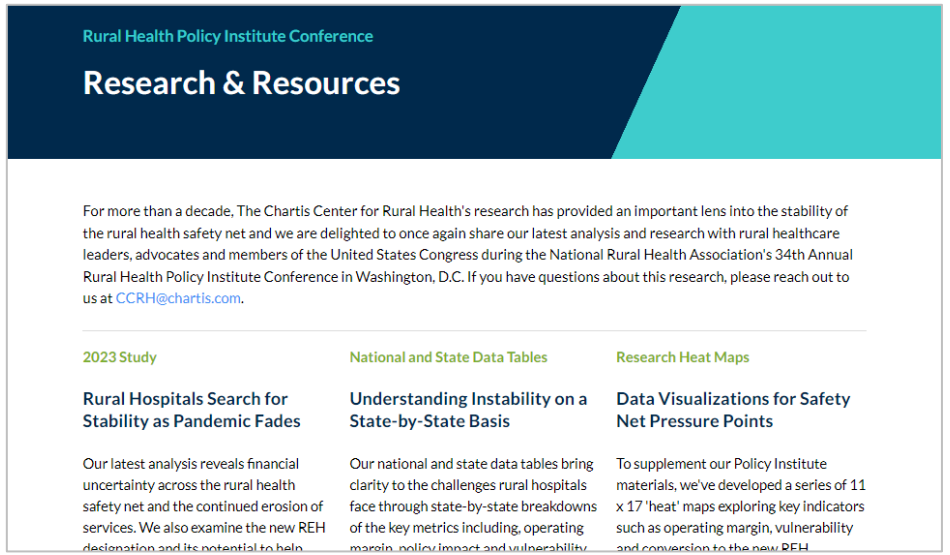
https://www.ruralhealth.us/advocate/chartis-rural-hospital-data

Policy Institute Advocacy: Research and National Data

1 **chartis.com/rural-health**



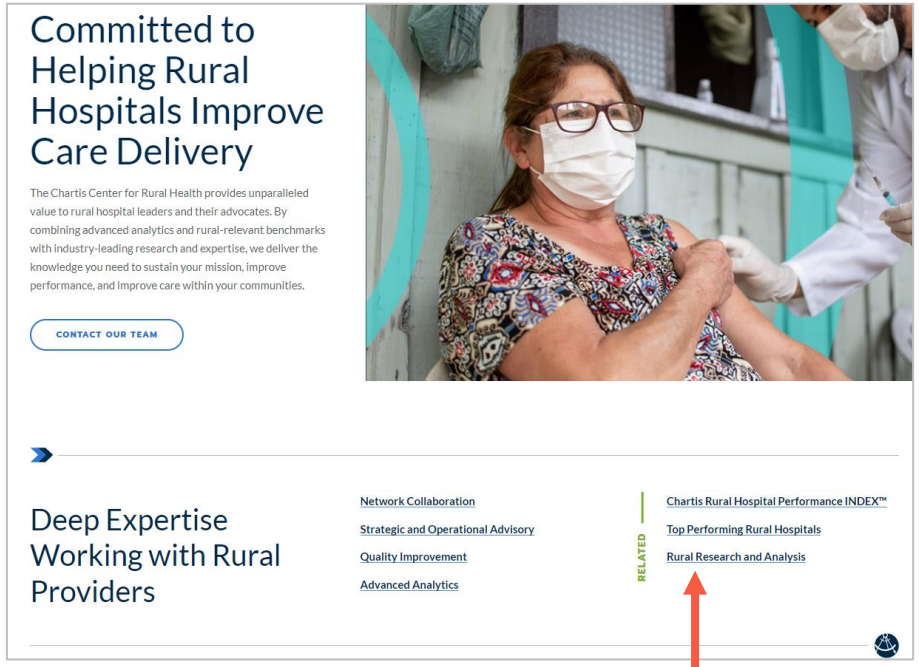
2 **Click: Policy Institute Materials**



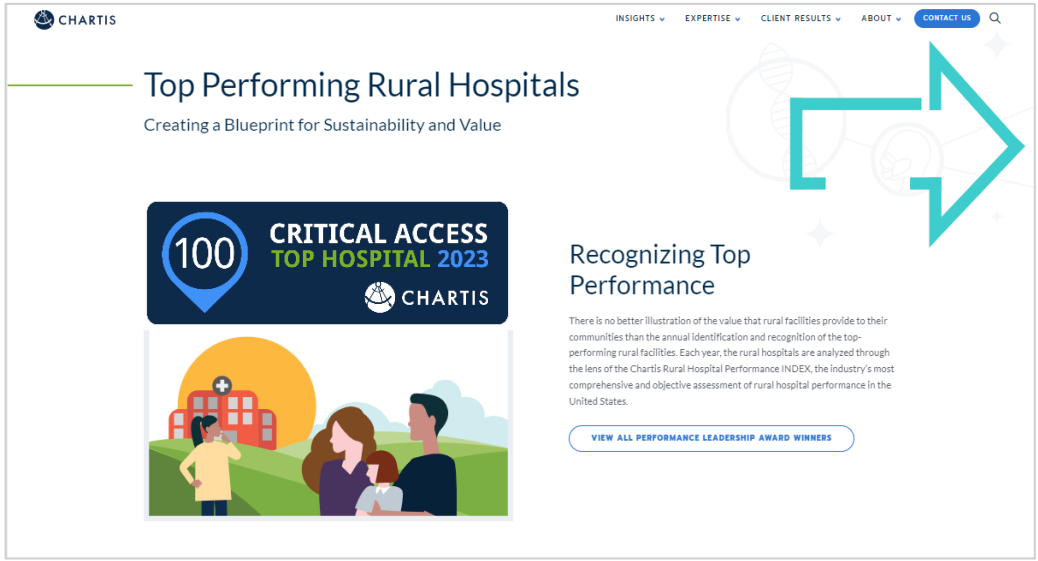
3 **Links to our new study, National Policy Impact Super Table, State Data and more.**

Top 100 Rural Hospital Marketing Materials

1 **chartis.com/rural-health**



2 **Click: Top Performing Rural Hospitals**



3 **Link to the list of award winners, award logo and press release templates.**

Helping Rural Providers Navigate a New Era

Network Collaboration, Strategic Advisory, Quality Improvement and Advanced Analytics

At the Chartis Center for Rural Health, we deliver a rural-relevant framework through which leadership teams and frontline staff can better understand performance and initiate further clinical and financial improvement.

Our expertise and research has been featured in some in some of the nation's leading news outlets.

CHARTIS

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