

Rural Health Safety Net Under Renewed Pressure as Pandemic Fades



CHARTIS

➤ New Rural Emergency Hospital designation will provide relief for most vulnerable rural hospitals, yet concern returns for majority of facilities and their communities

As we move into a post-pandemic era, the long-term stability of the rural health safety net is strained. Pandemic relief fund programs and other safeguards, such as the suspension of the sequester (which helped to prop up rural hospitals financially), have concluded. The efforts on the part of the government to offset the financial impact of the pandemic provided a much-needed respite for rural hospitals struggling to keep facility doors open. It is no coincidence that during the last 2 years of the pandemic that just 9 rural hospitals closed as compared to 19 (a single-year record) in 2020.¹ For rural hospitals, many of the factors coalescing pre-pandemic to erode revenues, such as nursing and staffing shortages, will once again ratchet up the pressure in 2023.

Our research indicates that health disparities are persistent, as are gaps in access to primary and mental health care in rural communities across the nation. Over the course of the last 13 years, 143 rural hospitals closed, and [research conducted by Chartis](#) indicates that another 453 are vulnerable to closure. Issues of access to care, however, are not exclusive to instances of rural hospital closures. Services such as Obstetrics (OB) and Chemotherapy continue to vanish at an alarming rate—and not only due to financial considerations. Our research shows that the nurse staffing shortage continues to influence decisions to admit patients and decisions about whether to suspend specific services.

In 2023, one of the most significant considerations for rural hospital leadership teams will be whether to convert to the new Rural Emergency Hospital (REH) designation. This new, much-anticipated provider type offers a pathway for struggling rural hospitals to avert closure and retain some services (e.g., Emergency Department, outpatient, and clinics) within their communities. Our analysis evaluated approximately 1,600 rural hospitals eligible to convert to REH and stratified the likelihood of REH conversion on a percentile ranking. The model indicates that there are nearly 400 rural hospitals “most likely” to consider conversion. Within this group, the model has identified 77 facilities which are ideal for conversion to REH based on their performance profile. That said, the data also suggests that conversion will be a very nuanced decision, and the combination of conversion requirements (i.e., ceasing inpatient services) and other considerations (i.e., system affiliation, government control status, and participation in the 340B program) will likely result in a relatively small number of conversions that do not necessarily fit the mold. While the number of ideal candidates may be a relatively small number, the possibility of potentially staving off the closure of 77 rural hospitals is not insignificant, given our understanding of how the loss of a facility can ripple across a rural community.

This study builds upon our existing body of research exploring multiple facets of rural healthcare and offers a lens into where the rural health safety net stands as we move firmly into a post-pandemic era. In compiling this study, our analysis revealed the following:

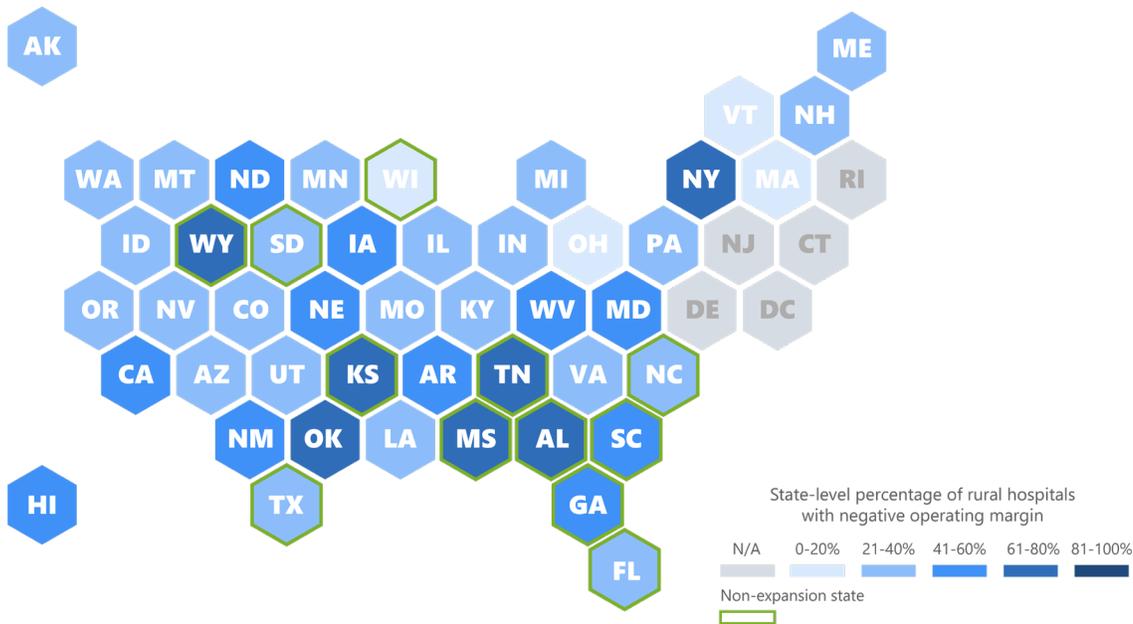
- 01** Overall, 43% of America’s rural hospitals have a negative operating margin, while 51% of facilities located in states that have resisted or not yet implemented Medicaid expansion are in the red. Our analysis of rural hospital financial performance excludes the influence of measures and relief programs designed to ease the financial burden of the pandemic.
- 02** The rate of rural hospital closures was below pre-pandemic levels as pandemic-related relief programs again helped to ease financial pressure. However, more than 3 times as many hospitals closed in 2022 compared to 2021.²
- 03** Conversion requirements and other considerations make it unlikely that the new REH designation will deliver widespread relief to the rural health safety net. Of the 389 rural hospitals “most likely” to consider converting to REH, Chartis’ data model has identified 77 ideal candidates for conversion.
- 04** At a time when rural areas are more susceptible to deaths of despair and higher mortality rates, these communities appear to be falling farther behind their urban counterparts as health disparities and inequity indicators show persistent gaps.
- 05** Nationally, access to care in rural communities is dwindling. The number of rural hospitals eliminating OB increased from 198 to 217, and the number of hospitals ceasing to provide chemotherapy jumped from 311 to 353.
- 06** Nursing departures are forcing hospitals to fill multiple nursing positions. According to our survey data, 56% of respondents have up to 5 open bedside nursing positions, and nearly 20% said staffing shortages are resulting in the suspension of services.

For Nearly 45% of Rural Hospitals—and 51% in Non-Expansion States—Operating Margins Remain Mired in the Red

Prior to the pandemic, we tracked the steady erosion in rural hospital operating margin as the percentage of facilities operating in the red crept toward 50%. The pandemic—through various financial relief programs—boosted hospital bottom lines and created a muddled picture of financial strength. As we did last year in our study, [“Pandemic Increases Pressure on Rural Hospitals and Communities,”](#) we’ve once again excluded pandemic relief funds (PRF) from our analysis of operating margins. For time periods in which the sequester was on pause or reduced to 1%, we ensured that a full 2% reduction of Medicare revenues was reflected to provide a more realistic view of operating margin without public health emergency (PHE) exceptions. Our calculation also estimated Medicare Advantage-related revenues and applied the sequester’s impact. According to our analysis, a full 12 months of sequestration impact will cost rural hospitals more than \$500 million and result in the potential loss of more than 9,000 jobs.

Using this approach, our analysis reveals that 43% of the nation’s rural hospitals are operating in the red. Overall, the median rural hospital operating margin is 1.8%, with facilities in Medicaid expansion states outperforming their peers in non-expansions states on average 2.6% vs. -0.5%. In non-expansion states, more than half (51%) of rural hospitals have negative operating margins, while 39% of rural hospitals in expansion states are in the red. Among the states with the highest percentage of rural hospitals operating in the red are Kansas (79%) and Wyoming (78%). Kansas has the second most rural hospitals in the nation at 102, and the median operating margin for those facilities is -6.8%—the lowest in our analysis (Figure 1).

Figure 1: Nationally, 43% of rural hospitals are operating in the red, including 51% in states that have not adopted or implemented Medicaid expansion.



*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.

The overall national figure of 43% of rural hospitals in the red is an improvement over our analysis from last year (45%), albeit a small one. To better understand what may be driving this slight improvement, we dug deeper into the hospital cost report data. Our analysis revealed an increase for rural hospitals in both inpatient and outpatient revenue as well as an increase in non-Medicare and non-Medicaid patients. We also found that patients had a longer length of stay. While the reasons driving these increases are likely many, some are probably related to the pandemic, such as people re-engaging with various types of healthcare services and treatments. Thus, the performance gains are most likely an anomaly as opposed to a shift in fortune for the rural health safety net.

After Slowing in 2021, Rural Hospital Closures Begin to Tick Upward

Since 2010, the rural health safety net has lost 143 facilities to closure.³ After a record-setting year in 2020 in which 19 hospitals closed, just 2 shut their doors in 2021 and 7 closed in 2022. As we have seen with operating margin, the reduction in the rate of rural hospital closures suggests the power of the PRF-related dollars and other pandemic assistance programs. But these programs have now all ended, and policy-related reimbursement cuts are back in full swing, meaning we are likely to see closures begin to accelerate. Even though the number of 2022 closures were relatively small compared to some of the other yearly totals since 2010, it represents an increase of more than 3 times the closures in 2021. When a rural hospital closes, the impact can be devastating for a community. In many rural communities, the hospital is among the largest (if not the biggest) employer, and the closing of a facility can set off a domino effect that strains the local community far beyond the loss of hospital jobs and delivery of healthcare services.

Two years ago, we published "[The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability](#)," which featured an innovative and sophisticated multi-level regression analysis to predict the likelihood of rural hospital closure. The model identified 453 rural hospitals vulnerable to closure. States with the highest rate of vulnerability are also states that have experienced high numbers of closures since 2010 and/or states that were slow to implement Medicaid expansion under the Affordable Care Act or continue to resist adoption. Among the states with the highest percentage of vulnerable rural hospitals are Tennessee (53%), Florida (50%), Texas (50%), Missouri (46%), and Mississippi (42%).



453

Hospitals are vulnerable to closure.

New Rural Emergency Hospital Designation Will Provide a Path Forward for Some Struggling Hospitals

Throughout the rural hospital closure and vulnerability crises, we have tracked and modeled several legislative proposals aimed at addressing widespread instability, including the American Health Care Act, Better Care Reconciliation Act, Graham-Cassidy, and the Save Rural Hospitals Act. The creation of the REH designation in the Consolidated Appropriations Act of 2021 (Public Law No: 116-260), however, is the only effort to support the rural health safety net that has become law. This is the most significant government action since the creation of the Critical Access Hospital designation through the Balanced Budget Act of 1997. REH has received significant attention in rural healthcare circles as this new designation is designed to help low-volume rural hospitals struggling financially to avert closure while continuing to provide some services within their community.

Converting to REH status carries with it several requirements, including foregoing all acute inpatient services, maintaining a staffed Emergency Department (24 hours a day, 7 days a week, 365 days a year), supporting observation care, and maintaining an annual average patient length of stay of 24 hours or less. The REH designation also allows for the provision of outpatient services and rural clinics. Outpatient services, our [research indicates](#), account for 76% of rural hospital revenue at the national median. So, for some of the smallest rural hospitals that already service their community through the Emergency Department and outpatient services, REH conversion may be a largely titular change. Under REH, patients in need of inpatient care will be discharged or transferred to another facility. As part of conversion, each REH designated facility will receive monthly payments, which for 2023, are expected to total more than \$3 million annually.

Since the designation was first announced, our working hypothesis has been that the requirements for conversion (e.g., no inpatient services, no swing beds, loss of CAH cost-based reimbursement, loss of 340B drug program savings) would make the designation applicable to a small segment of rural providers—specifically those losing money year over year, smaller in size (i.e., revenue), and with a very low average daily census of inpatient/swing beds, among other factors. To better understand the number of facilities most likely to consider conversion, Chartis has developed an REH data model built around 7 key indicators:



Years negative operating margin:

This indicator is a 3-year look-back to determine which facilities have shown sustained unprofitability and therefore are likely to benefit most from REH payments.



Net patient revenue (NPR):

Facilities with lower NPR would be more likely to consider converting for the financial benefits.



Average daily census (acute):

Since REH requires hospitals to drop acute, inpatient care facilities with lower utilization would be more likely to consider converting.



Average daily census (swing/SNF):

CAHs with high swing/skilled nursing facility (SNF) utilization would not be likely to consider converting as this is viewed as a necessary service to provide to the community.



Inpatient revenue to total revenue:

Hospitals that rely less on inpatient revenues are more likely to consider foregoing inpatient services.



Percentage of Medicare outpatient charges to total outpatient charges:

This percentage helps determine which hospitals are most likely impacted by REH's 105% Outpatient Prospective Payment System (OPPS) reimbursement rate.

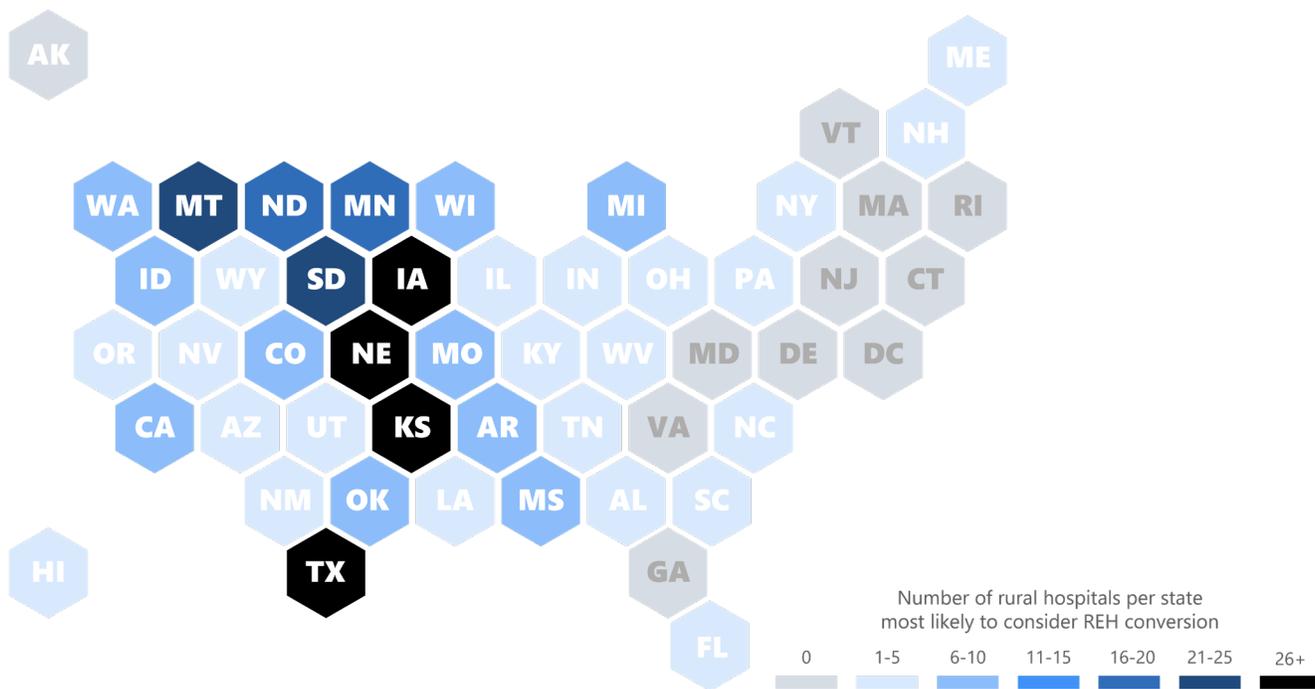


Case mix index:

This indicator identifies hospitals most likely providing complex inpatient services to their communities and therefore are less likely to consider converting.

Our REH Conversion Index percentile ranks a hospital’s performance for each of the 7 indicators on a 1% to 100% scale. We then percentile ranked the sum of all 7 equally weighted measures to arrive at an overall facility ranking. For initial discussions, we consider those “most likely to consider conversion” that fall between the 1st and 24th percentile; those that “may consider conversion” rank between the 25th and 49th percentile; those “less likely to consider conversion” fall between the 50th and 74th percentile; and those “unlikely to consider conversion” rank at the 75th percentile and above. Our analysis indicates that 389 rural hospitals fall into the first quartile and are therefore the most likely to consider REH conversion. Within this group of 389, there are 374 CAHs and 15 rural Prospective Payment System (PPS) facilities. Geographically, the breadth of this segment touches nearly every state. Those with the highest number of hospitals include Kansas (57), Iowa (37), Nebraska (36), Texas (35), and Montana (25) (Figure 2).

Figure 2: The highest concentration of rural hospitals most likely to consider REH conversion runs from Texas up to the Dakotas.



In this group of hospitals most likely to consider conversion, all the medians are below those of the REH eligible medians (Figure 3). The median number of years with a negative operating margin is 2, net patient revenue is \$11.6 million, average daily census for both acute and swing bed/SNF is 1, and the percentage of inpatient revenue to total revenue is 17%. Additionally, the percentage of Medicare outpatient charges is 40%, and the median case mix index is 1.07.

Figure 3: For hospitals in the first quartile, the median number of years operating in the red is 2 and the median net patient revenue is \$11.6 million.

	REH ELIGIBLE MEDIAN	FIRST QUARTILE MEDIANS
Years Negative Operating Margin	0	2
Net Patient Revenue	\$24.4M	\$11.6M
Average Daily Census (Acute)	3	1
Average Daily Census (Swing/SNF)	2	1
Inpatient Revenue to Total Revenue	19%	17%
Percentage of Medicare OP Charges	30%	40%
Case Mix Index	1.20	1.07

There are several requirements for conversion and other considerations, however, that we predict will weigh heavily on any facility's deliberations regarding REH conversion. The decision whether to pursue REH conversion cannot utilize a "one size fits all" template. The decision-making process is highly nuanced, and hospital leadership teams will need to carefully weigh these considerations against REH requirements to make the best decision for their facility and community.

Affiliation for CAHs with a health system, participation in the 340B program, and government control status are perhaps 3 of the more compelling considerations. The popular 340B drug program, for example, allows rural hospitals to secure drugs at discounted prices and share in the savings this produces. As for system affiliation, the Centers for Medicare and Medicaid Services (CMS) allows health systems to allocate costs related to shared services across their CAHs, thus enabling greater optimization of cost-based reimbursement. Health systems invest significant resources in their affiliated CAHs, supporting more robust services, and these investments are offset by these cost-based reimbursements. While the median corporate allocation for CAHs affiliated with a health system is \$2.9 million, the median value in the first quartile is \$1.1 million. For facilities owned by a municipality or county, conversion may prove difficult or even impossible, given challenges associated with unwinding local tax structure and the political challenges elected boards would likely face in perceived reduction of services to the community (Figure 4). That said, we may also see some rural PPS hospitals consider conversion due to sustained financial instability and the inability to seek CAH status.

Figure 4: Considerations such as system affiliation, government control status and participation in the 340B program will all factor into the REH decision making process.

	REH ELIGIBLE	FIRST QUARTILE
Critical Access	1,338	374
Rural PPS	219	15
System Affiliated	881	178
Corporate Allocation (median)	\$2.9M	\$1.1M
340B Participation	1,257	321
Government Controlled	605	200

To illustrate the impact these different considerations will have on the conversion decision-making process, we've outlined 2 "sample" rural hospitals. Rural hospitals A and B each landed in the first quartile of our REH data model (Figure 5).

Figure 5: The decision to convert to REH is highly nuanced even for hospitals identified by the model as "most likely to consider conversion."

	HOSPITAL A	HOSPITAL B
TYPE	CRITICAL ACCESS	CRITICAL ACCESS
REH Index Quartile	1	1
Yearly Negative Operating Margin	3	3
Net Patient Revenue	\$5.7M	\$35M
Average Daily Census (Acute)	0	3
Average Daily Census (Swing/SNF)	1	1
Inpatient Revenue to Total Revenue	55%	7%
Percentage of Medicare OP Charges	51%	39%
Case Mix Index	1.18	1.25
System Affiliated	N	Y
Corporate Allocation	-	\$9M
Government Controlled	Y	N
340B Program Participation	N	Y

In this example, Hospital A has been operating in the red for 3 years and its net patient revenue is well below the median for both the first quartile and REH eligible hospitals. The average daily census is below 1, and the hospital is not affiliated with a health system, nor does it participate in the 340B program. Even though the facility is owned by a government entity, all other indicators point to conversion warranting serious consideration.

Like Hospital A, Hospital B is in the REH Index's first quartile and operating in the red for the last 3 years. But the hospital has significantly higher net patient revenue than the first quartile median, participates in the 340B program, and is affiliated with a health system. As a result, the corporate allocation for the facility is \$9 million. In this instance, we have a first quartile hospital that is unlikely to consider converting to REH because of the benefits associated with corporate allocations and participation in the 340B program.

Within the first quartile (those 389 rural hospitals), there are noticeable differences in the model measures for those ranked at the very bottom of the quartile (0 through 4th percentile), for example, and those in the 20th to 24th percentile (Figure 6). For the 77 hospitals at the bottom of the ranking, the median net patient revenue is significantly lower (\$7.9 million compared to \$17.7 million) and the median number of years with a negative operating margin is higher (3 years compared to 2). A majority of the 77 hospitals are also not affiliated with a health system and inpatient-related revenue accounts for just 14% of total revenue at the median. The model, therefore, suggests that the 77 hospitals at the very bottom of the REH index are ideal candidates for conversion to REH. Geographically, more than half of the 77 hospitals are located in Nebraska (13), Kansas (12), Texas (11) and Iowa (7).

Figure 6: Variation exists within the first quartile, particularly between those ranked at the bottom compared to those in the 20th to 24th percentile.

	0-4 TH %TILE	5 TH -9 TH %TILE	10 TH -14 TH %TILE	15 TH -19 TH %TILE	20 TH -25 TH %TILE
Total Number	77	78	78	78	78
Number Critical Access	77	73	73	75	76
Years Negative Operating Margin	3	3	1	1	2
Net Patient Revenue	\$7.9M	\$9.9M	\$10.8M	\$13.7M	\$17.7M
Average Daily Census (Acute)	1	1	1	1	2
Average Daily Census (Swing/SNF)	1	1	1	1	1
Inpatient Revenue to Total Revenue	14%	17%	18%	15%	19%
Percentage of Medicare OP Charges	44%	42%	38%	39%	37%
Case Mix Index	1	1.07	1.06	1.12	1.10
System Affiliated	32	33	35	43	35
Corporate Allocation	\$697K	\$944K	\$987K	\$1.2M	\$2.3M
340B Program Participation	59	65	65	64	68

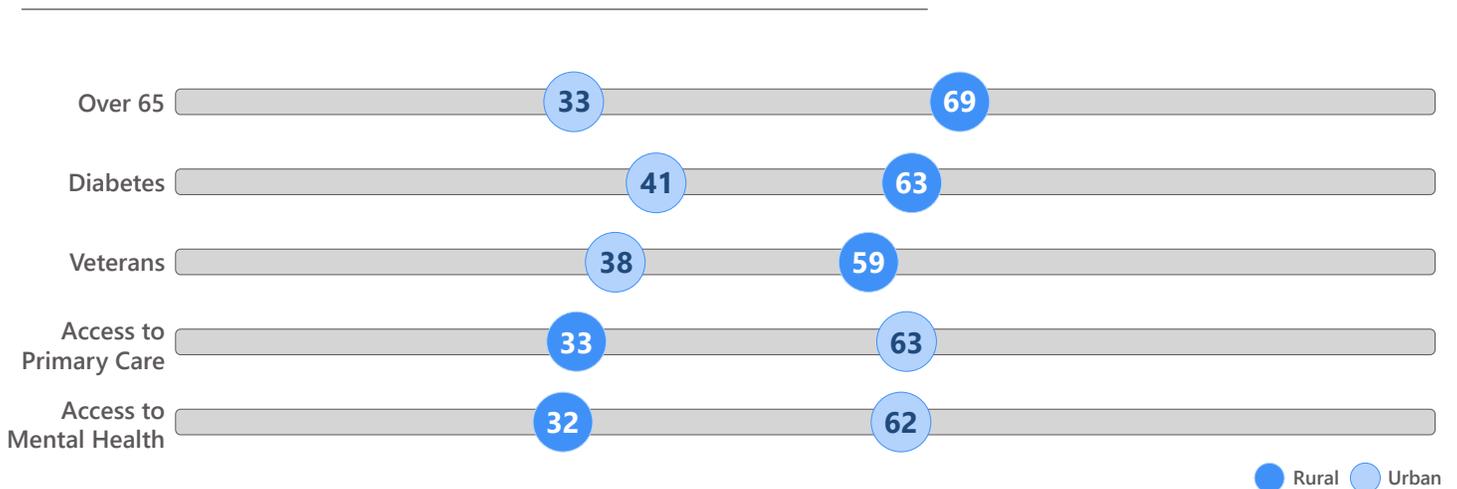
Even though 77 may represent a small percentage of REH eligible hospitals, the number is significant when you consider the broader impact the loss of a hospital has on a rural community. This new model represents a statistically rigorous approach to understanding the potential impact of the REH designation on the rural health safety net. Our model validates our initial hypothesis regarding REH by showing that the number of rural hospitals most likely to consider converting is a small percentage of the nation’s roughly 2,200 rural hospitals. While the new designation is not a panacea capable of curing the widespread instability and uncertainty we see across the rural health safety net, it nonetheless offers a pathway for some rural hospitals, and an opportunity for some communities to retain access to important services that would otherwise disappear.

Health Disparity and Inequity Gaps Ratchet up the Pressure on Already Vulnerable Rural Communities

For some time now, the general community health status of rural America has been on a divergent path from more urban communities. Chartis’ “[Rural Communities at Risk](#)” study (2021) explored widening health disparities and racial inequity in rural communities. While we have known for some time that rural America lagged urban America in health-related measures, this research determined that health disparities are persistent, meaning that when compared to their urban counterparts, rural communities are more vulnerable—they are older, less healthy, and less affluent, and they struggle to access care (i.e., primary care and mental health care). Across several of the core disparities metrics we evaluated, the gaps between rural and urban communities exceeded 30 percentage points (Figure 7).

This troubling trend comes at a time when other research appears to confirm the degradation of community health status in rural America. According to findings published in Scientific American, mortality rates for the top 10 causes of death in 2019 are all higher in rural communities than urban ones, and the pandemic saw rural America account for a higher share of mortality per capita.⁴ Particularly troubling is research involving “deaths of despair” (e.g., deaths by suicide, drug overdose, and alcohol poisoning), which indicates that geography plays a key role in these types of mortalities and that rural areas again show higher instances of death than non-rural areas.⁵

Figure 7: Disparity between rural and urban communities.



As we undertook this updated examination of rural health disparities and inequity, we had the benefit of overlaying the analysis with our research around rural hospital vulnerability. Surprisingly, gaps appeared in disparity measures within rural communities themselves. That is, in communities in which the local rural hospital is vulnerable to closure, we find the rural health safety net at its weakest. Our analysis found that residents in communities served by a hospital vulnerable to closure are less likely to be insured (adults and children), have less access to care, and are more likely to die prematurely than those living in rural communities where the rural hospital isn't vulnerable to closure. Given how substantially disadvantaged rural populations are across health disparity measures in our analysis, this expanded examination identifies areas where populations are most in need of healthcare—and most likely to lose points of access.

Our analysis of disparities also identified gaps in inequity across certain metrics for Black Americans and Hispanics in states where the population living in rural communities is above 15%. These states (i.e., Alabama, Georgia, Mississippi, Nevada, New Mexico, and Texas) tend to be states in which the safety net's instability is evident as a result of rural hospital closures and vulnerability. In both cases—for Black Americans and Hispanics—our analysis revealed higher rates of premature death and child poverty in those respective state groupings.

“Care Desserts” Grow as Access to OB and Chemotherapy Vanishes Across Rural America

The declining access to services across rural America isn't simply a byproduct of hospital closures (and efforts like REH to avert the complete loss of services in a community). While some of the access erosion is indeed the result of hospitals closing, a significant portion of the “care desserts” popping up throughout large swaths of states and regions is in fact occurring at hospitals that remain open. Over the course of the last several years, we have been tracking the disappearance of specific service lines in rural communities—most notably OB and Chemotherapy.

Last year, we reported that between 2011 and 2019, the number of rural hospitals that ceased to provide OB was 198. Our updated analysis of this service line loss reveals that the number of hospitals to cease OB has increased 9% and is now 217. According to our analysis, the states absorbing the highest loss of access to OB during the review period are Minnesota (17), Texas (15), Iowa (16), Kansas (13), and Wisconsin (12). Minnesota's inclusion here is notable as the state has the second highest number of rural hospitals offering OB (behind Texas) and is ground zero for innovative approaches to improving OB in rural settings, including one involving Blue Cross and Blue Shield of Minnesota.

217 Rural communities no longer have access to OB

353 Have lost access to chemotherapy

Loss of access to a local hospital offering OB means expecting mothers must travel farther for prenatal care and delivery. The added drive times also increase the risk to mother and baby in the event of an emergency. Published in 2019, our OB drive-time analysis showed that women in 89 communities were forced to drive up to an additional 30 minutes to reach the nearest OB provider. For women in another 52 communities, the added drive time was between 30 and 60 minutes. And for women in 11 communities, the extended time in the car amounted to more than 60 minutes.

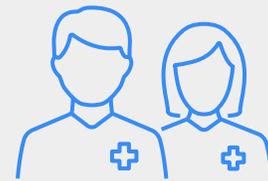
Our analysis of Chemotherapy also reveals a similar level of declining access. When we looked at the loss of access to Chemotherapy last year, we found that between 2014 and 2019, more than 300 (311) rural hospitals stopped providing this service. This year, our analysis indicates that 353 hospitals stopped providing Chemotherapy, representing an increase of 13%. States seeing the highest loss of access to Chemotherapy in rural communities are Kansas (28), Texas (25), Georgia (16), Illinois (16), and Mississippi (14).

Access to Care Will Remain Under Threat as Rural Hospitals Grapple With Nursing Shortage

Throughout the pandemic, news feeds were full of stories and reports of widespread staff burnout and departures at rural hospitals. In communities already confronting access to care issues and struggling to recruit skilled healthcare professions (60% of Healthcare Professional Shortage Areas (HPSAs) are in rural locations), the pandemic rapidly transformed staffing shortages from challenge to crisis. From spring 2021 to spring 2022, [Chartis conducted a series of surveys](#) with rural hospital leaders across the country in an effort to expand our understanding of how the nurse staffing shortage was impacting hospital operations and access to care. It is important to note that this wasn't just a period when rural hospitals were working to treat COVID-19 locally but a time when many facilities also served as a relief valve for urban facilities overwhelmed with COVID-related cases.

Nearly 40% of our survey respondents said that in 2021, between 1 and 5 nurses left, while nearly a quarter said between 6 and 10 departed the hospital. Despite the emphasis on staff burnout in the news media, our survey respondents told us that the No. 1 reason (as indicated by 48% of respondents) driving nurse departures was more financially lucrative opportunities at staffing agencies.

These departures have left hospitals racing to fill openings. More than half (56%) of respondents have up to 5 open bedside nursing positions, while another 17% indicated that the number of open bedside positions is between 6 and 10. As a result, the lack of sufficient staffing is having an adverse effect on the delivery of care. When asked if nurse staffing issues had prevented their facility from admitting patients in the last 60 days, 36% said yes. And 17% indicated that nurse staffing issues had resulting in the suspension of services at their facility.



48%

Among survey respondents, 48% ranked more financially lucrative opportunities at staffing agencies as the #1 reason for nurse staff departure in 2021.

How Can the Vision for REH Be Broadened to Apply to More Rural Hospitals?

Rural hospitals serve populations with disproportionate health disparities and socioeconomic challenges. These facilities continue to struggle financially, raising the risk of hospital closure: “No margin, no mission.” The loss of more than 140 rural hospitals since 2010 has created care deserts in regions where access to care is desperately needed. Even at hospitals that remain open, services such as OB and Chemotherapy are disappearing. Our research tells us that the vast majority of HPSAs are in rural areas, and the pandemic has exacerbated what was already a crisis of recruitment and retention of clinical providers. This is the backdrop for the new REH designation and the potential for it to be a much-needed relief valve for the rural health safety net.

As difficult and challenging as the last 3 years have been, we appear to finally have reached a point where the pandemic is largely in the rearview mirror. For the rural health safety net, the various pandemic relief programs and initiatives clearly helped to bring a measure of stability during an unprecedented crisis. But as those programs conclude, rural hospitals, elected officials and rural healthcare advocates are accelerating efforts to craft solutions that can deliver long-term stability for the rural health safety net. Our analysis outlined in this study confirms that all those pressure points that plagued rural providers prior to the pandemic—policy impact on reimbursement, staff recruitment and retention, population health, and inequity—will place further negative pressure on the safety net in the years ahead.

Our research shows that when you strip away the financial impact of pandemic-era relief, more than 4 in 10 rural hospitals nationally are in the red—including more than half of those facilities located in states that have yet to adopt or implement Medicaid expansion. These non-expansion states, not surprisingly, are also where the safety net has absorbed significant closures and sees the highest rates of vulnerability. The year ahead will likely see the number of rural hospital closures continue to climb and access to services further limited as hospitals face difficult financial decisions and contend with an unrelenting staffing crisis.

Based on our data model, the introduction of the REH designation will likely provide a path forward for some rural hospitals that would otherwise consider closing. That would be a significant reverse in fortune for those communities. While the requirements of REH and other conversion-related considerations mean it will not deliver the type of relief that so many rural hospitals are seeking, it nonetheless represents momentum toward solutions. For those invested in rural healthcare, the challenge then becomes harnessing that momentum before the instability we see across the safety net accelerates again.



SOURCES

1. Cecil G. Sheps Center for Health Services Research, University of North Carolina, Rural Hospital Closures, January 27, 2023.
2. Cecil G. Sheps Center for Health Services Research, University of North Carolina, Rural Hospital Closures, January 27, 2023.
3. Cecil G. Sheps Center for Health Services Research, University of North Carolina, Rural Hospital Closures, January 27, 2023.
4. Scientific American, "[People in Rural Areas Die at Higher Rates Than Those in Urban Areas](#)," December 14, 2022.
5. International Journal of Environmental Research and Public Health, "[Deaths of Despair: A Scoping Review of the Social Determinants of Drug Overdose, Alcohol-Related Liver Disease and Suicide](#)," September 29, 2022.

AUTHORS

Michael Topchik
National Leader
mtopchik@chartis.com



Troy Brown
Network Consultant
tbrown@chartis.com



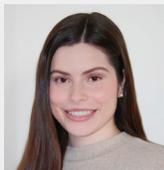
Melanie Pinette
MEM, Senior Analyst
mpinette@chartis.com



Billy Balfour
Marketing Manager
wbalfour@chartis.com



Ana Wiese
Data Analyst
awiese@chartis.com



About Chartis

Chartis is a leading healthcare advisory services firm serving healthcare providers, payers, health service and technology companies, and investors. Chartis brings an unparalleled breadth and depth of expertise in strategy, performance improvement, digital and technology, clinical quality and patient safety, health equity and belonging, and strategic communications. Learn how Chartis is helping to build a healthier world at www.chartis.com.

Connect with us: www.chartis.com | [LinkedIn](#) | [Twitter](#) | [YouTube](#)

© 2023 The Chartis Group, LLC. All rights reserved. This content draws on the research and experience of Chartis consultants and other sources. It is for general information purposes only and should not be used as a substitute for consultation with professional advisors.

