Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory

CHARTIS

America's rural health safety net has been in crisis mode for nearly 15 years. Rural hospital closures, decreasing reimbursements, declining operating margins, and staffing shortages have all coalesced to undermine the delivery of care in communities whose populations are older, less healthy, and less affluent. The mission of the safety net to serve under-resourced communities is unraveling. The latest research conducted by the Chartis Center for Rural Health points to a startling new phase of this crisis as rural hospitals fall deeper into the red, "care deserts" widen throughout rural communities, and the increasing penetration of Medicare Advantage could further disrupt rural hospital revenue.

MAJOR FINDINGS OF THIS STUDY[1] ARE:

01 The percentage of America's rural hospitals operating in the red jumped from 43% to 50% in the last 12 months.

02 55% of independent rural hospitals are operating in the red, while 42% of health system-affiliated rural hospitals are operating at a loss. Nearly 60% of rural hospitals are now affiliated with a health system.

03 Medicare Advantage now accounts for 35% of all Medicare-eligible patients in rural communities. In 7 states, Medicare Advantage penetration exceeds 50%.

04 Access to inpatient care continues to deteriorate as 167 rural hospitals since 2010 have either closed or converted to a model that excludes inpatient care.

05 418 rural hospitals are "vulnerable to closure" according to a new, expanded statistical analysis.

06 Between 2011 and 2021, 267 rural hospitals dropped OB services. This represents nearly 25% of America's rural OB units.

07 Between 2014 and 2022, 382 rural hospitals have stopped providing chemotherapy services.

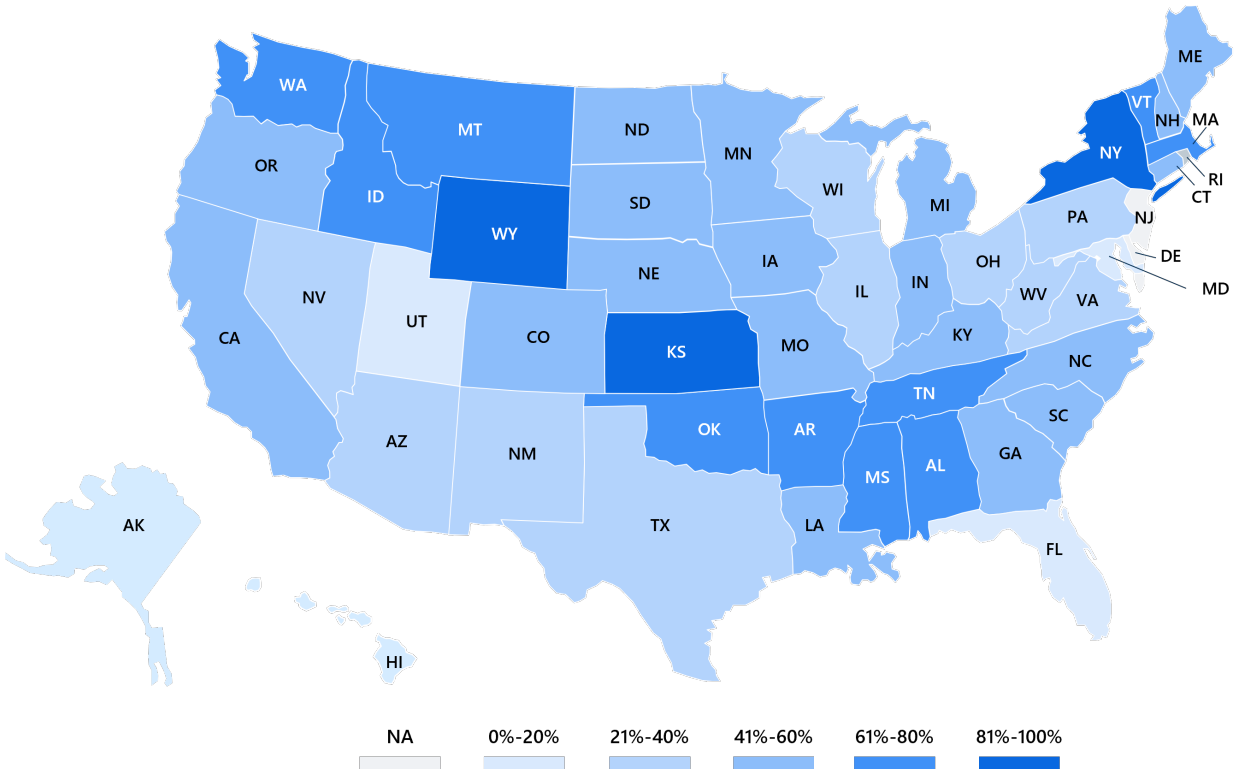
Rural Hospitals Sink into the Red

Our research has always used rural hospital operating margin as a foundation for understanding the stability of the safety net (e.g., "No margin. No mission."). Today, 50% of America's rural hospitals are operating in the red. This is the highest percentage of rural hospitals losing money in the past decade. The jump from 43% operating in the red last year to 50% this year is the single largest percentage change we have seen in a 12-month period.

50% of America's Rural Hospitals are in the Red.

Our analysis also found that in 19 states, the median operating margin is in the red. States with the highest percentage of rural hospitals operating at a loss include Kansas (89% in the red), New York and Wyoming (83% each), Vermont (75%), and Alabama (74%). In Kansas, which is home to 99 rural hospitals, the median operating margin is -10%. With the exception of Delaware (home to just 2 rural hospitals), Utah is the only state where the percentage of rural hospitals in the red is less than 20%.

Figure 1: State-level percentage of rural hospitals with negative operating margin



Although rural hospital instability is national in scale, facilities in states that have not expanded Medicaid have consistently performed worse financially than their expansion state counterparts. This year's analysis not only shows a continuation of that trend but a similar jump in the percentage of rural hospitals operating in the red.

Across the 10 remaining non-expansion states (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming), the percentage of facilities with a negative operating margin increased year-over-year from 51% to 55%. These states are home to more than 600 rural hospitals in total. Several of these states are among the most severely affected by hospital closures and a loss of access to care.

While the pandemic provided a measure of stability to rural hospital finances through various government intervention programs, this year's analysis indicates that any positive, residual financial affects have all but disappeared. Other government policies (e.g., sequestration and bad debt reimbursement) continue to chip away at rural hospital revenue. For example, our analysis shows that sequestration will cost rural hospitals more than $500 million this year and the equivalent of 9,000 healthcare jobs. Cuts in so-called bad debt reimbursement (i.e., the delivery of charity care to rural patients unable to pay for medical services) will claim approximately $175 million in revenue and the equivalent of an additional 3,100 healthcare jobs.

58% of America's Rural Hospitals are Now Affiliated with a Health System.

Our analysis also uncovered that 58% of rural hospitals are now affiliated with a health system—up from 56% in 2019. The median operating margin for these affiliated hospitals is 1.7%, compared to -2.2% for independent rural hospitals. Additionally, only 42% of health system-affiliated rural hospitals are operating in the red, compared to 55% of independent rural hospitals. While system affiliation may not make rural hospitals immune to the issues facing the rural health safety net, this data does confirm that affiliation can be financially and operationally advantageous. We expect the percentage of health system-affiliated rural hospitals to continue to grow. As it does, understanding the full impact of affiliation will be a priority.

Medicare Advantage Disrupts Rural Hospital Reimbursement

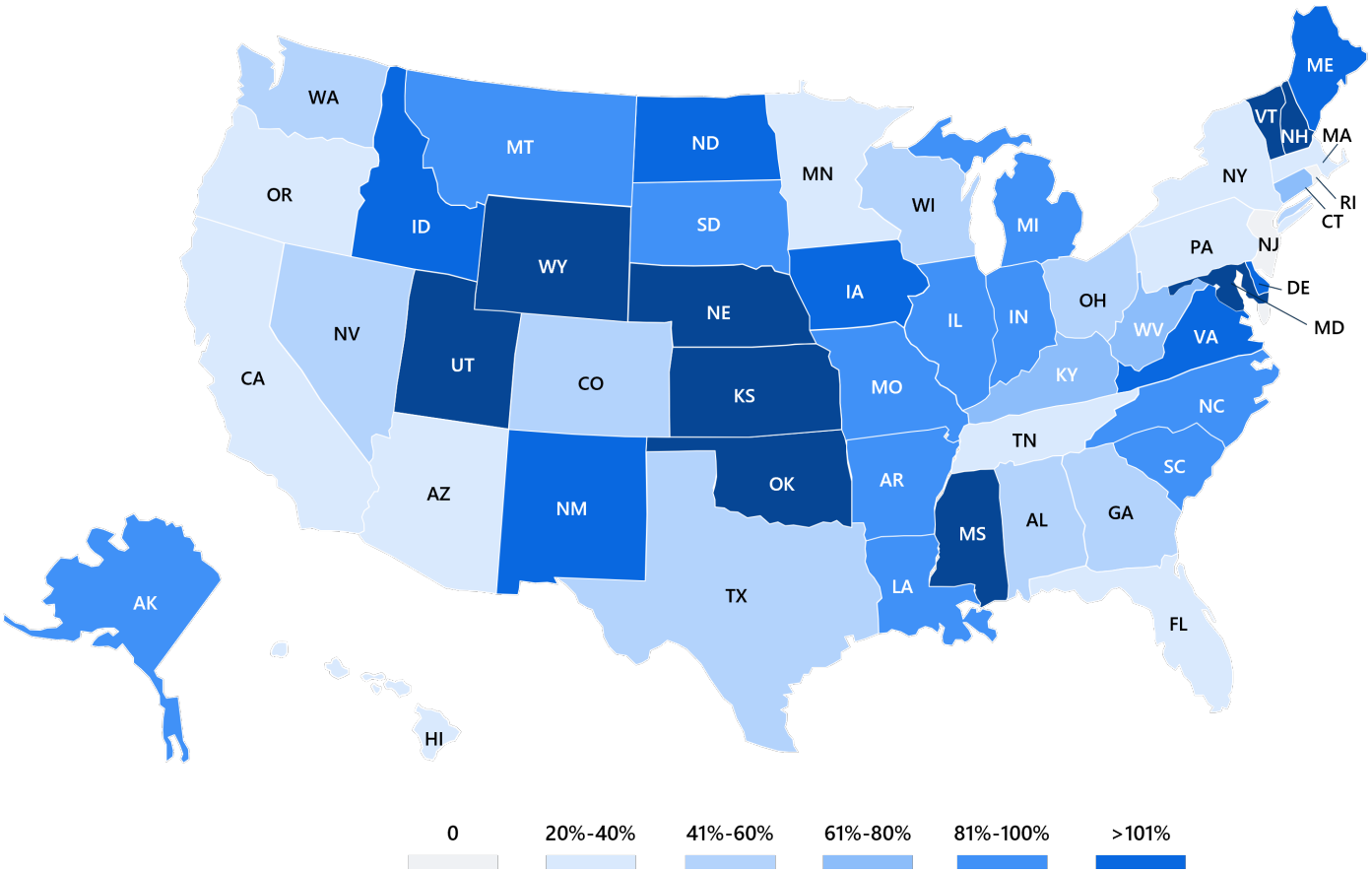
Traditional Medicare reimburses Critical Access Hospitals based on the cost of services provided. Since the advent of the Critical Access Hospital designation in 1997, this cost-based reimbursement has offset a rural hospital's typically low patient volume and revenue.

Recently, Medicare Advantage has attracted an increasing number of existing and newly eligible Medicare patients. Our analysis indicates that between 2019 and 2023, enrollment in Medicare Advantage in rural communities increased 48%. This rapid increase is highlighting differences between traditional Medicare and Medicare Advantage that have unique implications for rural hospitals. In particular:

- Medicare Advantage net reimbursement to Critical Access Hospitals is often lower for similar services than that of traditional Medicare because Medicare Advantage does not follow cost-based reimbursement.

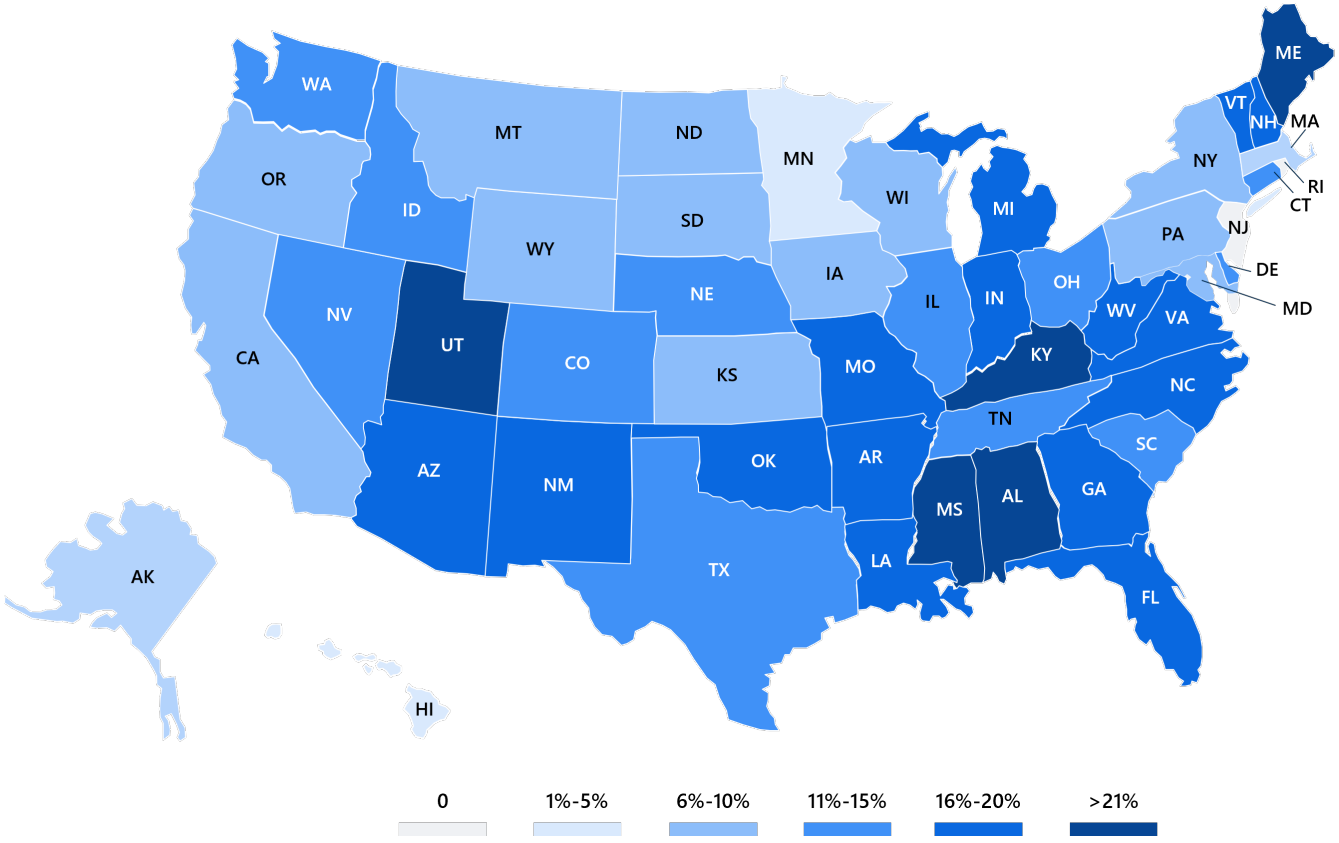
- Medicare Advantage may not cover all the services traditional Medicare does, including swing beds, which provide skilled nursing care for patients and are often a strong source of revenue stability for rural hospitals.
- Rural providers may not be equipped to efficiently navigate administrative requirements for payment introduced by Medicare Advantage, such as prior authorizations, which can lead to increased denials.
- Public data reporting differs for Medicare Advantage vs. Medicare claims, which may impede rural hospitals' ability to fully understand their population's healthcare experience and needs.

Figure 2: Percentage growth of Medicare Advantage enrollees in rural communities between 2019 and 2023



Across rural and urban communities, the popularity of Medicare Advantage has increased over the course of the last 5 years. According to Chartis' national data, penetration in these combined communities was less than 40% in 2019 but is now approaching 50%. Within communities that are home to a rural hospital, the increasing penetration of Medicare Advantage has been no less stunning.

Figure 3: Percentage growth of Medicare Advantage penetration in rural communities between 2019 and 2023



According to our analysis, the number of residents in rural communities enrolled in Medicare Advantage increased from 6.3 million to 9.2 million between 2019 and 2023. As a result, Medicare Advantage plans now account for 38% of all Medicare-eligible patients in rural communities. In 7 states (Alabama, Connecticut, Georgia, Hawaii, Kentucky, Maine, and Michigan), that percentage now exceeds 50%. Close behind this group is a large cluster of 15 states in which Medicare Advantage now serves between 40% and 49% of all Medicare beneficiaries.

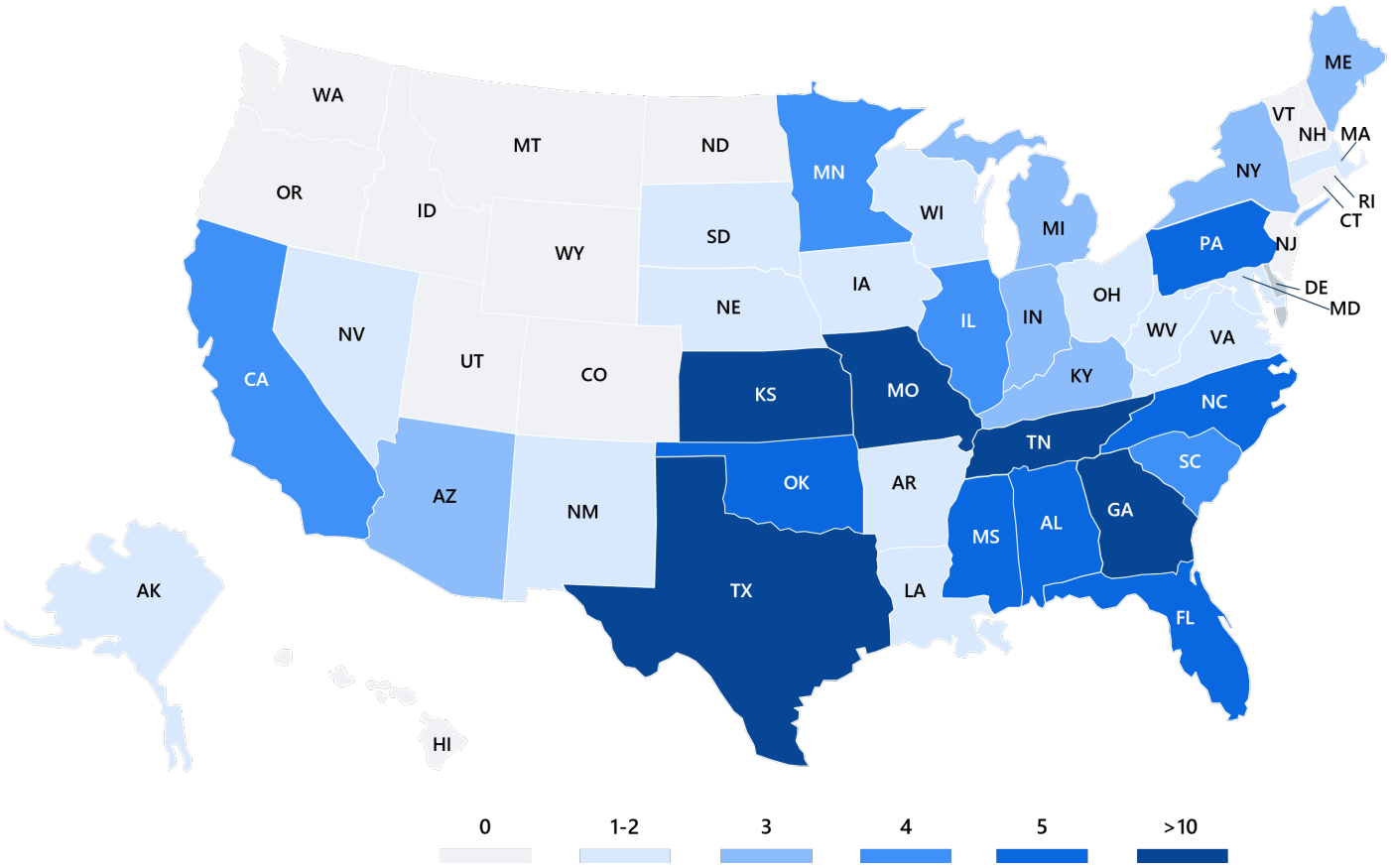
Understanding the extent to which Medicare Advantage's growing presence is impacting the rural health safety net will require action on the part of rural healthcare advocates and policymakers. There are several key levers that may need to be considered, such as:

- **Easing the administrative burden:** For instance, the Centers for Medicare and Medicaid Services' (CMS) new Interoperability and Prior Authorization rule should ease the burden surrounding care approval.
- **Increasing availability of data:** Establishing greater visibility into Medicare Advantage claims data would provide a much-needed lens into how well Medicare beneficiaries are being served.
- **Creating greater alignment:** Reconsidering how swing beds are handled and aligning clinical criteria more closely with traditional Medicare would help reduce denials and uncompensated care.

Erosion of Care Accelerates Through Closures and Conversions

As we have seen over the last 14 years, persistent downward pressure on rural hospitals often results in dire consequences for local care. Since 2010, 167 rural hospitals have either closed or adopted an operating model that excludes inpatient care (e.g., Rural Emergency Hospital conversion, urgent/emergency care center).[2]

Figure 4: Number of rural hospitals closed or ceasing inpatient care since 2010



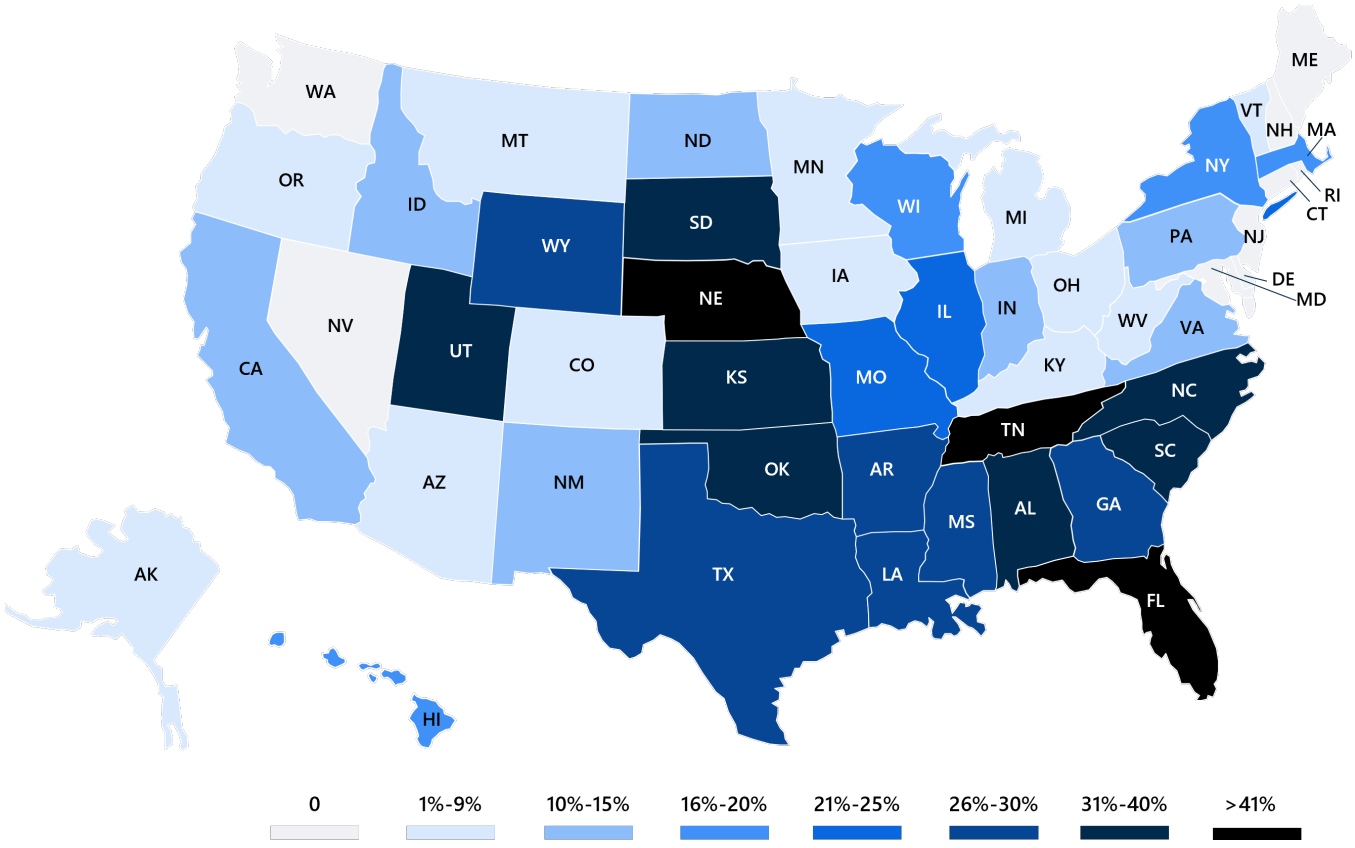
When a rural hospital closes, the ripple effects are felt throughout the community. Within many rural communities, the hospital is often among the largest employers and thus a major contributor to the local economy. Our analysis shows that when a rural hospital closes its doors, the loss of hospital jobs is nearly 220 at the median. The loss of non-hospital jobs in the community is 73 at the median.

Measuring the loss of access to inpatient care reveals that 2023 was a record-breaking year for rural healthcare. Inpatient care disappeared in 28 rural communities—easily surpassing the previous high of 18 set in 2020. Hospital closures and the loss of inpatient care continue to be concentrated highest in states such as Texas (26), Tennessee (15), Kansas (10), Missouri (10), and Georgia (10).

More Than 400 Facilities Vulnerable to Closure

In 2020, Chartis published an extensive, first-of-its-kind analysis of rural hospital vulnerability through a multilevel logistic regression model that determined the probability of closure. At the time, the model identified 453 rural hospitals vulnerable to closure. In the 4 years since the publication of that study, 30 of the facilities identified as vulnerable have closed. Utilizing an updated data model and more expansive methodology, our newest assessment indicates that 418 (approximately 20%) of America's rural hospitals are vulnerable to closure.

Figure 5: Percentage of state rural hospitals determined to be vulnerable



Our 2024 vulnerability data model analyzed 16 indicators and determined 9 to be statistically significant in predicting hospital closure. Among these 9 indicators, those most likely to decrease the risk of closure are case mix index, government control status, Medicaid expansion, and average daily census for swing beds/skilled nursing facility (SNF).

A particularly noteworthy protective measure against closure is the average daily census for swing beds/SNF. Despite the financial importance of swing beds and the benefits they provide to patients, they are not allowed as part of the new Rural Emergency Hospital (REH) designation. And prior authorization requirements and denials are sources of friction with Medicare Advantage.

Table 1: In our vulnerability model, 9 indicators were identified as statistically significant

VULNERABILITY MODEL INDICATORS	
Case Mix Index	State Status for Medicaid Expansion
Government Control Status	Traditional Medicare Percent Days
Critical Access Hospital	Medicare HMO Percent Days
Number of Beds	Traditional Medicaid Percent Days
Average Daily Census Swing/SNF	Medicaid HMO Pct Days
Occupancy	Years Negative Operating Margin
Average Age of Plant	Change in Net Patient Revenue
Average Length of Stay	Social Vulnerability Index

Our analysis of rural hospital vulnerability found the highest levels across the whole of the Southeast, part of the Southwest, and up into the Great Plains. States with the highest percentage of vulnerable rural hospitals are Florida (43%), Nebraska (41%), Tennessee (41%), North Carolina (40%), Kansas (38%), and Utah (38%). With several of these states, there is noticeable overlap with other metrics indicating vulnerability, such as operating margin and the loss of access to inpatient care.

When we shift our focus from state-level percentages to the highest number of vulnerable rural hospitals, many of the same states top the list. Texas has the most rural hospitals vulnerable to closure in our analysis: 45. Next are: Kansas (38), Nebraska (29), Oklahoma (22), North Carolina (19), and Georgia and Mississippi (18 each).

Although vulnerability stretches nationwide, our analysis shows a small number of states do not have any vulnerable rural hospitals. States such as Connecticut and Delaware may not be surprising inclusions, given the small number of rural hospitals in those states. But Washington (45), Maine (24), New Hampshire (15), and Nevada (14) are notable. Washington and New Hampshire interestingly have also thus far avoided any rural hospital closures or conversions to models that exclude inpatient care.

REH Offers a Lifeline for Some Facilities

Last year, 19 rural hospitals took advantage of CMS' new Rural Emergency Hospital (REH) designation.[3] Introduced in January 2023, the REH designation offers a pathway for struggling rural hospitals to retain some healthcare services within their communities. Rural hospitals converting to REH are no longer able to provide inpatient care, participate in the 340B drug program, or take advantage of swing beds.

Last year, Chartis developed a unique data model that assessed the likelihood of REH-eligible facilities in pursuing conversion. We found that nearly 400 rural hospitals fell into the model's first quadrant (i.e., most likely to consider pursuing conversion). Of this group, 77 hospitals fell in the 0 to 4th percentile overall and were identified as "ideal candidates" for REH conversion.

NEARLY 400 Rural Hospitals Likely to Consider REH Conversion.

Given that this program is in its infancy, more time may be required for conversions to pick up speed. REH conversions will likely increase as individual states complete the required regulatory approval processes and more hospitals give REH greater consideration in the wake of the different pressure points discussed within this study.

That said, we may also see adjustments to the requirements governing REH conversion. The 340B program, for example, has provided a wide range of benefits to rural hospitals. Allowing hospitals converting to REH to maintain participation in the 340B program may open the door for some rural hospitals to consider the new designation more strongly.

A survey conducted in 2023 by Chartis in partnership with the National Rural Health Association found that nearly 80% of respondents had been participating in the 340B program for more than 5 years, and 38% said that their hospital's estimated annual 340B benefit was $750,000 or more.

When asked to identify how 340B savings are utilized, most survey respondents selected "support workforce/staffing needs," "add or expand clinical services," and "provision of charity care." This provides an insightful lens into just how rural hospitals put the 340B savings to use to support care delivery.

America's Rural Care Desserts Keep Growing

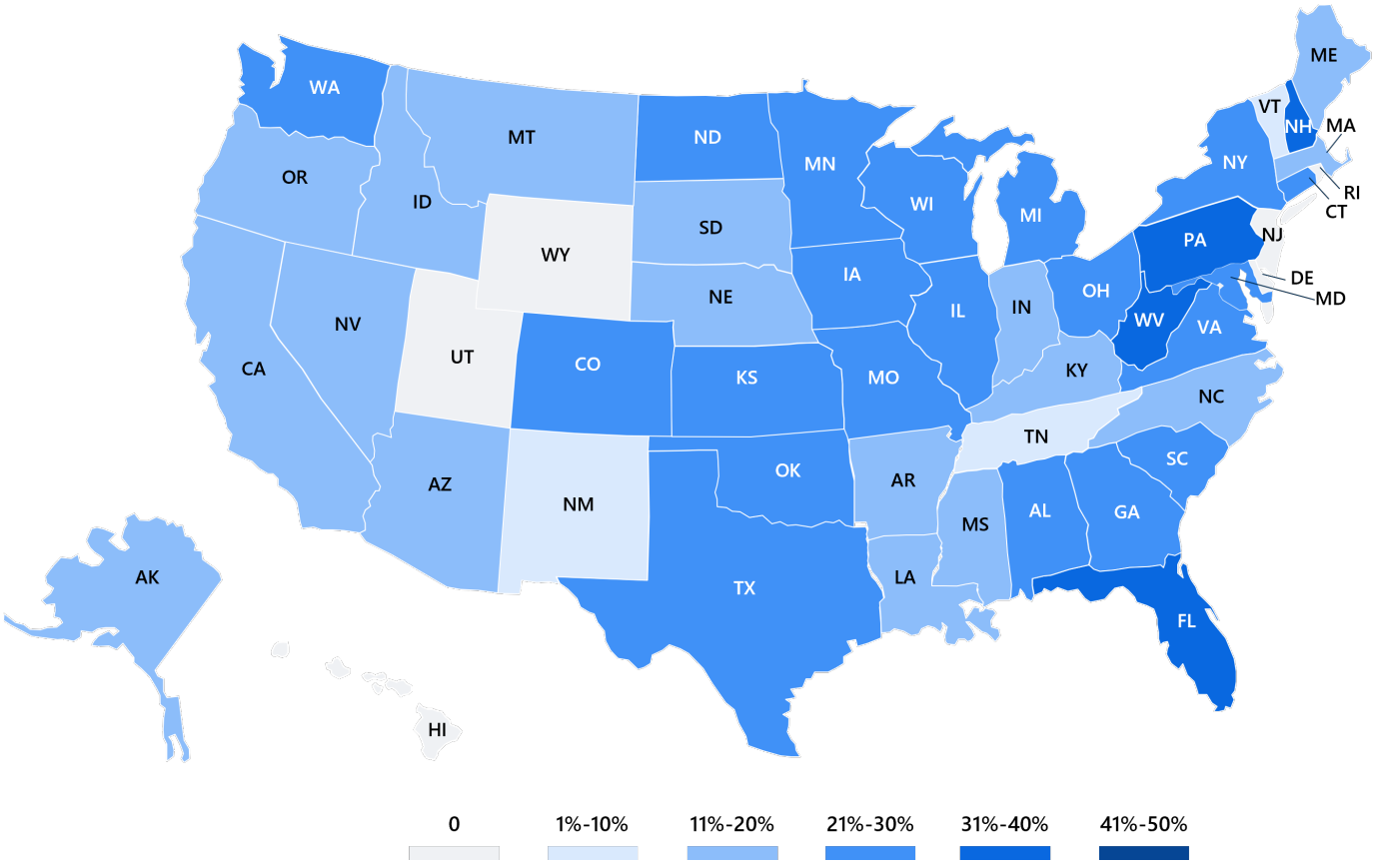
OBSTETRICS

Diminishing access to care within rural communities is not limited to instances of hospital closure or conversion to a model such as REH. As part of our safety net analysis, we have been tracking the loss of other services, most notably OB.

When we first assessed the availability of OB services in rural communities in 2019, our analysis indicated that access to OB services disappeared in 152 rural communities between 2011 and 2018. Our latest analysis reveals a dramatic escalation, especially during the height of the pandemic. Nearly 25% of America's rural hospitals (267) have stopped providing OB services since 2011. During the peak years of the pandemic (2020 and 2021), 63 rural hospitals ceased to provide OB services.

West Virginia has the highest percentage of rural hospitals dropping OB services from 2011 to 2021. Nearly half (46%) of the rural hospitals that offered OB services in West Virginia eliminated them during our review period. Close behind are Florida (43%), Pennsylvania (41%), and New Hampshire (40%). In West Virginia, Florida, and New Hampshire, the number of rural hospitals left in the state offering OB services is fewer than 10.

Figure 6: Percentage of rural hospitals that stopped offering OB between 2011 and 2021



Looking at states losing the greatest overall number of rural OB units between 2011 and 2021, Minnesota (22), Iowa (20), Texas (17), Wisconsin (16), and Kansas (14) are at the top of the list. States such as Utah and Wyoming (with 20 and 16 rural hospitals offering OB services, respectively) have not yet lost any rural OB units.

Given the long-established challenges rural providers face recruiting and retaining healthcare professionals—more than 60% of Healthcare Professional Shortage Areas (HPSAs) are in rural locations—the impact of abortion bans and restrictions bears watching closely. Published news reports indicate that in some states with bans or restrictions, OB-GYNs are reconsidering practicing there.[4] Many of the states that banned abortion (e.g., Alabama, Arkansas, Idaho, Indiana, Mississippi, and South Dakota) in the wake of the Supreme Court of the United States' ruling on Dobbs v. Jackson Women's Health also lost OB services in rural communities during our data review period. This issue seems likely to further erode access to OB services and maternal care in these states, many of which have been hard hit by rural health safety net instability.

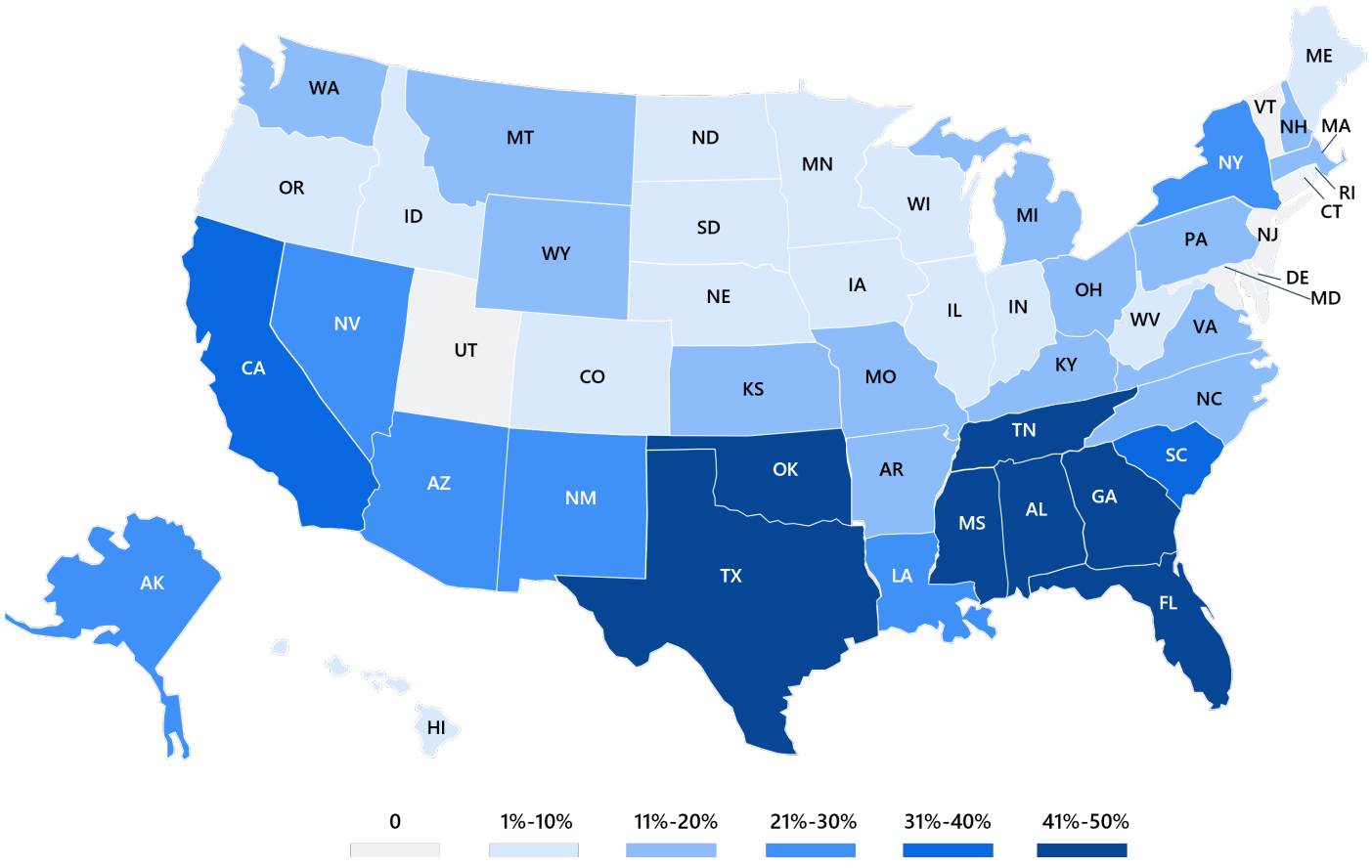
CHEMOTHERAPY

Across the safety net, OB is not the only service closing. Our analysis also indicates that access to chemotherapy is diminishing at an equally worrisome rate. Between 2014 and 2022, 382 rural hospitals stopped providing chemotherapy in their communities—an increase from the 353 reported in our 2023 safety net study.

Texas has the highest percentage of rural hospitals eliminating chemotherapy from 2014 to 2022. Within Texas, 47% of rural hospitals that offered chemotherapy have since stopping offering the service. After Texas, Alabama (46%), Mississippi (45%), Tennessee (44%), and Florida (39%) round out the group of 5 states with the highest percentage losses.

As is the case with our OB analysis, some of the same states suffering the greatest percentage loss have also seen the greatest number of rural hospitals drop chemotherapy. The state of Texas (57) again tops the list, followed by Oklahoma (23), Georgia (23), Tennessee (22), and Mississippi (21).

Figure 7: Number of rural hospitals that stopped offering OB between 2011 and 2022



Responding to the Reality within the Data

The fact that 50% of rural hospitals are operating in the red and nearly 420 are vulnerable to closure should serve as an urgent call to accelerate efforts at the state and national levels to reinforce the rural health safety net and ensure access to care for under-resourced and socioeconomically disadvantaged communities. For rural healthcare leaders and those advocating on their behalf, some of the key questions that emerge from this study's findings include:

- Can the surge of Medicare Advantage rural beneficiaries and the resulting impact on rural hospital revenues be mitigated through better alignment with traditional Medicare guidelines and faster, more streamlined care approval processes?
- Would amendments to REH conversion requirements (such as swing beds and 340B Drug Program participation) help make the new designation a more likely pathway for hospitals struggling the most?
- Which actions can be taken at the local, state, and national levels to address rural hospital staffing shortages and enable these facilities to support existing services as well as offer new services needed within their communities?
- Can hybrid models be developed (leveraging local, rural healthcare resources together with those in urban settings) to address diminishing access to services such as OB and chemotherapy?

The new REH designation, a larger stake in rural healthcare at the health system level, and the resourcefulness and collaboration born from the pandemic all have laid a foundation upon which hospital leaders, advocates, and elected officials can build to release some of the pressures driving rural hospitals into the red. These efforts, however, will have to be accompanied by innovative ideas that can ensure rural communities have appropriate and affordable access to the care they need.

America's rural hospitals have proven capable of incredible resiliency and an unwavering commitment to serve their communities. Our annual recognition of Top 100 performers serves as a lens into rural hospital success stories. The experiences, insights, and best practices from these types of facilities could jumpstart the exchange of ideas across the whole of the rural health safety net.

SOURCES

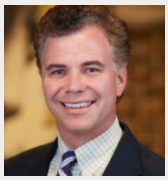
1. Chartis' analysis of rural hospital operating margins for this study utilized CMS' Healthcare Cost Report Information System (HCRIS) Q3 2023. Operating margin is computed in accordance with Flex Monitoring Team guidance. Outliers are excluded. Hospitals for which data are unavailable are excluded. 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. Policy impact data utilizes a number of sources including the Budget Control Act 2011, the Middle-Class Tax Relief and Job Creation Act of 2023, the National Center for Rural Health Works 2016, the World Bank 2021, and the Budget Enforcement Act of 1990.

   Rural hospital vulnerability utilizes a multi-level logistic regression model developed by Chartis. A methodology for the vulnerability analysis can be found here.

   The baseline period for the chemotherapy service line loss is 2014-2021 and utilizes Medicare SAFOP. Chemotherapy services were identified using HCPCs codes recommended by The Surveillance, Epidemiology, and End Results (SEER) Program for identifying Chemotherapy Administration and Drugs in Medicare analyses. HCRIS data is used to determine the loss of obstetrics in rural communities. The baseline period for the analysis is 2011-2021. Medicare enrollment and penetration analysis utilized most recently available HCRIS data as of March 1, 2023.
2. The Cecil G. Sheps Center for Health Services Research. Closed and converted count as of February 2, 2024.
3. The Cecil G. Sheps Center for Health Services Research. REH conversion count as of February 2, 2024.
4. Julianne McShane, "Pregnant with No OB-GYNs Around: Maternity Care Became a Casualty of Idaho's Abortion Ban," Yahoo News, October 2, 2023, https://www.yahoo.com/news/pregnant-no-ob-gyns-around-130000805.html

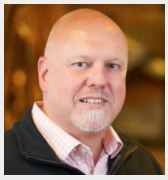
AUTHORS

Michael Topchik
National Leader, Chartis Center for Rural Health
mtopchik@chartis.com



Billy Balfour
Marketing Communications and Client Engagement
wbalfour@chartis.com

Troy Brown
Network Consultant and Performance Improvement Specialist
tbrown@chartis.com



Ana Wiesse
Data Analyst
awiesse@chartis.com

Melanie Pinette
Senior Analyst and Network Consultant
mpinette@chartis.com

CHARTIS

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

CHARTIS