

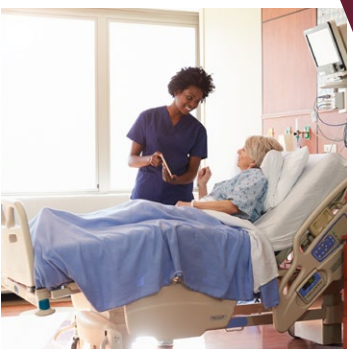
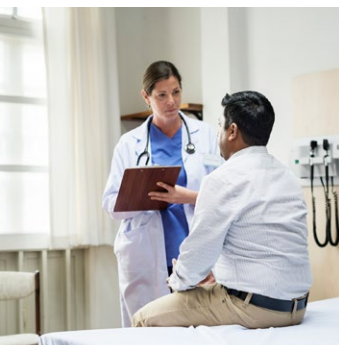


American Hospital Association™

Advancing Health in America

# Rural Hospital Closures Threaten Access

Solutions to Preserve Care in Local Communities





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## Rural Hospital Closures Threaten Access

In rural communities across America, hospitals and health systems are cornerstones for the health and well-being of the patients and communities they serve. Rural hospitals and health systems provide much needed access to affordable, quality health care for patients close to home, and operate as economic anchors in their local communities, supporting good paying jobs and infusing the local economy with spending on goods and services. In 2020, rural hospitals supported one in every 12 rural jobs in the U.S. as well as \$220 billion in economic activity in rural communities.

The vital role of rural hospitals has never been more apparent than during the COVID-19 pandemic, which has hit rural areas **especially hard**. Since the start of the pandemic, rural hospitals and health systems have been on the front lines in providing health care to their communities. Their perseverance is crucial to the nearly 46 million people – 14% of all Americans – living in rural areas across the U.S. who currently face a **significant** shortage of health care services.

Yet 136 rural hospital and health systems have closed from 2010 to 2021 (see Figure 1 below), according to the UNC Cecil G. Sheps Center for Health Services Research, which has had a detrimental impact on their communities in a variety of ways. While rural hospitals were partially buoyed by the Provider Relief Fund and other sources of COVID-19 assistance that limited closures in 2021, the financial outlook for many rural hospitals moving forward is precarious. These closures — whether due to declining financial performance, geographic isolation or low patient volume — have an **outsized impact** on the health and economic well-being of rural communities. Additionally, rural hospitals are disproportionately impacted by issues such as coverage trends, workforce and regulatory barriers.

## Key Findings

- **Between 2010 and 2021, 136 rural hospitals have closed, according to the UNC Cecil G. Sheps Center. Nineteen of these closures occurred in 2020, the most of any year in the past decade.**
- **The majority (74%) of rural closures happened in states where Medicaid expansion was not in place or had been in place for less than a year.**
- **Rural hospitals face significant staffing shortages. Only 10% of physicians in the United States practice in rural areas despite rural populations accounting for 14% of the population. Nearly 70% of the primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.**
- **An AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 shows that slightly more than half of the hospitals that have been closed were independent.**
- **Despite facing ongoing challenges, a number of pathways exist for rural hospitals' financial sustainability.**

**Figure 1 – Overview of Rural Hospital Closures 2010-2021**

YEAR	FULL CLOSURES	CONVERTED CLOSURES	TOTAL CLOSURES
2010	1	2	3
2011	2	3	5
2012	5	4	9
2013	5	8	13
2014	8	8	16
2015	11	6	17
2016	5	5	10
2017	8	2	10
2018	9	5	14
2019	9	9	18
2020	10	9	19
2021	0	2	2
<b>Total</b>	<b>73</b>	<b>63</b>	<b>136</b>

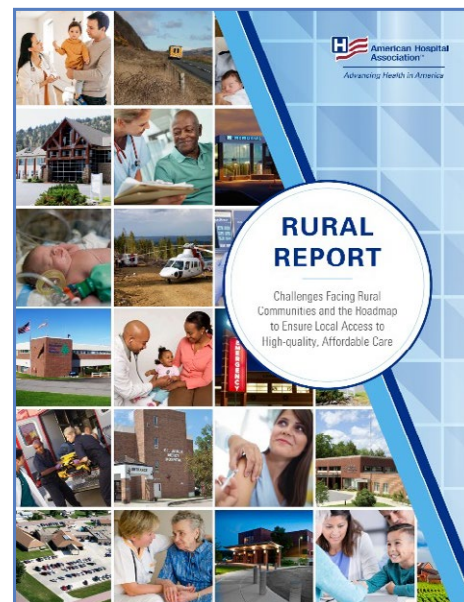
**Source:** [The Cecil G. Sheps Center for Health Services at the University of North Carolina at Chapel Hill](#)

Given their unique constraints, rural hospitals and health systems often need to be resourceful in pursuing opportunities that improve financial stability and viability. Participation in innovative payment models that provide additional investment and flexibilities can be a helpful resource to rural hospitals. Access to capital is important to stabilizing a vulnerable hospital or advancing an innovative one. For some rural hospitals, partnerships, collaborations, mergers or affiliations also can be a good option. Research indicates that these options are important lifelines for rural hospitals, increasing access to **much-needed capital**. It's also shown not to drive closures – contrary to some claims that rural closures are driven by consolidation. An estimated 40% of hospitals may be **financially challenged or distressed** prior to an M&A transaction. These acquisitions are associated with a **3.3% reduction** in annual operating expense per adjusted admission at the acquired hospitals.

### Challenging Demographics

Rural hospitals make up about **35%** of all hospitals in the U.S. Nearly **half** of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby. As a result, in rural hospitals, the acute care occupancy rate (37%) is less than **two-thirds** of their urban counterparts (62%).

Compared to their non-rural counterparts, a significantly higher percentage of rural hospitals are owned by state and local governments – 35% compared to just 13% of urban hospitals. Moreover, a significantly lower percentage of rural hospitals are investor-owned. In 2020, just **11%** of rural hospitals operated as for-profit compared to 34% of urban hospitals.



The COVID-19 pandemic has increased existing pressures on rural hospitals, contributing to declining financial margins and patient volumes. Despite the documented importance of rural hospitals, these continued financial pressures caused a [record number](#) of rural hospital closures in 2020. A variety of factors have contributed to these closures, most notably, financial pressures, challenging patient demographics and staffing shortages. The risk of increased closures has now returned as hospitals deal with the mounting financial challenges created by the pandemic, longstanding difficulties facing rural hospitals and new economic pressures, including rapidly increasing input costs.

## Rural Hospital Closures 2010-2021

Between 2010 and 2021, **136 rural hospitals closed**, with 73 complete closures<sup>1</sup> and 63 converted closures<sup>2</sup> (see Figure 1 above). Nineteen of these closures occurred in 2020, the most of any year in the past decade. Many rural hospitals were in precarious financial positions even before the COVID-19 pandemic, and the pandemic has exacerbated the challenges that many rural hospitals were already experiencing, including workforce shortages, limited access to critical supplies and aging infrastructure.

## Trends Affecting Rural Hospital Financial Sustainability

There are a number of trends driving rural closures, forcing hospitals to take a wide variety of approaches in addressing them. Despite myriad challenging circumstances, there are many pathways for rural hospitals' sustainability. Flexible models of care, decreased regulatory burden and state Medicaid expansion can all support rural hospitals in maintaining access to care for their communities.

### *Patient Volume and Health*

Population densities are categorically lower in rural areas, and as a consequence, rural hospitals have much lower patient volumes. Lower patient volumes makes it challenging for rural hospitals to maintain fixed-operating costs. This has been especially true during the COVID-19 pandemic as patient volumes and patient acuity have been more volatile.

Lower patient volumes also can impede rural hospitals participation in performance measurement and quality improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement. Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. This can limit rural hospitals' participation in innovative payment models that can help improve patient outcomes and provide alternative streams of revenue.

In addition to lower patient volumes, [rural hospitals](#) often treat patient populations that are older, sicker and poorer compared to the national average. For example, a higher percentage of patients in rural areas are [uninsured](#). A 2016 Department of Health and Human Services Assistant Secretary for Planning and Evaluation [issue brief](#) found that 26% of uninsured, rural

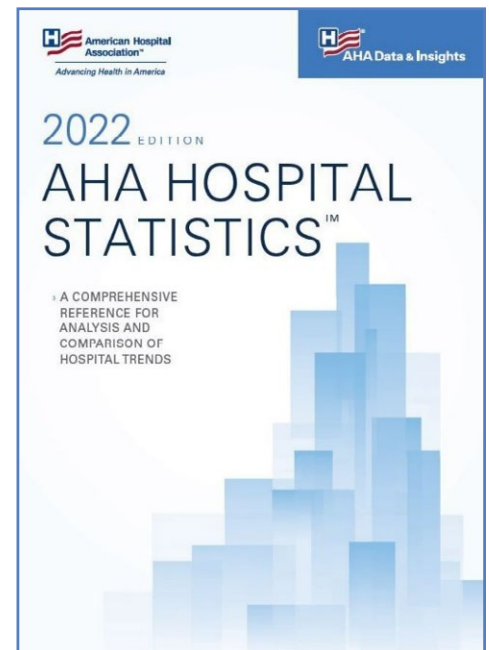
patients delayed seeking care due to cost. These delays contribute to sicker, and subsequently more costly, patients seeking care. These delays in care are further worsened by the fact that people in rural areas face geographic isolation and limited access to transportation to receive care at medical facilities. Indeed, this challenging patient mix and lower volumes strains rural health systems as the resources needed to provide care are more varied and intense than those in other regions.

### *Overcoming Low Reimbursement*

The bulk of rural hospital revenue comes from government payers, of which Medicare comprises nearly half. Yet, both Medicare and Medicaid reimburse less than the cost of providing these services. This resulted in rural hospitals incurring \$5.8 billion in Medicare underpayments and \$1.2 billion in Medicaid underpayments in 2020, on top of \$4.6 billion in uncompensated care provided by rural hospitals. For Medicare reimbursements in particular, these underpayments grew by nearly 40% from 2016 to 2020. Medicare sequester cuts, which to fully resumed July 1, will further strain rural hospital finances.

Because rural hospitals are more likely to serve a population that relies on Medicare and Medicaid, rural hospitals are not able to offset low public program payment rates with revenue from patients with commercial coverage, which often has higher reimbursement rates than government payers. Additionally, two programs designed to address these issues, the Medicare-dependent Hospital (MDH) and enhanced Low-volume Adjustment (LVA) program, which provide vital support to rural hospitals to offset financial vulnerabilities associated with being rural, geographically isolated and low-volume, are scheduled to expire Sept. 30, 2022. COVID-19 relief prevented many closures in 2021 but as that assistance expires, the financial position of many rural hospitals, especially MDH and LVA hospitals, is grim. In 2020, one in five rural closures were MDHs. Extending these programs or making them permanent will be critical to these rural hospitals moving forward. In 2020, one in five rural closures were MDHs.

In the commercial insurance market, rural hospitals are often forced to accept below average rates or are left out of plan networks entirely. Rural hospitals with low commercial patient volume and a lack of market power are often forced to “take it or leave it” when large insurers refuse to negotiate. In cases where rural hospitals are, in effect, excluded from certain plan networks due to unfair insurer negotiation tactics, patient access can be negatively affected. Many patients residing in rural areas may already have to drive long distances to seek in-network care. Plan practices that restrict access to network providers in rural areas further exacerbate these challenges by impeding timely patient access to care, compromising the stability of rural health care providers, and circumventing the intent of network adequacy requirements.



Additionally, affordable coverage remains a pressing challenge facing the health care system. Lack of health insurance coverage in rural areas results in high uncompensated care costs for hospitals. Medicaid expansion is one policy that has helped rural hospitals remain viable. The majority (74%) of rural closures happened in states where Medicaid expansion was not in place or had been in place for less than a year. Research has found that Medicaid expansion has been associated with improved hospital financial performance and lower likelihood of closure, especially in rural areas that had many uninsured adults prior to expansion.

### *Managing Staffing Shortages*

Rural hospitals face significant staffing shortages. Only 10% of physicians in the United States practice in rural areas despite rural populations accounting for 20% of the population. Nearly 70% of the primary care Health Professional Shortage Areas (HPSAs) are located in rural or partially rural areas.

The shortage of primary care services has detrimental effects on the overall health of rural populations. For example, health outcomes in rural areas are significantly lower compared to more densely populated regions. Additionally, while clinical care shortages exist across the care continuum, the shortage of behavioral health and substance abuse professionals in rural populations is immense. Recent research finds that 65% of rural counties do not have a psychiatrist; 47% do not have a psychologist; and 81% do not have a psychiatric nurse practitioner. Clinician shortages are difficult to fill as rural hospitals find it challenging to recruit and retain qualified practitioners.

The COVID-19 pandemic has only worsened existing staffing shortages. At the height of the January 2022 omicron surge, nearly one-third of hospitals indicated that they were anticipating critical staffing shortages. These shortages have pushed hospitals to utilize incredibly expensive contract labor firms to bolster staffing when there are surges in patient volume. Average pay for hospital contract nurses has more than doubled over the course of the pandemic, increasing labor expenses by more than 50% on a per adjusted discharge basis compared to pre-pandemic levels. For rural hospitals, the rising costs for labor can be especially challenging when close to half of rural hospitals already have negative operating margins.

Recruitment and retention of health professionals has long been a persistent challenge for rural providers. Acute workforce shortages and increasing labor expenses resulting from the pandemic have placed additional pressure on rural hospitals. Many rural providers are seeking novel approaches to recruit and retain staff. Existing federal programs, such as the National Health Service Corps, work to incentivize clinicians to work in rural areas. Other programs, such as the Rural Public Health Workforce Training Network Program, help rural hospitals and community organizations expand public health capacity through health care job development, training and placement. Additional and continued support to help recruit and retain health care professionals in rural areas is needed from state and federal governments.



## Navigating COVID-19 and Rising Input Costs

Hospitals and health systems are facing significant financial instability due to the COVID-19 pandemic. Expenses for labor, drugs, purchased services and personal protective equipment have all increased compared to pre-pandemic levels. For example, drug expenses have increased dramatically, **36.9%** on per patient bases, compared to pre-pandemic levels. Hospitals also are seeing sicker patients requiring longer hospital stays, with average length of stay up **9.9%** compared to pre-pandemic levels. However, patient volume, particularly among outpatient centers, has not returned to pre-pandemic levels. Discharges are down **16%** compared to pre-pandemic levels. Hospitals are continuing to utilize more expensive labor, drugs and other supplies and seeing higher acuity patients, while patient volume continues to fluctuate with COVID-19 surges.

At the same time, rural communities were especially hit **hard** by the pandemic with sicker patients seeking care. Rural hospitals have been forced to cancel or postpone non-emergent procedures to adjust for the influx of COVID-19 patients. The loss of outpatient revenue significantly impacts how rural hospitals can remain viable, especially given that the national median for outpatient revenue, as a percentage of total revenue, is **77%**. Indeed, under this pressure, some rural hospitals have **struggled** to maintain access to health care services. By the fall of 2020, more than **three dozen** hospitals had already gone bankrupt.

The federal government developed funding programs to help rural hospitals sustain services during the COVID-19 pandemic. Rural hospitals received COVID-19 relief funds from the Coronavirus Aid, Relief and Economic Security (CARES) Act and the American Rescue Plan Act. As these funding streams run out, however, rural hospitals will once again shoulder the brunt of the costs incurred by the pandemic, putting them in a financially precarious position moving forward. Of particular note is that in 2021 only two rural hospitals closed. The critical support from the Provider Relief Fund and sources of COVID-19 relief certainly proved to be a lifeline to many rural hospitals, contributing to a temporary slowdown of the alarming trend of rural closures. Without additional relief and halting payment cuts, we will likely see more years of record rural closures, with devastating impacts to the communities they serve.

Additionally, the Centers for Medicare & Medicaid Services (CMS) utilized waiver authority tied to the Public Health Emergency to enable the expansion of telehealth services during the COVID-19 pandemic. These flexibilities have had a huge impact on rural hospitals, who used

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**Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems**  
Hospitals are experiencing significant increases in expenses for workforce, drugs and medical supplies

**Introduction**

For over two years since the outset of the COVID-19 pandemic, America's hospitals and health systems have been on the front lines caring for patients, comforting families and protecting communities. With over 80 million cases<sup>1</sup>, nearly 1 million deaths<sup>2</sup>, and over 4.6 million hospitalizations<sup>3</sup>, the pandemic has taken a significant toll on hospitals and health systems and placed enormous strain on the nation's health care workforce. During this unprecedented public health crisis, hospitals and health systems have confronted many challenges, including historic volume and revenue losses, as well as skyrocketing expenses (See Figure #1).

Hospitals and health systems have been nimble in responding to surges in COVID-19 cases throughout the pandemic by expanding treatment capacity, hiring staff to meet demand, acquiring and maintaining adequate supplies and personal protective equipment (PPE) to protect patients and staff and ensuring that critical services and programs remain available to the patients and communities they serve. However, these and other factors have led to billions of dollars in losses over the last two years for hospitals, and over 33% of hospitals are operating on negative margins.

The most recent surges triggered by the delta and omicron variants have added even more pressure to hospitals. During these surges, hospitals saw the number of COVID-19 infected patients rise while other patient volumes fell, and patient acuity increased. This drove up expenses and added significant financial pressure for hospitals. Moreover, hospitals did not receive any government assistance through the COVID-19 Provider Relief Fund (PRF) to help mitigate rising expenses and lost revenues during the delta and omicron surges. This is despite the fact that more than half of COVID-19 hospitalizations have occurred since July 1, 2021, during these two most recent COVID-19 surges.

At the same time, patient acuity has increased, as measured by how long patients need to stay in the hospital. The increase in acuity is a result of the complexity of COVID-19 care, as well as treatment for patients who may have put off care during the pandemic. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019.<sup>4</sup>

As hospitals treat sicker patients requiring more intensive treatment, they also must ensure that sufficient staffing levels are available to care for these patients, and must acquire the necessary expensive drugs and medical supplies to provide high-quality care. As a result, overall hospital expenses have experienced considerable growth.

Data from Kaufman Hall, a consulting firm that tracks hospital financial metrics, shows that by the end of 2021, total hospital expenses were up 11% compared to pre-pandemic levels in 2019. Even after accounting for changes in volume that occurred during the pandemic, hospital expenses per patient increased significantly from pre-pandemic levels across every category. (See Figure #1)

**Figure #1: Increase in Hospital Expenses Per Patient from 2019 to 2021**

Category	Increase (%)
Drug	36.9%
Labor	19.1%
Supply	20.6%
Total	20.1%

Source: January 2022 Kaufman Hall National Hospital Flash Report

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these telehealth waivers to increase access, avoid hospitalizations and improve outcomes. Without congressional action, however, these waiver flexibilities will expire, jeopardizing the progress made to increase patient access over the last two years.

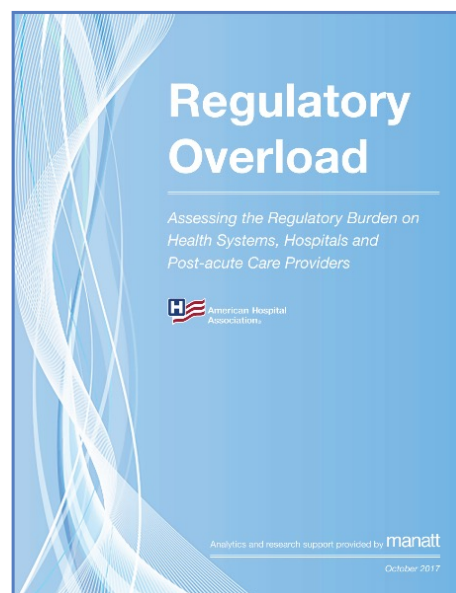
### *Implementing Flexible Models of Care*

Rural hospitals can employ new models of care and embark on pathways to transformation, but they need flexibility and resources to be successful. In 2020, the CMS **announced** a new value-based payment model for rural health care providers called the Community Health Access and Rural Transformation (CHART). The new payment model would provide increased financial stability through predictable upfront payments, as well as increased operational and regulatory flexibility for care delivery.

Additionally, new legislation in 2020 also established the Rural Emergency Hospital designation under Medicare allowing critical access hospitals and certain small, rural hospitals to meet a community's need for emergency and outpatient services without also providing inpatient care. This designation would help ensure patients in rural communities maintain access to essential emergency and outpatient services and support rural hospitals' ability to remain financially viable, serving as a critical access point for their communities. These models are promising, but additional opportunities are needed to develop and expand successful models for rural communities.

### *Overcoming Regulatory Barriers*

Rural hospitals face a number of regulatory burdens that impact their ability to provide care. According to a 2017 AHA **study**, the nation's hospitals, health systems and post-acute care providers spend \$39 billion each year on non-clinical regulatory requirements. While rural hospitals are subject to the same regulations as other hospitals, lower patient volumes mean that, on a per-discharge basis, their cost of compliance is often higher than for larger facilities. For example, while Medicare's Conditions of Participation (CoPs) and other compliance metrics are important to ensure the safe delivery of care, future CoPs should be developed with more flexibility and alignment with other laws and industry standards. Rural hospitals can protect their communities' access to health care by receiving relief from outdated and unnecessary regulations.



### *Exploring Partnerships, Collaborations, Mergers, and Affiliations*

For some rural hospitals, partnerships, collaborations, mergers and affiliations can be effective options to preserve access to care in their communities. Hospital partnership, collaboration, merger and affiliation activity has **increased significantly** in the past decade, with hospitals and health systems looking to create operational, strategic and financial value to help them meet

their mission of caring for patients and communities. A main driver is the pursuit of [economies of scale](#), the ability to decrease unit costs, or to improve productivity and outcomes through increased volumes. For example, a hospital that does not offer a particular service line may seek a joint venture partnership with a leading organization in the field. A hospital in severe financial distress with little prospect of significant capital investments may look to engage in a merger and acquisition arrangement. Having this access to capital is particularly important for rural hospitals, since they face additional challenges such as aging infrastructure and new technology investments for telehealth and broadband.

Increasingly, rural hospitals and health systems have sought varying forms of integration. Despite claims by some that consolidation drives rural closures, the data clearly show that system affiliation is not driving this trend. For example, even though most rural community hospitals are affiliated with a health system, an AHA analysis of the UNC Sheps Center rural hospital closure data between 2010 and 2020 shows that less than half of the hospitals that have been closed were system affiliated. This would indicate that of all the challenges facing rural hospitals that contribute to closures, being part of a system is likely not one of them.

These integrations cannot only preserve patient access to care, but they also can enhance quality of care. They have given rural hospitals the ability to provide resources for patient support and engage in partnerships with larger employers to increase access. Additionally, they also have given rural hospitals the ability to obtain capital at an [affordable cost when traditional funding from state and federal capital programs has been difficult to secure](#).

## Conclusion

To mitigate rural hospital closures, hospitals continue to explore strategies that allow them to remain viable within the community. Although rural hospitals have long faced circumstances that have challenged their survival, we will most likely see more rural hospital closures as they attempt to adapt to the unprecedented challenges brought on by the COVID-19 pandemic. Rural hospitals also require increased attention from state and federal government to address barriers and invest in new resources in rural communities. The [AHA continues to support policies](#) that would help address these challenges, including:

1. Extending the MDH program (Rural Hospital Support Act, S.4009, and Assistance for Rural Community Hospitals Act, H.R.8747).
2. Extending the LVA program (Rural Hospital Support Act, S.4009, and Assistance for Rural Community Hospitals Act, H.R.8747).

**Without the appropriate support and evaluation of existing policies by the state and federal government, rural hospitals will continue to be on life support.**